Original Article

Healthcare Services Access, Use and Barriers among Migrants in Europe: A Systematic Review

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Abstract

Background: The issue of migrants health and access to health services is dynamic and complex posing a challenge to health systems worldwide.
Aim: To investigate migrants' access to health services in European countries, the use of health services by migrants and the barriers encountered by migrants in the use of health services.
Material and methods: The search was conducted in January 2022 in five databases; PubMed, Medline, Web of science, Scopus and Cinahl. We used the following keywords: migrants, immigrants, use, access, utilization, healthcare services, services, needs, health, difficulties, barriers. The inclusion criteria were the following: (a) the studies investigated the access of migrants to health services, the use of health services by migrants and the barriers encountered by migrants in using health services. (b) migrants self-assessed access, use and barriers. (c) studies were conducted in European countries. (d) studies included adult migrants. (e) the language of articles was English.
Results: Sixty-five studies were met our inclusion criteria. among studies, 89.2% were quantitative and 11.8% were qualitative. All quantitative studies were cross-sectional. for data collection, 58.5% of studies used questionnaires and 30.8% used historical files. Also, personal interviews were performed in 9.2% of studies and focus groups in 1.5% of studies. in our studies, 73.8% of natives stated that they had better access to health services and used health services better than migrants, while 26.2% found that migrants stated that they had better access to health services and used health services better. The most common barriers were the following: inability to understand the language and communicate, lack of insurance, lack of information and knowledge, lack of family support, low educational level, short duration of stay in the country of migration, low income, lack of a family doctor and high costs.

Conclusions: Migrants face several barriers both in accessing and using health services in Europe. Intensive efforts are needed to increase migrants' knowledge, implement culturally sensitive interventions in migrant communities and better inform healthcare professionals so that they can approach migrants more effectively.

Keywords: migrants, Europe, access, use, barriers, healthcare, services

Introduction

The high mobility of populations, the economic crisis and the significant increase in unemployment have defined the last decades, with the economic crisis affecting vulnerable groups, such as migrants. Thus, a particular aspect of health inequalities has emerged, which mainly concerns the barriers and difficulties encountered by migrants in accessing healthcare services, which has a direct impact on the quality of the services provided. The Americas is the continent with the largest number of migrants, with the number increasing from 47 million in 2000 to 60 million in 2012 (Loue & Sajatovic, 2012). The situation is similar in Europe, with migrants making up around 9% of the total population (Loue & Sajatovic, 2012). In fact, in Europe, 7-13% of migrants do not have legal residence documents (Karl-Trummer et al., 2010).

Access to high quality health services is an extremely important issue for migrants, as they face unequal opportunities for treatment interventions (The Lancet Public Health, 2018). The growing migrant population is also reflected in the increasing need for health services. For this reason, a corresponding adjustment of health policies at international level is required to better provide health care for migrants (Macpherson et al., 2007). Indeed, in recent years the issue of migrants' health has expanded from providing health care to patients to health promotion and prevention. The World Health Organization plays an essential role in better addressing health issues related to migrants (World Health Organization, 2008).

The issue of migrants health and access to health services is dynamic and complex, involving different stages of migration such as the pre-migration period, the first years of migration and migrants after several years of residence in the host country (Lassetter & Callister, 2009; Ullmann et al., 2011). Furthermore, this issue is also related to various social determinants that are not only related to the characteristics of migrants, e.g. gender, cultural diversity, experiences, etc., but also to the cultural environment of the host countries, e.g. the health care system, living conditions, moral, religious and cultural values, etc. (Malmusi et al., 2010; Spallek et al., 2011).

Migrants and their children are less often insured and use health services less often than natives (Abe-Kim et al., 2007; Alegría et al., 2006; Callahan et al., 2006; Cunningham, 2006; Guendelman et al., 2001; Huang et al., 2006; Jackson et al., 2007; Javier et al., 2007; Lasser et al., 2006; Yu et al., 2006). In addition, the cost of health care for migrants is lower, with the exception of the cost of emergency care for migrant children (Derose et al., 2009).

The aim of this systematic literature review was to investigate migrants' access to health services, the use of health services by migrants and the barriers encountered by migrants in the use of health services.

Material and Methods

The search was conducted in January 2022 in five databases; PubMed, Medline, Web of Science, Scopus and Cinahl. We used the following key-words: migrants, immigrants,

use, access, utilization, healthcare services, services, needs, health, difficulties, barriers.

The inclusion criteria were the following: (a) the studies investigated the access of migrants to health services, the use of health services by migrants and the barriers encountered by migrants in using health services. (b) migrants self-assessed access, use and barriers. (c) studies were conducted in European countries. (d) studies included adult migrants. (e) the language of articles was English

Studies that included in the systematic literature review are presented in Table 1, while the flowchart is presented in Figure 1.

Results

Sixty-five studies were met our inclusion criteria. Countries that studies were conducted in our review were Spain, Italy, United Kingdom, Greece, Austria, Belgium, France, Netherlands, Wales, Portugal, Germany, Denmark, Switzerland, Norway, Sweden and Czech Republic.

Among studies, 89.2% were quantitative and 11.8% were qualitative. All quantitative studies were cross-sectional. In qualitative studies, the minimum sample size was 10 and the maximum number was 55, while in the quantitative studies, the minimum sample size was 74 and the maximum number was 3,739,244.

For data collection, 58.5% of studies used questionnaires and 30.8% used historical files. Also, personal interviews were performed in 9.2% of studies and focus groups in 1.5% of studies.

Natives were also included in 73.8% of studies allowing comparisons with migrants. In these studies, 73.8% of natives stated that they had better access to health services and used health services better than migrants, while 26.2% found that migrants stated that they had better access to health services and used health services better.

Among studies, 18.5% investigated migrants' access to health services in general, while 81.5% investigated access to specific health services, such as primary health care services, general practitioner, emergency department, hospitalization, etc.

The barriers faced by migrants in accessing and using health services are shown in Table 2. The most common barriers were the following: inability to understand the language and communicate, lack of insurance, lack of information and knowledge, lack of family support, low educational level, short duration of stay in the country of migration, low income, lack of a family doctor and high costs.

The barriers that migrants face in accessing and using health services can be summarized in the following five broad categories: social and economic barriers, health system-related barriers, cultural barriers, knowledge-related barriers and personal barriers.

Social barriers included low educational attainment, lack of insurance, high costs, low income, frequent travel, limited social integration and inability to understand language and communication.

Barriers related to the health system included lack of a family doctor, limited understanding of doctors' instructions, long waiting time, difficulties in access, lack of translators and living in rural areas.

Cultural barriers included stigma, shame and modesty on the part of females and religious beliefs.

Knowledge-related barriers included lack of knowledge about how to access and navigate the health system, lack of knowledge about screening, perception that screening is unnecessary and self-perception of good health status.

Personal barriers include lack of family support, short length of stay in the country of migration, fear, lack of time, anxiety, lack of confidence and functional incapacity.

Discussion

According to our review, migrants face several barriers both in accessing and using health services.

Firstly, there are significant social and economic barriers that limit migrants' access to

health services, as well as their use. More specifically, low social and economic level, as well as living in areas characterized by low income, is a determining factor that reduces the use of health services by migrants, especially those services related to screening, such as in the case of mammography (Ahmad et al., 2012; Donnelly et al., 2009). In many cases, migrants with low social and economic status are paid an hourly rate, resulting in the use of health services leading to lost time and thus reduced income (Donnelly et al., 2009; Meana et al., 2001). This is supported by the fact that moving to health services requires some costs. A typical example is women with a low level of education and limited social integration, who make very little use of screening services (Donnelly et al., 2009; Meana et al., 2001). It is noted that low educational and economic level also leads to a lack of knowledge and understanding which further limits the use of health services by migrants. It is clear that the high cost of some services acts as a deterrent to their use by migrants, as they are unable to cover it (Lobb et al., 2013).

Inability to understand the language is an extremely important barrier faced by migrants, as it leads to inability to communicate, frustration and ultimately abandonment of efforts to use health services (Ahmad et al., 2012; Sun et al., 2010; Todd et al., 2011; Woloshin et al., 1997). Language difficulties reduce the ability of migrants to communicate with healthcare staff and understand their instructions. In addition, the ability of migrants to inform themselves and increase their knowledge, such as the ability to browse websites related to health services or screening, is also significantly limited. Unfortunately, an important obstacle related to the health care system also contributes to this, which is the lack of translators who could improve the quality of communication between migrants and medical staff.

The lack of a family doctor is another important barrier related to the health system, especially in the case of screening, such as in the case of mammography (Ahmad et al., 2012; Meana et al., 2001; Steven et al., 2004; Sun et al., 2010; Todd et al., 2011; Vahabi et al., 2016). Moreover, in some cases, the increased workload of doctors does not allow them to spend more time with migrants to explain more to them and answer their questions and queries especially in the case of screening. In fact, the lack of translators further exacerbates this problem, as doctors are unable to communicate with migrants, with the result that doctors' instructions and recommendations are not understood by migrants.

Particular reference needs to be made to the cultural barriers that migrants face in using health services. A typical example is the case of migrant women with particular religious beliefs. In this case, the existence of male doctors is a particular inhibiting factor for the use of health services related to sensitive issues, such as mammography (Ahmad et al., 2012; Steven et al., 2004; Todd et al., 2011; Vahabi et al., 2016). Some religions recognize women's bodies as 'sacred' and 'private', with the result that women may feel shame and guilt when a male doctor has to look at their bodies in the case of, for example, mammography. Many women, moreover, believe that the occurrence of a disease is God's will or the result of fate, so they do not use screening methods as they consider them unnecessary. In even more extreme situations, some societies consider breast cancer to be the result of immorality, so they view mammography negatively. The problem is further exacerbated by the fact that in some cases medical staff avoid discussing sensitive issues with migrants, in order to respect their cultural sensitivity and avoid possible friction and misunderstandings. This problem is extremely important, as in many cases the recommendation from health professionals is the most important motivation for migrants to undergo screening (Hanson et al., 2009). It is a fact that in most countries not much attention is paid to the cultural and religious specificities of migrants, which, especially in the case of the use of health services, are a decisive factor (Lobb et al., 2013).

Lack of knowledge is a key barrier to the use of health services by migrants, particularly in the case of screening. For example, migrant women are largely unaware of the risk factors for breast cancer (Ahmad et al., 2012; Meana et al., 2001; Vahabi et al., 2016). It is common, moreover, for migrant women to seek medical help only if they develop symptoms and signs, as health systems in their countries mainly emphasize treatment rather than prevention (Lobb et al., 2013). Similarly, many migrant women have limited knowledge about the benefits, side effects and the internetAsia of mammography and other screening methods. Thus, the lack of knowledge leads migrants to not use screening services as they consider them unnecessary (Hyman et al., 2001). The problem is magnified in the case of migrants who self-assess their health status as good, so that they consider that screening is not necessary (Garcia-Subirats et al., 2014; Jiménez-Rubio & Hernández-Quevedo, 2011). Moreover, the lack of knowledge about how to access and navigate the health system creates even more problems, as migrants do not even know how to access the different services. It should be noted that the lack of knowledge is often combined with a lack of understanding of the language and a lack of translators in health services (Lobb et al., 2013).

Many migrants do not undergo screening because they are concerned about the consequences of being diagnosed with cancer, such as stress, access to necessary services, social isolation, poor prognosis, etc. (Ahmad et al., 2012; Vahabi et al., 2016). In addition, due to lack of knowledge, migrants are also concerned about the adverse effects of different tests, such as exposure to radiation during a mammogram, adverse effects of a therapeutic intervention (e.g. surgical removal of a tumor), etc. (Ahmad et al., 2012).

In conclusion, intensive efforts are needed to increase migrants' knowledge, implement culturally sensitive interventions in migrant communities and better inform health professionals so that they can reach migrants more effectively. Migrants are now a significant part of the population in host countries and appropriate conditions should be created for their best possible adaptation in order to safeguard and promote both migrant and public health.

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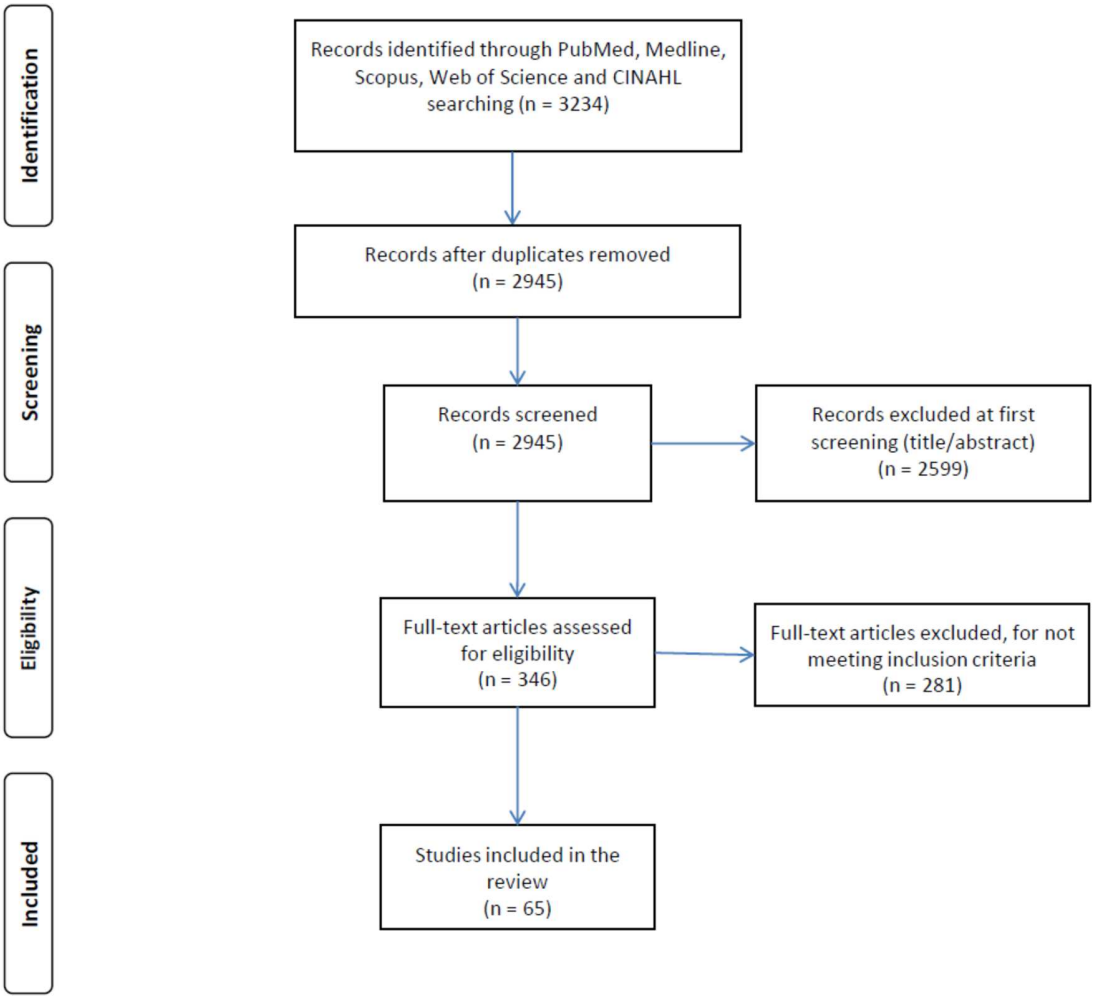

Figure 1. Flowchart of the systematic review.

Table 1. Studies on migrants' access to health services, use of health services and the relative barriers.

Reference	Country	Study year	Study design	Participants (n)	Continent/country of migrants	Data collection tools	Comparison with natives	Access and use of healthcare services	Barriers
(X. Liu et al., 2017)	United Kingdom	2017	Qualitative	54	China	Focus groups and interviews		↓	↑
(Ellins & Glasby, 2016)	United Kingdom	2012	Qualitative	20	Asia	Interviews		↓	↑
(Suurmond et al., 2016)	Netherlands	2012	Qualitative	55	Turkey, Morocco, Surinam	Interviews		↓	↑
(Saltus & Pithara, 2015)	Wales	2013	Qualitative	32	Asia	Interviews		↓	↑
(Thyli et al., 2014)	Norway	2009	Qualitative	15	Iran, Iraq, Bosnia-Herzegovina, Vietnam	Interviews		↓	↑
(Z. Liu et al., 2015)	United Kingdom	2015	Qualitative	33	China	Interviews		↓	↑
(Doshani et al., 2007)	United Kingdom	2007	Qualitative	24	Asia	Focus groups		↓	↑
(Nielsen et al., 2012)	Denmark	2007	Cross-sectional	4.952	Serbia, Croatia, Iran, Iraq, Lebanon, Pakistan, Somali, Turkey	Questionnaire	X	↑ family physician ↑ hospitalization ↑ outpatients clinics ↑ ER ↓ dentist	
(Buja et al., 2014)	Italy	2013	Cross-sectional	35,541	Europe, Asia, Africa, Latin America, Oceania	Questionnaire	X	↑ ER	
(Berens et al., 2014)	Germany	2010-2011	Cross-sectional	208,500	Turkey	Files	X	↑ screening	
(Garcia-Subirats et al., 2014)	Spain	2006-2012	Cross-sectional	31,063	Europe, Asia, Africa, Latin America	Questionnaire	X	↑ family physician	
(Ricardo-Rodrigues et al.,	Spain	2011	Cross-sectional	5,303		Questionnaire	X	↓ screening	

2015)									
(Solé-Auró et al., 2012)	Austria, Belgium, Denmark, France, Germany, Greece, Italy, Netherlands, Spain, Sweden, Switzerland	2004	Cross-sectional	27,395	Europe, Asia, Africa, Latin America	Questionnaire	X	↑ family physician	
(Glaesmer et al., 2011)	Germany	2011	Cross-sectional	2,510	Europe, former Soviet Union, Turkey	Questionnaire	X	↑ family physician ↑ hospitalization ↓ outpatients clinics	
(Muñoz et al., 2012)	Spain	2008	Cross-sectional	63,257	Europe, Asia, Africa, Latin America	Files	X	↑ family physician ↑ outpatients clinics	
(Martín-López et al., 2013)	Spain	2009	Cross-sectional	5,771		Questionnaire	X	↓ screening	
(Diaz et al., 2014)	Norway	2008	Cross-sectional	2,977,933		Files	X	↑ family physician	
(Denktaş et al., 2009)	Netherlands	2003	Cross-sectional	1503	Turkey, Morocco, Surinam	Questionnaire	X	↑ family physician	
(Hernández-Quevedo & Jiménez-Rubio, 2009)	Spain	2003-2006	Cross-sectional	51,086	Europe, Asia, Africa, Latin America, Oceania	Questionnaire	X	↑ hospitalization ↑ ER ↓ outpatients clinics ↓ family physician	
(Malmusi et al., 2014)	Czech Republic	2008	Cross-sectional	1,955	Ukraine	Questionnaire	X	↓ outpatients clinics ↓ family physician ↓ ER	

								↓ dentist	
(Jiménez-Rubio & Hernández-Quevedo, 2011)	Spain	2003-2006	Cross-sectional	51,086	Europe, Asia, Africa, Latin America, Oceania	Questionnaire	X	↑ ER ↓ family physician ↓ outpatients clinics	
(Diaz & Kumar, 2014)	Norway	2008	Cross-sectional	1,605,873		Files	X	↓ family physician	
(de Back et al., 2015)	Netherlands	2009-2010	Cross-sectional	58,274	Antilles	Files	X	↓ family physician	
(Gimeno-Feliu et al., 2013)	Spain	2007	Cross-sectional	594,145	Europe, Asia, Africa, Latin America, Oceania	Files	X	↓ family physician	
(Sanz et al., 2011)	Spain	2006	Cross-sectional	13,305	Europe, Asia, Africa, Latin America, Oceania	Questionnaire	X	↓ outpatients clinics ↓ ER	
(De Luca et al., 2013)	Italy	2004-2005	Cross-sectional	102,857	Europe, Asia, Africa, Latin America	Questionnaire	X	↑ ER ↓ outpatients clinics	
(Rinaldi et al., 2016)	Italy	2011-2014	Cross-sectional	45,645	Asia, Africa, Ukraine, Moldova, Servia, Albania	Files	X	↑ hospitalization	
(de Bruijne et al., 2013)	Netherlands	1995-2005	Cross-sectional	433,501	Morocco, Turkey, Surinam, Antilles	Files	X	↑ hospitalization	
(Ramos et al., 2013)	Spain	2011	Cross-sectional	42,839	Europe, Asia, Africa, Latin America	Files	X	↓ hospitalization	
(Neergaard et al., 2013)	Denmark	2006	Cross-sectional	599	Europe	Files	X	↑ outpatients clinics	
(Ruud et al., 2015)	Norway	2009	Cross-sectional	3,864	Sweden, Pakistan, Somali, Poland	Questionnaire	X	↑ ER	
(Carrasco-Garrido et al., 2009)	Spain	2006	Cross-sectional	28,042	Europe, Asia, Africa, Latin America	Questionnaire	X	↑ ER	
(Sandvik et al., 2012)	Norway	2008	Cross-sectional	715,278	Poland, Germany, Iraq, Somali	Files	X	↓ ER	
(Jensen et al., 2012)	Denmark	2008-2009	Cross-sectional	149,234	Europe, Asia, Africa,	Files	X	↓ screening	

					Latin America				
(Carrasco-Garrido et al., 2014)	Spain	2012	Cross-sectional	7,938		Questionnaire	X	↓ screening	
(Linne et al., 2014)	Sweden	2010-2012	Cross-sectional	18,876	Europe, Asia, Africa, Latin America	Questionnaire	X	↓ screening	
(Azerkan et al., 2012)	Sweden	1993-2005	Cross-sectional	2,176,255	Europe, Asia, Africa, Latin America	Files	X	↓ screening	
(Kristiansen et al., 2012)	Denmark	1991-2008	Cross-sectional	89,973	Europe, Asia, Africa, Latin America	Files	X	↓ screening	
(Simou et al., 2011)	Greece	2004-2009	Cross-sectional	9,682	Albania , Bulgaria	Questionnaire	X	↓ screening	
(Pons-Vigués et al., 2011)	Spain	2006	Cross-sectional	16,767	Europe, Asia, Africa, Latin America	Questionnaire	X	↓ screening	
(Frederiksen et al., 2010)	Denmark	2005-2006	Cross-sectional	85,374	Europe, Asia, Africa, Latin America	Questionnaire	X	↓ screening	
(S. F. Dias et al., 2008)	Portugal	2008	Cross-sectional	1513	Asia, Africa	Questionnaire		↓ PR	
(S. Dias et al., 2011)	Portugal	2011	Cross-sectional	1375	Asia, Africa	Questionnaire		↓ PR	
(Ehmsen et al., 2014)	Denmark	2011-2013	Cross-sectional	830	Europe, Asia, Africa	Questionnaire		↓ PR	
(Brindicci et al., 2015)	Italy	2009-2010	Cross-sectional	272	Asia, Africa	Questionnaire		↓ PR	
(Teunissen et al., 2014)	Netherlands	2014	Cross-sectional	541	Asia, Africa	Questionnaire		↓ PR	
(de Jonge et al., 2011)	Netherlands	2010	Cross-sectional	1141	Asia, Africa	Questionnaire		↓ outpatients clinics	
(Biswas et al., 2011)	Denmark	2011	Qualitative	10	Asia	Interviews		↓ ER	
(Almeida et al., 2014)	Portugal	2012	Cross-sectional	277	Africa	Questionnaire	X	↓ PR	↑
(Diaz et al., 2015)	Norway	2008	Cross-sectional	3,739,244	Europe, Asia, Africa	Files	X	↑ ER ↓ PR	↑
(Esscher et al., 2014)	Sweden	2010	Cross-sectional	74	Europe, Asia, Africa	Files	X	↓ PR	↑
(Franchi et al., 2016)	Italy	2010	Cross-sectional	51,016	Europe, Asia, Africa	Files	X	↑ hospitalization ↓ PR	↑
(Klaufus et al., 2014)	Netherlands	2008	Cross-sectional	14,131	Europe, Asia, Africa	Questionnaire	X	↑ PR	

(Koopmans et al., 2013)	Netherlands	2001-2003	Cross-sectional	9,077	Europe, Asia, Africa	Questionnaire	X	↓ PR	↑
(Nielsen et al., 2015)	Sweden	2007	Cross-sectional	3,573	Europe, Asia, Africa	Questionnaire	X	↓ PR	↑
(Spinogatti et al., 2015)	Italy	2001-2010	Cross-sectional	139,775	Europe, Asia, Africa	Files	X	↑ ER ↓ PR	↑
(Straiton et al., 2014)	Norway	2008	Cross-sectional	2,712,974	Europe, Asia, Africa	Files	X	↓ ER ↓ PR	↑
(Villarroel & Artazcoz, 2016)	Spain	20	Cross-sectional	22,234	Europe, Asia, Africa	Questionnaire	X	↓ PR	↑
(Galanis et al., 2013)	Greece	2012	Cross-sectional	191	Asia, Africa, former Soviet Union, Balkan	Questionnaire		↓	↑
(Sourtzi et al., 2020)	Greece	2013-2014	Cross-sectional	1152	Asia, Africa, former Soviet Union, Balkan	Questionnaire		↓ PR	↑
(Tsitsakis et al., 2017)	Greece	2005-2011	Cross-sectional	14,034	Asia, Africa, former Soviet Union, Balkan	Files	X	↑ ER ↓ hospitalization	↑
(Kaitelidou et al., 2020)	Greece	2013-2014	Cross-sectional	1854	Asia, Africa, former Soviet Union, Balkan	Questionnaire	X	↓	↑
(Stathopoulou et al., 2018)	Greece	2016	Cross-sectional	1006	Albania (mainly)	Questionnaire	X	↓	↑
(Chantzaras & Yfantopoulos, 2018)	Greece	2016	Cross-sectional	1332	Albania (mainly)	Questionnaire	X	↓	↑
(Boutziona et al., 2020)	Greece	2014	Cross-sectional	167		Questionnaire		↓	↑

PR: primary healthcare

ER: emergency department

Table 2. Detailed description of the barriers encountered by migrants in accessing and using healthcare services.

Reference	Language and communication difficulties	Lack of information and knowledge	Family support failure	Cultural and religion issues	Fear for pain	Difficulties to understand physicians' guidelines
(X. Liu et al., 2017)	X	X	X	X		
(Galanis et al., 2013)	X					
(Boutziona et al., 2020)	X			X		
(Koopmans et al., 2013)	X		X			
(Nielsen et al., 2015)	X		X			
(Spinogatti et al., 2015)			X			
(Straiton et al., 2014)			X			
(Villarroel & Artazcoz, 2016)			X			
(Beiser & Hou, 2014)	X		X			
(Diaz et al., 2015)			X			
(Durbin et al., 2014)	X					
(Esscher et al., 2014)	X					
(Klaufus et al., 2014)			X			
(Almeida et al., 2014)			X			
(Ho et al., 2005)			X			
(Ellins & Glasby, 2016)	X	X				
(Suurmond et al., 2016)	X	X	X			
(Thyli et al., 2014)	X		X		X	
(Z. Liu et al., 2015)	X					X
(Doshani et al., 2007)		X				
(Garcia-Subirats et al., 2014)					X	
(Denktaş et al., 2009)	X					

Table 2 (continued). Detailed description of the barriers encountered by migrants in accessing and using healthcare services.

Παραπομπή	Females shame and modesty	Long waiting hour	Lack of time	High cost	Lack of insurance	Emotional barriers	Functional disability
(Galanis et al., 2013)		X		X		X	
(Boutziona et al., 2020)				X	X		
(Almeida et al., 2014)					X		
(Doshani et al., 2007)	X				X		
(Garcia-Subirats et al., 2014)		X	X	X	X		
(Denktaş et al., 2009)					X		
(X. Liu et al., 2017)		X			X		
(Sourtzi et al., 2020)	X				X		
(Boutziona et al., 2020)	X				X		
(Esscher et al., 2014)	X				X		
(Klaufus et al., 2014)	X						X
(Nielsen et al., 2015)	X						X
(Spinogatti et al., 2015)	X						
(Villarroel & Artazcoz, 2016)	X						
(Jiménez-Rubio & Hernández-Quevedo, 2011)	X						
(Garcia-Subirats et al., 2014)	X						
(Suurmond et al., 2016)			X				
(Denktaş et al., 2009)			X				

Table 2 (continued). Detailed description of the barriers encountered by migrants in accessing and using healthcare services.

Παραπομπή	Short length of stay	Low income	Stay in rural areas	Low educational level	Limited social integration	Lack of trust	Self-esteem of good health status
(Saltus & Pithara, 2015)					X		
(Spinogatti et al., 2015)				X			
(Straiton et al., 2014)	X	X					
(Villarroel & Artazcoz, 2016)				X			
(Sourtzi et al., 2020)		X					
(Beiser & Hou, 2014)	X						
(Diaz et al., 2015)		X	X	X			
(Durbin et al., 2014)		X		X			
(Esscher et al., 2014)		X		X			
(Klaufus et al., 2014)		X		X	X		
(Koopmans et al., 2013)				X			
(Nielsen et al., 2015)	X	X					
(Almeida et al., 2014)		X		X			
(Ricardo-Rodrigues et al., 2015)			X	X			
(Solé-Auró et al., 2012)							
(Diaz et al., 2014)	X	X					
(Jiménez-Rubio & Hernández-Quevedo, 2011)		X					
(Diaz & Kumar, 2014)	X						
(Kristiansen et al., 2012)				X			
(Pons-Vigués et al., 2011)		X					
(Jiménez-Rubio & Hernández-Quevedo, 2011)							X
(Garcia-Subirats et al., 2014)							X
(Thyli et al., 2014)						X	

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