

# BMJ Open Barriers to access of healthcare services by the immigrant population in Scandinavia: a scoping review protocol

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## ABSTRACT

**Introduction** Access to healthcare services for legal immigrants in Scandinavia is part of the policy agenda of the various governments as they strive to provide equal healthcare services to its citizens. Legal immigrants have the same rights as natives; however, studies have shown that there are inequalities in access to healthcare services between legal immigrants and natives. The extent of access depends on several factors, including organisational, social, financial and cultural factors. The lack of these factors acts as a barrier to access of healthcare services. The aim of this review is to map and report the evidence available on the barriers to access of healthcare services by legal immigrants in Scandinavia.

**Methods and analysis** We will adopt the six-stage framework developed by Arksey and O'Malley: (1) identifying the research question(s); (2) searching for relevant studies; (3) selecting studies; (4) charting the data; (5) collating, summarising and reporting the results; (6) conducting consultation exercises refined by Levac *et al* and the Joanna Briggs Institute. The search strategy for this scoping review will involve electronic databases including Ovid Medline, PsycINFO, Ovid EMBASE, PubMed and Google Scholar, in addition to grey literature from websites of relevant organisations. Data will be extracted and charted by two independent reviewers. A narrative summary of the findings will be presented.

**Ethics and dissemination** This is a review of the literature and all data will be obtained from publicly available materials; therefore, ethics approval is not required. The findings from this study will be disseminated as publications in peer-reviewed journals, at relevant national and international conferences, and as presentations to the health authorities in several municipalities in the Trøndelag region of Norway.

## INTRODUCTION

Migration is rising worldwide as people move from their home countries voluntarily to work or join family members in foreign countries due to wars and political unrest that have increased in many parts of the world in recent years, leading to people being forcibly uprooted from their home countries to seek refuge in foreign countries. The Scandinavian countries of Norway, Sweden and Denmark have many political and social similarities, and like the rest of Europe, have

## Strengths and limitations of this study

- This proposed scoping review will map current knowledge on barriers to access of healthcare services by legal immigrants in Scandinavia, which is, to the best of our knowledge, the first such review on this important topic.
- The search strategy includes studies conducted in English and the three Scandinavian languages. This will ensure that a wide range of literature relevant to the review questions will be accessed and the findings can be widely applied to policies and practices.
- As scoping reviews do not assess the quality of evidence and risk including bias of the reviewed studies, the findings from this review will be subject to the strengths and limitations of the included studies.

experienced a continuous inflow of immigration during the last five decades, although in varying degrees.<sup>1–3</sup> There are different categories of immigrants, with the two main categories being legal and illegal immigrants. A legal immigrant is a person of foreign birth who has a right to enter, settle and work in a country with no restrictions, having the same rights and obligations as the native population.<sup>4</sup>

Access to healthcare services by legal immigrants has been identified as a challenge in the Scandinavian countries as studies have shown that immigrants are not able to access healthcare in the same way as natives.<sup>5–6</sup> Financial constraint was found to be one of the major barriers in accessing healthcare in some countries.<sup>7</sup> Scandinavian health systems are built on the principles of universalism and equity and financed primarily through taxation.<sup>1–8–9</sup> There are co-payments at consultation and for the cost of prescription drugs in Norway and Sweden.<sup>10</sup> In Denmark, consultation is largely free of charge,<sup>11</sup> but there is co-payment for prescription drugs.<sup>12</sup> The patient co-payments are capped at modest levels in relation to the standard of living in these countries. For example, in Norway, the annual payment is capped at 2369 Kr in 2019



(approximately US\$259).<sup>13</sup> This system of heavily subsidised or free healthcare service is to ensure that healthcare service coverage is universal.<sup>14</sup> Access to primary care in the three countries is largely through the general practitioner; however, some differences exist in how the access is organised.<sup>10 15</sup> In Denmark and Norway, all citizens can choose or be assigned to a general practitioner and are listed with that general practitioner whereas in Sweden, citizens are not listed with specific practitioners but can register with a primary care centre.<sup>10</sup> Immigrants with legal residence status in the three countries are guaranteed the same access to healthcare as native-borns and there are no special assessment charges for refugees with legal residence. Furthermore, healthcare laws and regulation in these countries demand equal care for all inhabitants regardless of their level of language proficiency hence interpreters are required to interpret to patients with poor language proficiency during clinical consultations.<sup>16–18</sup> Despite the efforts to ensure equal access to healthcare services by the immigrant population in the Scandinavian countries as described above, studies have shown that inequalities in access to healthcare exist in practice and immigrants are unable to access healthcare in the same manner as natives.<sup>5 6</sup> The question of interest is, what are the factors that prevents legal immigrants in Scandinavia from accessing healthcare effectively?

Studies have shown that immigrant health overall is poorer than that of the natives.<sup>7 9</sup> Generally, studies show that on arrival in host countries, immigrant health is better than that of the natives when measured through self-report and health indicators.<sup>7 8 19</sup> After a while in the host country, this phenomenon called ‘healthy migrant effect’ wears off and their health seems to decline.<sup>7 9</sup> Holmboe-Ottesen and Wandel<sup>20</sup> found, for example, that compared with ethnic Danes, the prevalence of type 2 diabetes was higher among immigrants. Furthermore, some immigrants are also susceptible to poor health due to exposure to numerous health hazards before, during and after immigration.<sup>21</sup> Hence, the evidence suggests that immigrant health overall is poorer than that of the natives, and therefore, intervention is needed to improve the situation. Some of the explanations given for poorer immigrant health after a period of stay in the host country are that immigrants tend to use healthcare services less frequently than native residents, terminate treatment early and receive lower-quality healthcare.<sup>22</sup> It is therefore important to ensure equal access to healthcare services in practice for all citizens.

### Access to healthcare

Conceptualisation of ‘access to healthcare services’ ranges from the narrow approach of services entry to the multidimensional approach including availability, accessibility, affordability, acceptability and accommodation.<sup>23</sup> According to Gulliford *et al*,<sup>24</sup> the opportunity for a community to gain access of healthcare services exists only if the services are available and supplied adequately, and the extent of access depends on organisational,

social, financial and cultural barriers. Barriers are the factors that prevent an individual from gaining access to healthcare services. Hence, identifying barriers to accessing healthcare services and understanding factors that can influence access to services may improve the delivery of primary and secondary healthcare services to immigrants with legal residence in Scandinavia. Factors such as language proficiency, cultural differences, lack of education or knowledge of the system, lower economic status and lack of culturally sensitive healthcare services have been shown to impede access to healthcare services among the immigrant population in several studies.<sup>2 25–28</sup>

We have not identified any review on the topic of barriers to access of healthcare services by legal immigrants in Scandinavia, except a master’s thesis by a student. Reviews on the topic are also limited in the literature.<sup>29</sup> The few available reviews include those by Woodward *et al*<sup>29</sup> about undocumented immigrants in the European Union, and Kalich *et al*<sup>30</sup> about migrants in Canada. The literature search for the aforementioned thesis was conducted in 2017 and included only studies in English. However, the preliminary search for studies included some relevant studies published in the Scandinavian languages<sup>31 32</sup> in addition to many studies in English. Furthermore, the proposed scoping review will include the optional sixth stage from the scoping review strategy proposed by Arksey and O’Malley.<sup>33</sup> The results from this scoping review will form the basis for future research. It is also hoped that the findings will help shape guidelines dealing with access to healthcare services for legal immigrants at the municipal level since the findings will be presented at workshops at the local level.

### Objective

The main objective of this scoping review is to map and report the evidence on the barriers to access of healthcare services by legal immigrants in Scandinavia available in the literature.

### METHODS AND ANALYSIS

Scoping reviews aim to identify and map key concepts, types of evidence and gaps in research related to a defined area of the field by searching, selecting and synthesising existing knowledge.<sup>34</sup> We will conduct a scoping review on barriers to access to healthcare services for legal immigrants in Scandinavia. Arksey and O’Malley’s<sup>33</sup> six-stage approach which are (1) identifying the research question; (2) identifying relevant studies; (3) selecting studies; (4) charting the data; (5) collating, summarising and reporting the results; and (6) expert consultation (optional and included) refined by Levac *et al*<sup>35</sup> and the Joanna Briggs Institute,<sup>36</sup> and will be adhered to in the planned review. This scoping review’s protocol follows the Preferred Reporting Items for Systematic Reviews and Meta-analysis Protocols Extension for Scoping Reviews (PRISMA-ScR).<sup>37</sup>

### Stage 1: identifying the research question

The nature of scoping reviews demands a broad research question as the focus is on summarising breadth of evidence.<sup>35</sup> Drawing on our healthcare services experiences, we (LA and FF) discussed and formulated a broad research question, namely, “What are the barriers to access to healthcare services for legal immigrants in Scandinavia?” The rationale behind this broad question is the recognition that barriers to access to healthcare services by immigrants exist in the Scandinavian countries<sup>38</sup> and the various governments’ quest for evidence that can be used in policy formulation to change the situation. We defined the concept, target population and context applicable to our review as recommended by Levac *et al*<sup>35</sup> and JBI guidelines.<sup>39</sup> The population of interest is the legal immigrants residing in Scandinavia. Refugees are included in this group as they have the right to live in the countries. Studies that include asylum seekers, undocumented migrants, tourists and students will not be considered. The rationale behind the exclusion of these groups is that some of them do not have full access to healthcare services, for example, undocumented migrants and asylum seekers that overstay, or have a different type of healthcare service coverage (eg, tourists and some student groups). This review focuses on legal migrants that should have full access to healthcare services. The concept of interest is barriers to access to all types of healthcare services for immigrants in Scandinavia as reported by legal immigrants and health personnel. The context is Scandinavian, meaning studies on all legal immigrants living in these countries’ communities and having the same rights as the natives, irrespective of where they migrated from, will be considered. The context is limited to Scandinavia because while some reviews on the

topic have been conducted elsewhere, we have not identified any review on the topic in Scandinavia and we want to fill this knowledge gap.

### Stage 2: identifying relevant studies

The second stage of the planned scoping review will involve identifying relevant studies through a systematic search to select and extract data. We will develop literature search strategies using text words and medical headings related to the study’s population, concept and context, as shown in [table 1](#). The searched databases will include Ovid Medline, CINAHL, PsycINFO, Ovid EMBASE, PubMed, Google Scholar and the WHO website. Furthermore, as recommended by Godin *et al*,<sup>40</sup> we will search for relevant grey literature by scanning the websites of relevant organisations, including WHO, the New York Academy of Medicine Library’s grey literature database, greylit.org, as well as relevant websites of the various countries. Finally, to explore all potential sources of information, the reference lists of all selected articles will be scanned for relevant articles. An initial limited search of Ovid Medline and Ovid PsycINFO on 16 June 2019 identified articles on the topic. The text words contained in the relevant articles’ titles and abstracts, and index terms used to describe the articles were used to develop a full search strategy for the Ovid Medline database, generating 418 articles. An updated search on 22 November 2019 for Ovid Medline database using the same full search strategy with ‘refugee’ as an additional search word yielded 64 articles (see online supplementary appendix 1). The same procedure will be used for the planned review. The search strategy, including all identified keywords and index terms, will be adapted to each data source. The database search queries will be set to select articles published between 2007 and

**Table 1** PCC grid showing identified search terms with truncated keywords and MeSH terms for the PubMed search

	Population	Concept	Context
Text word	“migrants” “emigrants” “immigrants” “refugees” “transients” “access” “delivery” “transients and migrants”(MeSH)	“healthcare delivery” “disparities” “health services” “accessibility” “healthcare disparities” “health services need” “usage” “barrier” “barriers” “facilitator” “access” “health services need” “emergency care”	“emigration and immigration”(MeSH) “primary healthcare”(MeSH) “emergency treatment”(MeSH) “emergency care” “Norway” “Denmark” “Sweden” “Scandinavian” “nursing homes”(MeSH) “hospitals”(MeSH)
PubMed	“emigrants and immigrants”(MeSH) “immigrant” “transients and migrants” “migrant” “transients”	“healthcare disparities”(MeSH) “health services”(MeSH) “health services accessibility”(MeSH) “community health services” “community healthcare” “emergency medical services”(MeSH) “healthcare”	“healthcare services”(MeSH) “primary healthcare”(MeSH) “health services accessibility” “utilisation” “emergency treatment” “Scandinavian and Nordic countries”(MeSH) “nursing homes” “hospital” “pharmacists”(MeSH) “emigration and immigration”(MeSH)

PCC, Population, Concept and Context.

2019 in English, Danish, Norwegian and Swedish. The preliminary search that was not limited by publication year revealed that most of the Scandinavian immigrant health studies were post-2007, hence the limitation of the publication date was set as 2007. All three authors understand the Scandinavian languages and will read and interpret the identified articles themselves. Search results will be downloaded into a citation management system, where the articles will be screened for inclusion. The electronic search will be documented by stating the date, keyword searched, search engine used, number of publications retrieved and number of publications selected.

### Stage 3: study selection

Titles and abstracts of the identified studies from stage 2 will be screened independently by two authors (LA and FF). These criteria must be met for inclusion of the studies in the scoping review:

1. They refer to barriers to access of healthcare services by legal immigrants.
2. They were conducted in one or more of the Scandinavian countries.
3. They are published in English or any of the Scandinavian languages.
4. They can be full reports of studies using different methodologies and designs, including qualitative studies, quantitative and mixed methods, and cross-sectional and systematic reviews.
5. They are primary research and review articles published in peer-reviewed journals, open grey literature, or theses and dissertations addressing the research question. Conference papers will not be included.

Studies will be excluded if:

1. They include illegal immigrants or solely use illegal immigrants as participants.
2. They are conducted in countries other than Norway, Denmark and Sweden.
3. They are published earlier than 2007.
4. They are published in languages other than those in the inclusion criteria.

The full text of potentially relevant studies will be retrieved and the full text of selected studies will be assessed thoroughly by the same authors using the inclusion criteria. Reasons for exclusion of full-text studies not meeting the inclusion criteria will be recorded and reported in a PRISMA flow diagram. Any disagreements between the reviewers at each stage of the study selection process will be resolved through discussion or a third reviewer (PUP). The search results will be reported in full in the final systematic review and presented in the PRISMA flow diagram.

### Stage 4: charting the data

After the studies have been identified for inclusion in the review, data will be extracted and charted by the same two authors. A data extraction form from the Joanna Briggs Institute<sup>36</sup> will be adapted to collect key information including relevant details about the population,

concept, context, study methods and key findings (see online supplementary appendix 2). To ensure common understanding of the extraction tool, we will organise a trial data charting where both reviewers will chart the same studies (10% of all identified studies) and compare the findings, after which each reviewer will work independently with the remaining studies. Any disagreements between the reviewers will be resolved through discussion, and if necessary, a third reviewer. The draft data extraction tool will be modified as necessary during the data extraction process. Modifications will be detailed in the full scoping review report and as an appendix if the modifications require a lengthy explanation.

### Stage 5: collating, summarising and reporting the results

The next stage of the scoping review process will involve summarising, collating and reporting the results as was done in Arksey and O'Malley's<sup>33</sup> study. A narrative summary mapping the findings from the extracted data will accompany the tabulated results and describe how the results relate to the review's objective and question.

### Stage 6: expert consultation

Six public health nurses, two doctors and two pharmacists with experience in scientific research who work directly with immigrants in the Health Service will be approached for consultation. The aim of the consultation is to share and discuss our preliminary findings and interpretations with the experts who work in the field to elicit their views on our findings and find out whether they would be able to identify any additional barriers that have not yet been published. The consultation will also be used as an avenue to disseminate our findings by knowledge transfer. The experts will be recruited from our network in Norway and Denmark. The methodology for the consultation will be individual interviews. We will first send the preliminary findings and outline of our preliminary interpretations to the experts, and then follow up with the interview, which will be recorded. The transcriptions from the interviews will be analysed using thematic analysis and the findings will be presented under the heading 'Expert Consultation' in the article.

### Patient and public involvement

Patients and public were not involved in the preparation of this protocol and will not be involved in the final scoping review.

## DISCUSSION

The proposed review will summarise the main results including overviews, themes and types of evidence available in relation to the review question and study objectives. In a scoping review, all available literature on a subject or field can be included in the study, enabling an in-depth and broad result. As scoping reviews do not assess the quality of evidence and risk including bias of the included studies, the findings from this review will be subject to the strengths and

limitations of the included studies. Reviews of studies about the barriers to healthcare services among legal immigrants in Scandinavia is lacking in the literature. The findings from the scoping review will be used as a basis for future research and will be disseminated as publications in peer-reviewed journals, at relevant national and international conferences, and as presentations to the health authorities in several municipalities in the Trøndelag region of Norway.

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