REVIEW

TACKLING BARRIERS IN ACCESS TO HEALTHCARE SERVICES. A REVIEW

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ABSTRACT

Barriers to effective and equitable healthcare can result from linguistic differences between patients and clinicians. Increasingly, healthcare professionals include migrants whose first language is not the commonly used language. Patients who are linguistic minority migrants, a group also increasing in number, must similarly use a second language during their healthcare encounters, or rely on the availability and accuracy of an interpreter. Thus growing numbers of patients using a country's healthcare system do not share communication with their practitioner and vice versa. Language discrepancies may result in increased psychological stress and medically significant communication errors for already anxious patients, something to which patients in language-congruent encounters are less vulnerable. Moreover, it is not just language that can cause barriers to equitable healthcare: inequities inherent in the social dynamic of the patient-practitioner encounter are well documented, and these inequities occur independent of whether language is shared.

Keywords: healthcare services, intercultural communication, inequities in health, access to healthcare, cultural barriers.

INTRODUCTION

Access refers not only to the availability of services, but to service characteristics that make it possible or comfortable for persons in need to utilize such services. In the literature related to language access, however, there is often a failure to differentiate between "access" and "utilization". As a result, many studies on access report on disparities in service utilization. Problems with access may be experienced at all points of the health maintenance and health seeking process: access to health information (e.g. benefits of immunization); knowledge of available health services (e.g. where and when one can receive such immunizations); participation in health promotion or prevention services (e.g. receiving immunization); participation in screening (e.g. cancer screening); first contact for non-urgent care; access to specialist care or specialized services; access to emergency and hospital care; and access to support services after discharge from hospital, access to Mental Health Services. There are additional and specific barriers to access to mental health services [1-3]. There is perhaps no other health area where diagnosis and treatment is as dependent on language and culture [4].

All human interaction is influenced to some degree by the cultural, social, and physical settings in which it occurs. These settings are called communication contexts. Social interaction is neither arbitrary nor disorderly, but is patterned by interaction rituals that specify normative ways of speaking and behaving in specific social situations such as business meetings, parties, or sports events.

When communication rules are shared the rules configure and orchestrate their social interaction in accord with these norms and communication proceeds smoothly. If, however, communication rules are not shared, or if speakers actively resist these norms, then communication may break down. In the case of intercultural interaction, communication rules often diverge, and accordingly there is a greater risk of misunderstanding. Culture helps determine the appropriate communicative behaviour within a variety of social and physical contexts by prescribing certain rules. When communicating with members of the own culture, cohorts rely on deeply internalized cultural rules that delineate the normative behaviours for specific communication situations. These rules facilitate the ability to communicate effectively with each other. And since they are integrated into a personality, persons do not have to think consciously about which rules to use.

When engaging in intercultural communication, however, things can be different because the communication partners may not be operating under the same sets of rules. Indeed, communication rules display a great deal of cultural diversity. One must be fully aware of the differences, otherwise, they may encounter a variety of surprises—some of which could

be embarrassing, detrimental, or both.

Understanding communication in the context of a medical encounter is thus critical for understanding the problems that might result when patients and healthcare practitioners speak a different language. This review is designed to explore these potential barriers in a natural healthcare setting, across a range of hospital in- and outpatient departments.

Barriers in communication

Although there has been much information published on communication of risk between patients and healthcare practitioners in healthcare situations, this review has focused predominantly on language congruent situations but also on inequities and interventions to overcome barriers in access to healthcare. It is not clear how health-related risk is appropriately and accurately conveyed to a patient when their first language is discordant with that of the practitioner and the wider community. There is evidence that miscommunication is more likely to occur when clinicians use an inadequately mastered second language and cannot correctly convey certain nuances of risk and certainty.

Complicating matters further, people from different cultural groups describe pain and distress quite differently: culturally-specific terms, expressions, or metaphors can be difficult to navigate even when language competence is high. Also, when clinicians lack the linguistic and cultural skills needed and interpreters are not available, patients may have to rely on medically inexperienced, bilingual relatives or non-medical staff, compromising quality of care and worsening health outcomes for migrant communities.

Theoretical framework

There are at least three theoretical approaches to understanding why communication problems arise in language-discrepant medical communication settings. One is a psycholinguistic approach discussed by Segalowitz and Kehayia [5], in which the focus is on the way in which speakers direct the other person's focus of attention to key elements of their message by using semantic and syntactic features of the language to package the message appropriately, and on the listener's ability to infer the speaker's intention.

A second theoretical approach considers the conversational dynamics of patient-doctor interactions. The focus here is on the power of relation differences between doctor and patient, and how the language used, both reflects these relationships and serves as a tool for manipulating them.

Little is known regarding the social dynamics that operate in language-discrepant healthcare contexts. Here, a third theoretical approach should be applied, namely the framework of Communication Accommodation Theory (CAT). This approach has a particular relevance for comparing language-discrepant and language congruent communication. In theoretical terms, CAT proposes that:

1. Speakers attempt to converge (or not) their manner of speaking, to accomplish important social goals around attaining social approval, identity, etc.;
2. The extent to which speakers converge reflects in part the need for communication efficiency;
3. Convergence is viewed as positive and normative;
4. Divergence in manner of speaking reflects a specific intention to do so, and is normally perceived negatively.

CAT thus provides a useful framework for examining the dynamics of patient-practitioner communication, especially when at least one of the speakers uses another language. In such cases, an inability to achieve convergence (i.e. to appear more similar in speech) can affect how the speakers perceive not only each other, but also the quality of the working relationship between them e.g. The relevant research goal here is to identify what specific impact language discrepancy has on accommodation, and what the consequences are for patient-practitioner communication [6].

In summary, to address the problem of language barriers successfully, we must know when they are most likely to arise and what their specific nature is. To do so, new research methods must be developed, and a theoretical framework formulated to generate research questions and guide research. This will allow us to:

1) Explore new ways to systematically study — at a micro-level of analysis — the nature of language barriers in healthcare communication;

2) Address specific aspects of language barriers in healthcare communication in a way that will inform the design of language training programs for clinicians; and

3) Articulate a research agenda for future theoretical, empirical, and applied work aimed at overcoming language barriers in healthcare delivery (e.g. in indigenous communities; rural/remote healthcare) [6].

Classification of barriers in access to healthcare services

Although we acknowledge that there is no universally accepted definition of access to health services [7], we use the definition by Peters et al. [8] which implies 'the timely use of service according to need'. Access has four dimensions: availability, geographic accessibility, affordability and acceptability [9, 10]. Barriers to accessing health services can stem from the demand side and/or the supply side.

Demand-side determinants are factors influencing the ability to use health services at individual, household or community level, while supply-side determinants are aspects inherent to the health system that hinder service uptake by individuals, households or the community. The need to differentiate demand-side

from supply-side barriers is related to the formulation of appropriate interventions, although O'Donnell [9] notes that both sides have to be addressed concurrently. This is reinforced by James et al. [10], who argue that access barriers may not always be mutually exclusive and may interact and influence each other. Peters et al. [8] provide a framework for assessing barriers along the four dimensions of access (each of them having supply-side and demand-side aspects) while Ensor and Cooper [11] present a framework of supply-side and/or demand-side barriers. [12].

Interventions to enable access to health services

Primary health care (PHC) was endorsed in 1978 by WHO member countries as a paradigm designed to reduce inequities in health, partly through enabling universal access to health services [13]. While universal coverage is the aim, imperfect health systems suffer from what is called the 'inverse equity hypothesis', which states that new health interventions initially reach the socio-economically better-off, while the majority of the poor benefit only later in time [14]. Because of this time lag, especially in developing countries that are to a considerable extent dependent on donor funding for the health sector, targeting is often a preferred strategy [15, 16].

In the absence of universal coverage, there are two main targeting options for enabling greater access to health services for poor and vulnerable patients, namely to build the capacity of health care providers to target service provision on selected groups (a supply-side strategy), or to reduce the barriers to access and participation (a demand-side strategy) [17]. Both of these approaches to developing interventions to address barriers to health care are described and considered in this paper.

Interventions aimed at facilitating access to health services need to be implemented at district level, as this is known to constitute the most appropriate geographical situation for PHC [18-20]. However, Ekman et al. [18] advises caution that due consideration should be given to the potentially limited capacity of district health managers in LIC. Moreover, because most barriers to care cannot be overcome by the health sector acting alone, inter-sectorial collaboration is called for [10, 21]. Although considered the most neglected aspect of PHC [22], community participation should be built into interventions addressing access barriers as it 'reduces the power gaps between the population and health systems' [12]. Whatever interventions are developed, monitoring their service uptake should be an integral part of the strategy [21, 23, 8].

Before presenting the analytical framework for analysing interventions to address supply-side and demand-side barriers to access, we present an overview of interventions that can be implemented at district level by the health sector alone or in collaboration with other government departments and non-government or civil-society organizations through the public and/or private sector. It is assumed that higher levels in the health sector, such as provincial and national health authorities, set out the broad policy framework, enforce legislation, ensure provision of a relatively steady supply of funds, goods and equipment, and conduct monitoring and supervision of the lower echelons in the health system.

Many proposed interventions take a monetary-incentive approach to addressing access barriers to health services. Often, these financial incentives are channelled through the demand-side, seemingly due to a donor reaction to governments' failure to deliver sufficient health services and a perception of inertia of authorities at all levels [24]. Despite the sizable amount of literature focusing on financial demand-side interventions, the highest number of interventions appears to be non-financial and supply-side based. Although Standing [24] identified five interpretations of the meaning of 'demand side', we use the term here to mean the direct channelling of resources to a population group to obtain health services, in line with the definition used by Schmidt et al. [25]. Demand-side financing may be linked to output when providers are paid according to the number of services delivered. The objectives of this approach are: (1) targeting service delivery; (2) improving provider behaviour; (3) promoting competition and consequently improving quality of care; and (4) improving care-seeking by targeted groups [10, 26].

In conclusion, when communicating the details of a diagnosis or treatment, it is crucial to convey accurately the likelihood of the associated risk factors. Failure to communicate properly the seriousness of risk can have negative consequences: patients may fail to comply with instructions or elect not to have potentially life-saving treatment.

Utilization of health care is used as an operational proxy for access to health care. Supply-side financing is considered a means for strengthening health service delivery based on the amount of financial input and does not imply a particular method of provider payment.

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