Access and effective use of healthcare services by temporary migrants in Cyprus

Christalla Pithara, Michalinos Zembylas and Mamas Theodorou

Christalla Pithara, Michalinos Zembylas and Mamas Theodorou are all based at the Open University of Cyprus, Nicosia, Cyprus.

Abstract

Purpose – *This paper aims to discuss factors affecting temporary migrants' ability to access and make effective use of public and private healthcare services in the Republic of Cyprus (hereafter referred to as Cyprus). These factors are raised in the context of a larger study focusing on the healthcare needs of temporary migrants from non-EU countries living and working in Cyprus.*

Design/methodology/approach – *Semi-structured interviews with 13 domestic workers and 17 students from Sri Lanka, Pakistan, Bangladesh, India and the Philippines explored migrants' experiences with accessing and utilizing healthcare services in Cyprus. The theoretical framework utilized is grounded in the health capability approach which focuses on individuals' confidence and ability to be effective in achieving optimal health.*

Findings – *The study highlights issues concerning the accessibility and acceptability of healthcare services which emerge as the result of both the organisation and delivery of healthcare services and social, political and economic structures.*

Research limitations/implications – *The implications of this study are relevant in the current debate taking place at the EU level about the opportunities and challenges of temporary migration. Specifically, it is argued that governments and societies should promote individual freedoms and opportunities that empower people to lead the lives they want to live.*

Originality/value – *Temporary migrants form a group whose experiences and needs have not been as extensively investigated as those of other migrant groups, particularly in Cyprus. The capability approach allows for assessing both policy and health systems taking into consideration equity and the impact of multi-sectoral influences on health.*

Keywords *Cyprus, European Union, Temporary migrants, Third country nationals, Access to care, Health capability, Immigrants, Health services*

Paper type *Research paper*

Introduction

The term ''migrant'' encompasses different groups of individuals who leave their country of origin for a number of reasons and includes legal and undocumented migrants, asylum seekers, victims of human trafficking, migrant workers and others. Temporary migrants form one such group that has re-emerged in European Union (EU) discourse, following the need of EU countries for skilled and unskilled labour (European Migration Network, 2011; Lenard and Straehle, 2010; McLoughlin *et al.*, 2011). The European Migration Network Glossary has defined temporary migration as ''migration for a specific motivation and/or purpose with the intention that, afterwards there will be a return to country of origin or onward movement'' (European Migration Network, 2011).

This paper is concerned with the factors affecting temporary migrants' ability to access and make effective use of needed healthcare services during their stay in the Republic of Cyprus (hereafter referred to as Cyprus). Data reported in this paper came as part of a larger study investigating experiences of access and utilisation of healthcare services, healthcare needs, and quality of life, of temporary migrant Third Country Nationals (TCNs) working and

This research has received approval and funding from the Open University of Cyprus and the Ministry of Health of Cyprus. Acknowledgements go to Aristos Constantinou for transcribing most of the interviews; and Marios Kantaris and Elena Vasiliou for conducting three of the interviews. Special acknowledgement goes to all the participants who agreed to take part and help with recruitment.

studying in Cyprus. This paper adopts a capability approach to health and healthcare access as this was described and developed by Jennifer Ruger on the basis of Amartya Sen's capability approach (Ruger, 2006a, b, c, 2010). This approach is argued to be especially relevant to migrant health because it addresses the link between availability of resources and the role of human agency in achieving the desired level of health (Abel and Frohlich, 2012). In particular, this approach allocates equal responsibility to public policy and to the individual, the former being accountable for the opportunities it provides for promoting optimum functionality, and the latter being free to make choices based on health needs and health norms. In addition, it brings into the discussion individual, political, economic and social factors, adopting a holistic multi-dimensional approach to health, while at the same time it looks at the individual as the focus of analysis and source of information.

This is the first study to explore the health experiences of temporary migrants living and working in Cyprus. It is also filling a gap in EU literature as very little is known about the health experiences of legal temporary migrants in an EU country. Because of their legal status, temporary migrants may not be perceived as a vulnerable group in terms of healthcare access. They are known, however, to face exploitation and human rights discriminations in employment and social life through violations of their employment rights including low wages, high dependency on their initial employer, racism and xenophobia, human trafficking (ILO, 2010) and fear of becoming illegal unwittingly due to, among others, complicated procedures of renewing residency and employment visas (Lenard and Straehle, 2010). It is important to understand in more detail the healthcare experiences of this group in order to improve healthcare practice, provide user-appropriate services, and design policy which protects temporary migrants' rights and addresses their health needs.

This paper will first describe the capability approach and its application to health and healthcare. It will then set the context of the study by providing an overview of the migration situation in Cyprus and its existing healthcare system. Next, the research population, data collection and analysis will be described, followed by the research findings. Finally, the paper will end by discussing the implications of the study at the levels of health practice and policy.

Health and the capability approach

The capability or capabilities approach was developed by Amartya Sen as an interdisciplinary framework whose core claim is that ''assessments of the well-being or quality of life of a person, and judgements about equality or justice, or the level of development of a community or country, should not primarily focus on resources, or on people's mental states, but on the effective opportunities or freedoms that people have to lead the lives they have reason to value'' (Robeyns, 2006, p. 351). Its core concepts are individual functionings, which refer to a person's beings and doings, and capabilities which are defined as the genuine opportunities or freedoms to realise these functionings (Sen, 1985, 1992).

Jennifer Ruger has applied the principles of the capabilities approach to health and healthcare and has proposed a health capability framework which introduces a capability view to health and access to healthcare. In her framework, Ruger (2010) describes health capability as the confidence and ability to be effective in achieving optimal health. Ruger (2010) presents a conceptual model of health capability where health capability is influenced by internal and external factors presented within a health capability profile and categorised under four dimensions: biology and genetic predisposition; intermediate social context; macro, social, political and economic environment; and the public health and healthcare system.

Ruger (2006a, b, c) argues that existing frameworks which are used to address injustices in the field of health and healthcare policy, including the right to health approach, fail to take into account issues of healthcare quality (high quality of healthcare services rather than a decent minimum of healthcare should be provided to all individuals), health agency (the ability of individuals to choose healthier life strategies and conditions for themselves and for future generations), and health norms (individual or social shared attitudes towards health and illness). Ruger (2006a, b, c) believes that public policy should aim to remove barriers to freedom where these barriers leave individuals with little choice or opportunity to exercise their reasoned agency; the fundamental obligation of society according to Ruger (2010), is to

ensure that the conditions necessary for all to be able to be healthy are in place, rather than ensure equal welfare, happiness, or employment opportunities. In this sense the health capabilities framework promotes human agency and empowerment rather than focus on process or outcome equality, e.g. provide the same services to all.

The capability approach has been very influential within economic theory as well as within development studies and political philosophy, while the United Nations Development Programme (UNDP) has based its methodology for the annual Human Development Report on the capability approach (UNDP 1990-2005). In recent years it has also been introduced into health policy development (Robeyns, 2005, 2006; Ruger, 2006a) and health economics research (Anand and Dolan, 2005; Coast *et al.*, 2008a), with the ICECAP capability index for older people being the first outcome measure to be designed guided by the capabilities approach (Coast *et al.*, 2008b). The capabilities approach has also been discussed in the context of immigration, and health inequalities (Abel and Frohlich, 2012; Gasper and Truong, 2010; Risse, 2009).

The presence of health inequalities in the migrant population is well known, yet policies addressing health inequalities and temporary migration impose a dichotomy between the two. Health inequalities are situated within the context of health promotion, where maximum opportunities should be made available to the maximum number of people to promote healthy choices and healthy lives (Abel and Frohlich, 2012). On the other hand, temporary migration is situated within a rigid policy framework aimed to control as much as possible the entitlements of migrants in the receiving country in order to discourage permanent residency (McLoughlin *et al.*, 2011). In the context of globalization and increasing interconnectedness between countries, migration and in particular temporary migration need to be situated within the discussion of health inequalities. The capabilities approach allows for the ethical and moral assessment of existing policies and social and organisational infrustructure while acknowledging the role of migrants' health agency in health functioning.

The case of Cyprus

Cyprus is a country at the borders of the EU and the Middle-East, and thus at the centre of the EU migration phenomenon. Migrant numbers, both legal and undocumented have exponentially increased in recent years, both as a result of the high demand for unskilled labour, and the geographical position of the island (Trimikliniotis and Demetriou, 2011). A recent population census has placed the migrant population (both EU and TCNs) to 21.4 percent of the total population whereas the same category formed 9.4 percent of the population in 2001 (CYSTAT, 2011). Non-EU citizens (coming mainly from Asian countries) form 8 percent of the total population (67,123) or 37.4 percent of the migrant population and the biggest ethnic migrant group is Filipino (5.4 percent of the TCNs migrant population). Despite the large numbers whose presence is promoted by the Cypriot Government and has considerably boosted the Cypriot economy (Michael *et al.*, 2005), not much has been done to either integrate those migrants who are or have the potential to be long-term residents, or promote basic freedoms in temporary migrants (Huddleston *et al.*, 2011; Health for Undocumented Migrants and Asylum-seekers (HUMA) Network, 2011; Trimikliniotis and Demetriou, 2011).

Access to healthcare services has also been found to be compromised by restrictive social and political regulatory procedures in the case of asylum seekers and undocumented migrants (HUMA Network, 2011). Cyprus has adopted a mixed-provider (public and private) model of healthcare service provision and the lack of comprehensive health insurance coverage has divided the population into distinct groups entitled to differing levels of healthcare coverage (Antoniadou, 2005; HUMA Network, 2011). Non-EU residents are not entitled to any coverage unless they possess a health insurance scheme with a private insurance company. Guest workers and students are obliged to buy private health insurance schemes in order to be granted a temporary residence permit and have their permit renewed. Established insurance schemes enable them to use the public and private health sectors and be reimbursed for up to 90 percent of the cost incurred. The specific schemes encompass: direct payments which need to be made at the point of access; coinsurance where the healthcare cost is shared between the insurer and the insured (90-10 percent);

and a fixed amount threshold where the insurer will not reimburse over and above this excess. However, several services are excluded from reimbursement such as dental and preventative care. It remains to be seen, therefore, whether the insurance package put in place is actually effective in covering migrant needs.

Looking into the way the social, political, economic, and healthcare systems and structures impact on the health capability of temporary migrants will assist in identifying areas in need of attention, both in the delivery of healthcare services and in the design of policies which take into consideration temporary migrants' health needs. Specifically, the research questions driving this study were:

RQ1. What are the experiences of legal migrants with heath and illness and with the healthcare system in Cyprus?

RQ2. Are their healthcare needs being met?

RQ3. What are the factors which influence access to and effective use of healthcare services?

Methods

Data collection and participants

Following research approval from the Cyprus Ministry of Health, TCNs temporary migrants living and studying in Cyprus were approached for recruitment. Legal migrants who lived in Cyprus with a four-year workers', domestic workers' or students' residence permit from non-EU countries were eligible to take part. These are the dominant groups of TCN temporary migrants living on the island and belong to the same category of health insurance schemes.

The snowball sampling method was used for recruitment. This involved the use of participants as liaisons, introducing the researchers to other migrants until enough participants were recruited and saturation of data was achieved (Patton, 2002). Information leaflets in English were prepared and disseminated to organizations working with migrants, and to migrants themselves in various socialization sites. The research objectives, the anonymous nature of data collection, the need for voice-recording the interview, and the right for withdrawal were explained to all participants through the information leaflets and verbally before the interview. All participants were asked to provide verbal or written participation consent before the interview commenced, depending on the literacy skills of the participants.

Data were collected through one-to-one semi-structured interviews. The interviews focused on the following topics: health needs while in Cyprus; experience with accessing and utilizing healthcare services; satisfaction with healthcare services; and expectations and proposed solutions.

Overall, interviews with 30 migrants from five Asian countries took place. The sample included 13 domestic workers and 17 students. All domestic workers were women with the majority between 26 and 30 years of age and married. All domestic workers lived in Nicosia (the capital of Cyprus) and almost half of those (six participants) reported living with their employer. The majority of domestic workers were in Cyprus for more than five years (nine participants). In the case of students, the majority (15 participants) were male. Most of the students (eight males and two females) lived in Nicosia and reported sharing accommodation with friends. 11 students reported living in Cyprus for four years or less and six had been in Cyprus between five and seven years. A summary of information on the participants' demographics is provided in Table I.

Interviews took place between November 2009 and March 2010 at a location chosen by the participant and lasted on average 40 minutes (between 30-60 minutes each). All interviews were conducted in English and/or Greek by the first author with the exception of three interviews which were conducted by two assistants due to time pressures. The two individuals were given special training on how to conduct interviews and how to use the semi-structured interview guide. This was done to ensure homogeneity in the way the interviews were conducted. One Bangladeshi woman who was able to communicate in the main dialects of the region was acting as translator when participants indicated in advance that they could not communicate in Greek

Table I Characteristics of interview participants

	Total
Total population	
Total	30
Domestic workers	13
Female	13
College students	17
Female	2
Age distribution (*years*)	
Domestic workers	
26-30	5
31-40	3
41-50	3
51-60	2
Students	
18-25	13
26-30	4
Country of origin	
Domestic workers	
Philippines	5
Sri Lanka	7
Bangladesh	1
Students	
Pakistan	8
Bangladesh	7
Sri Lanka	1
India	1
Accommodation arrangements	
Domestic workers	
Employer	6
Friends	4
Family	2
Alone	1
Students	
Friends	11
Family	5
Alone	1
District	
Domestic workers	
Nicosia	13
Students	
Nicosia	10
Larnaca	7
Years living in Cyprus	
Domestic workers	
1-4	4
4-8	5
8 +	4
Students	
< 1	1
1-4	11
4 +	5

or English. In general, some problems were encountered due to communication issues and time limitations from the part of the migrants due to long working hours. The interviews were audio-recorded, fully transcribed (the grammar and syntax used by participants was retained) and data were imported into NVivo9.0 for analysis and data management.

Data analysis

Transcripts were analyzed using thematic analysis (Braun and Clarke, 2006) and the constant comparative approach (Charmaz, 2008). Initial categories were created based on

the discussed factors affecting access to needed care. Subsequent interviews were analysed based on these initial categories based on the constant comparative technique data were compared within and across codes; this process led to the refinement of existing codes and the creation of new ones until the final themes were formed. Six themes were identified relevant to access and utilization of services; four were related to the accessibility of healthcare services and two focused on the acceptability of services received. Each of these themes is presented below.

Results

Accessibility

Affordability. Both categories of migrants – that is, domestic workers and students – were of a low economic status and the frequently high cost at the point of entry and out-of-pocket payments even at the presence of health insurance, made healthcare finance the most often discussed barrier to care:

> . . .when I have something when my master don't have money, if I don't have money I will die here, everything with money here [in] Cyprus (domestic_worker_F04).

The presence of private health insurance barely improved the situation and only three participants reported using their insurance. These were domestic workers, one of whom was previously working for a foreign embassy with administrative procedures in place to deal with employees' requests and the other two reported being taken care of by their employer. Some students were unaware of how their insurance scheme worked. Four students reported using services for free and thought this was due to their health insurance. Through the discussion, however, it emerged that they were only accessing the no-cost services of public Accidents and Emergency (A&E) departments. The majority of participants reported problems in being reimbursed for received treatment or not being covered for the treatment received. The health insurance package appeared to have significant gaps, and did not cover for many common ailments and preventive procedures. For domestic workers, whose salary was significantly lower than the minimum salary threshold, the cost involved in obtaining preventative care (e.g. pap tests, mammography screening and general checkups), made these services unaffordable:

> The salary is not, [. . .] enough, for us to have a medical check-up for our own, [. . .] I will not go to the doctor and then spend the money, although there is medical insurance but that is not enough. . . (domestic_worker_F24).

The main difficulty in using the health insurance scheme faced by students was reimbursement. Several students mentioned the difficulties they faced with insurance companies trying to evade their obligations and problems they had encountered with college administration dealing with their claims. Six participants mentioned that discrimination on the part of college employees had created significant obstacles in being reimbursed:

> I didn't know what to do, the insurance company wouldn't reimburse for 17 euro, how would they reimburse for 500 [euro]? The college simply thought this is a black who doesn't know anything, doesn't understand (student_M13).

16 participants mentioned that they had avoided the private sector due to higher costs when compared to the public sector, though in some cases the private sector was preferred due to a perceived higher quality of service. Access however appeared to be determined by cost and ability to pay:

> I went to the Latsia hospital [where the A&E unit is situated], maximum students in Nicosia go to Latsia hospital [. . .] because there is no other way to have treatment [because only there the treatment is free]. Have private hospital but private hospital is too much expensive (student_M17).

Language accessibility. Language problems were a recurring theme in all interviews and affected all aspects of the healthcare experience, from accessing and understanding health-related information to receiving the right diagnosis and treatment. Communication due to language problems was explicitly raised as a problem by 22 participants:

> I speak Greek [. . .] not very good, (the doctor) don't know English, that time [was] very difficult because[of] language [. . .] I ask but he don't understand what I say, he speak with me I don't understand what he say (domestic_worker_F04).

Notably, problems in communication were mainly associated with the public sector, since participants described that in the private sector healthcare providers spoke in English:

> They look after me [in the private hospital], because we pay, if I went to the [public] hospital it would be very difficult, in the private sector they ask you what language you want to talk to, you can ask them again and again the same questions (domestic_worker_F01).

As a way to deal with language problems many participants and specifically students accessed hospitals accompanied by other migrants who could communicate in Greek or English. The following quote is from a student acting as translator for other students:

> Lots of time I went with my friends to visit doctors, [. . .] and I sit near to doctor and I explain lots of things about him, maybe doctor something don't understand, I explain he has like that problem, like that problem (student_M14).

Language problems were inherent in all contacts with the healthcare system to some degree, sometimes resulting in frustration and lack of trust in the doctor or in a minority of cases misdiagnosis.

Information accessibility. The lack of information was a theme closely linked to language problems. Lack of information about health-related issues such as insurance schemes and access pathways to health professionals emerged in interviews with 23 participants. There was generally little knowledge about the structure of the healthcare system and available services, the nature of social and health insurances, access pathways, and issues of availability and cost:

> The other workers are unaware of the health insurance, what will the health insurance do to them, because the employer doesn't explain and nobody explain[s] (domestic_worker_F24).
>
> If you want to get some information, you have to suffer, you have to go find [out] by your own (student_M33).

Migrants were often unaware of the bureaucratic procedures of the public health system and this caused frustration and feelings of discrimination and exclusion. The following quote is from a domestic worker describing her experiences, when she visited paediatric services for her daughter's vaccination:

> The Cypriots just go there and ask their file and then (go into see the doctor), [. . .] we third countries were left behind [. . .] we are there for hours [. . .] they didn't tell us, (the appropriate procedures for seeing the paediatrician) so we went up again, going up and up and down, up and down, up and down [from the outpatients clinic to the registration desk] (domestic_worker_F06).

Five participants from Sri Lanka and two from the Philippines discussed having training before their departure to Cyprus as an induction to their working life in Cyprus. There they were given information on Cypriot culture and weather and what they would be expected to do as domestic workers. However, no information was provided about the healthcare system in Cyprus or pathways to accessing treatment. For many participants, the main source of information was their peers in the migrant community:

> The thing is when I came here, I didn't know anything. They (the employers) didn't tell me anything about that, but now I know because I'm coming out and talking with friends (domestic_worker_F09).

Information available only in Greek further intensified the problem, since Greek was not spoken by the large majority of migrants.

Disempowerment and lack of control. Another finding was that discrimination and suppression of human freedoms was an important obstacle to health. Disempowerment referred to limitations in autonomy, decision-making and direct access to facilities due to restrictive civil, administrative, and social discriminatory practices embedded in the system and Cypriot society. This resulted in difficulties in accessing needed care, particularly among domestic workers. Factors affecting autonomy included the employment contract that placed responsibility of care upon the employer. Two participants reported that their

employers kept their passports and other ID documents, needed to access public services, and another mentioned having to ask for her passport every time she wanted access to needed healthcare services. The role of the employer in ''looking after'' domestic workers was introduced before their arrival in Cyprus during induction and training seminars:

> They (training providers in country of origin) say all employer do, when I am sick, agreement (employment contract) also says all do employer (domestic_worker_02).

The employer did not hinder care for all participants, but for some took an active and protective role in ensuring the worker had access to the care needed:

> I developed an allergy and itchiness and I didn't know what to do, when I told this to my madam she took me to the doctor (domestic_worker_F01).

Other employers were reported to provide pharmaceutical care to their employee themselves without medical consultation. Employer's preference for over-the-counter treatment rather than accessing formal medical care was reported by many domestic workers and by one student who held a part-time job:

> I know one of my friends, she has too much headache every day, I ask what do you do now, not tell your employer? She told, she is give only two [painkiller pills] (domestic_worker_F02).

Fear of repatriation due to the legal ability of employers to repatriate domestic workers in case of persistent illness further limited migrants' access to care, acting as a disincentive to reporting health-related problems:

> Most employers don't help, they are not interested, at most they could give some medicine they have at home, if there is something more seriously wrong they may send the girls back to their country and employ another girl (domestic_worker_F01).

> Some people, they afraid because [. . .] maybe after she is angry maybe she send me back Sri Lanka, like this some people (domestic_worker_F02).

Acceptability/quality of care

Bureaucracy and waiting times. 23 participants discussed their dissatisfaction with healthcare services, and in particular with public services and A&E departments, due to the bureaucratic procedures and long waiting time:

> Every time they want your papers, yes, last time when we went there, and always they ask me my paper, my ID, and I know now I give them my ID now (domestic_worker_F05).

Dissatisfaction was more with A&E departments, mainly because participants expected to be seen by a health professional within a short period of time but administration staff acted as intermediaries or gatekeepers between them and healthcare providers implementing bureaucratic procedures:

> I had trouble that time, and my husband say can you [look after] my wife because I am dying that time is too painful [. . .] but they ask me my passport, my passport I forgot in my house because I was working at my boss, they didn't [look after] me at all, yes they didn't. . . because I don't have passport (domestic_worker_F19).

In several cases participants preferred the private sector in order to avoid the frustration of bureaucracy and long waiting time:

> I was really shocked [. . .] she (daughter) was teething then and she was throwing up so I run to (children's hospital) and then I really cried when they say that, you have to fill up this form and my baby is sick and then after you have to pay so what I did I just went to a private doctor (domestic_worker_F06).

Effectiveness of care. The majority of participants perceived effectiveness of care – particularly that of public hospitals – to be quite low, with 15 participants explicitly stating that private hospitals are better because of the financial incentive. Only one participant reported being satisfied with public health services and one student reported preferring the public sector because it is free at the A&E departments. Effectiveness involved clinical care and interpersonal communication, two aspects of care often intertwined in participants'

narratives. Incorrect diagnoses and inappropriate treatment were described by a few participants and miscommunication by many more. One participant described being misdiagnosed with leukaemia and she believed this was without the doctors having looked at blood test results. Correct diagnosis was only made when she visited a professional in her home country, Sri Lanka:

> [the doctors] are thinking something is like leukaemia [. . .] I afraid and I thinking too much about my children [. . .] after I went Sri Lanka they ask where is your blood picture, where is this paper, I said they didn't make any blood picture about me, how they find you have this, they shout (domestic_worker_F04).

In the majority of cases, the participants believed that health professionals were unwilling to fully look into their situation because of their migrant status:

> I have a problem eye, so first I go private doctor and he told me you need to (have an) operation [. . .] after again I go government hospital, and they told me no need to (have an) operation. [. . .] we give you some medicine. Ok they give me but is no good. After I told my boss and he take me and we go again private doctor. And also he told me you don't need operation. Just I give you some medicine is ok I think after 1 month. But until (now) is no good. [. . .] I think is not good in Cyprus for the health they don't care (for) us (student_M18).

What emerged through the narratives were frequent cases of interpersonal communication break-downs, where the migrant was excluded from the clinical encounter. Exclusion was often accompanied by a lack of cultural awareness where the health professionals judged medical cases using the same criteria as those used in the Western population. A few participants described how health professionals attributed their medical problems to their eating habits, such as eating rice or spices, causing irritation and resentment on the part of the migrant:

> When you go to the doctor the doctor said no you mustn't eat rice because you eat rice for that you have this problem, you need to understand that this kid by time he was born they eat all day rice (domestic_worker_F05).

Finally, some participants, especially domestic workers from Sri Lanka, admitted that perceived low quality of care resulted in migrants opting to have treatment in their own countries where treatment was understood to be of higher quality:

> I'll tell you about this, most people [. . .] if they want to do operation or something like that they are afraid to do that here because we are Sri Lankans they don't care about us too much. [. . .] So most people, when they want to do a surgery or like that, they are going back [home] (domestic_worker_F09).

Discussion and implications

The aim of this paper was to report on factors affecting access and utilization of healthcare services by temporary migrants in Cyprus. These findings partly reflect and confirm some of the results reported in the recent HUMA Network (2011) report looking into access to care and barriers to access by asylum seekers and undocumented migrants. Common findings included perceptions of higher quality of care in private facilities, cost as the most common barrier to care among undocumented migrants, difficulties in navigating the system due to administrative and bureaucratic procedures, language problems, waiting times and perceived discrimination. Lack of information about one's rights and where to go was another common theme. Data from the present study highlighted the need for information on the Cypriot health system to be made available in English, and specifically information about the differences between private and public services, health insurance packages and healthcare coverage options, contact details and access points to medical facilities, and ways to navigate the healthcare system.

The present study shows that language difficulties affected migrants' ability to interact with their social environment both within the local community and within the healthcare system. These difficulties compromised the quality of care on a number of levels such as discouraging migrants from accessing care as well as making it difficult to describe symptoms, understand recommended care and participate in the clinical encounter. Effectiveness of care,

which included interpersonal communication and clinical effectiveness, could be linked, at least to some degree, to language issues. Participants perceived private health providers as more willing to talk to them in English or explain things while miscommunication and perceptions of discrimination were more frequent in the public sector. This is not surprising since doctors' practices are known to be influenced by healthcare remuneration schemes, with doctors spending more time on clinical care with fee-for-service patients (Hennig-Schmidt *et al.*, 2011; Sarma *et al.*, 2010). Perceptions of discrimination or negative stereotypes from health providers, even though not emerging as a barrier to access, were linked to perceived low quality of care and again this reflects similar findings in the literature. Other research has shown that doctors' perceptions are influenced by their patients' race and socio-economic status (SES) and that doctors view patients from ethnic minorities and of low SES more negatively than white patients and patients from high SES categories (van Ryn and Burke, 2000). Even though this does not explicitly reflect delivery of substandard quality of care, our findings suggest that negative stereotypes and lack of cultural awareness may, even inadvertently, lead to inequalities in quality of care, compared to the non-migrant population.

Furthermore, the cost of healthcare services and insurance coverage were the most often cited barriers to healthcare resources, while in the case of domestic workers other factors were equally important. Even though the rest of the EU countries have set in place funding mechanisms linked to social insurance payments which ensure at least some level of coverage for all legal residents (Stanciole and Huber, 2009), Cyprus still lacks a comprehensive healthcare system (Antoniadou, 2005). Research has shown how health insurance coverage among migrants significantly affects access to primary care and health-seeking behaviour (Mou *et al.*, 2009; Siddiqi *et al.*, 2009) while increases in the number of health interventions undertaken are observed following health insurance coverage in the population (Chen *et al.*, 2011).

However, one important finding that distinguishes this study is that it highlights how temporary migrants' access to healthcare services does not always depend on insurance coverage. Participants reported that individual and organisational factors also impacted on their ability to make use of their insurance coverage, including knowledge of being insured, complicated reimbursement bureaucratic procedures, reliance on out-of-pocket payments at the point of entry, and the insurance package which did not cover for dental or preventative procedures. Guest workers and in particular domestic workers are among the lowest paid groups of the Cypriot labour force (Department of Labour Relations, 2010). Low economic status means that migrants might not be able to make payments for high-cost procedures such as surgery, even when this could impact on their health status and even if part of this cost could be reimbursed in the future. Other research has also shown that demographic characteristics and especially income play the most important role in persisting disparities in access, even with the presence of health insurance coverage (Zuvekas and Tallaferro, 2003).

From a theoretical perspective the findings of this study add evidence to the role of the capability perspective in healthcare research. Even though the literature on healthcare access and inequalities within the migrant population is extensive, it does not take into consideration temporary migrants and often distinguishes research between ethical and political approaches and research situated within healthcare practice. Discussions on equal access and a rights-based approach have also been criticised for lacking agreement on what constitutes a basic or adequate level of care and of not being persuasive (Ruger, 2006b; Sokolec, 2009). Perhaps more importantly, they have been criticised for disregarding the elements of health need, health norms and individual choice and ability to have control over personal or other situations in order to pursue the goal of health (Ruger, 2006b).

The role of the socio-economic and political environment over migrants' ability to exert control over decision-making and health behaviours in order to pursue the goal of health is highlighted in the findings of this study. Theorising these findings through the lens of the capability approach allows for a comprehensive framework to understand the grounding of health within broader socio-economic and political events. The capability approach focuses on empowerment of vulnerable populations in order to be able to make use of healthcare resources as they see fit as well as address inequities in service distribution. This might be

more realistic and efficient in the context of pressures experienced by the local healthcare system such as in the case of Cyprus. The Cypriot Government has so far been unsuccessful in implementing the National Health Insurance Scheme (Antoniadou, 2005) and this does not seem to change soon. By situating health within the broader social context, the capability approach allows for more realistic and manageable changes, partly due to already existing pressures from the EU and other international organisations to tackle issues of discrimination and lack of policies promoting integration (Huddleston *et al*., 2011; HUMA Network, 2011).

Tackling healthcare access of temporary migrants without setting in place capability-promoting activities in other areas, including employment and social integration, appears inadequate in fully protecting the health of this group. For example, even though the Cypriot Government has attempted to protect the health of migrants by making health insurance coverage a legal requirement before a residence permit is granted, restrictive policies, practices, and social norms in other areas of the migrants' life make the presence of health insurance a weak tool in improving quality of care. Employers were found to control access, transport and financing of care and also acted as middle-men between the health provider and the migrant worker. Fears of deportation, exacerbated by lack of knowledge of employment and healthcare rights, were found to infiltrate all decisions for assertiveness and claims of fairer treatment by the employer. In fact, previous research has shown that domestic workers in Cyprus who displayed assertive behaviour towards their employers were accused of being ''immoral'' and ''ungrateful'' and of exhibiting ''criminal'' conduct, often resulting in non-renewal or termination of their contract (Panayiotopoulos, 2005).

The case of Cyprus highlights the dangers of stringent migration programmes which limit the rights of temporary migrants. A new report by the European Policy Centre (EPC) (McLoughlin *et al*., 2011) discusses the importance of temporary migration for the EU but at the same time raises the unresolved concerns of the potential impact and costs of increased temporary migration on European society, particularly in the context of migrant integration. Even though migrant integration features strongly within EU migrant policy, integration policies are directed towards those migrants and their children who are expected to be or who are long-term residents of the guest country. The EPC report acknowledges that the reality of temporary and circular migration introduces an entirely new and complex set of integration challenges (McLoughlin *et al*., 2011). Despite these challenges, when viewed through the health capabilities approach, guest countries should aim to promote health capability and health agency in temporary and circular migrants living in their territories. This might involve integration of this category of migrants to existing integration programmes thus maintaining a common policy approach, or adapt existing policies and programmes towards temporary migrants.

Study limitations and directions for future research

This study has a number of limitations including the recruitment process. Participants' characteristics may not reflect the overall temporary migration population due to the difficulties involved in recruiting temporary migrants. For example, even though the large majority of domestic workers live with their employers, only six out of 13 participants were live-in domestic workers. It is possible that the most vulnerable of these women could not be reached due to limitations in movement and high dependency on their employer. Also, temporary labour workers were very difficult to recruit due to their very long working hours, limitations in movement from lack of transport, and their rural workplace. Language further compromised recruitment as many migrants, particularly domestic workers and labour workers, could not communicate in the Greek language and their English language skills were minimal. Finally, challenges pertaining to communication and time-constraints were also encountered during the interview process.

Despite these limitations, the findings of this study shed some light to the health experiences of temporary migrants living and working in Cyprus. Even though some factors emerging to influence access and utilization of healthcare resources have already been discussed, this study has highlighted the importance of situating the healthcare experience of migrants within the broader social context which so far has not been extensively considered within

healthcare research. The societal basis of health inequalities and the distinct role of the healthcare and socio-politico-economic systems have been acknowledged (Scambler, 2011) and yet little progress has been made in reducing these inequalities (Sheikh, 2009). The role of socio-economic and political factors in quality of care emerged through the theme of disempowerment, and was an important finding of the study. Categorising risk factors in terms of demand and supply while investigating issues of policy in parallel research can be simplistic and does not really capture the multidimentional, interwoven, and complex issues which affect health functioning in the migrant population.

Future research should attempt to investigate on a larger scale through population surveys the representativeness of the identified factors on the wider temporary migration population and link these to investigations of health-related quality of life and perceived healthcare needs. This will privide a more valid understanding of the importance of these factors in hindering health functioning, guide policy development and identify areas for improvement. Existing policies, both within health and in other domains such as integration, should also be analysed and critiqued through the capabilities approach so that the role of structural domains on individual freedom should be understood. At the same time, more qualitative research should attempt to explore how individual migrants understand their health and health norms including the time they should access healthcare and what type of healthcare. This should also explore the possible role of ethnicity in healthcare utilization through recruiting from a number of ethnic groups, e.g. Asians, Middle Eastern, Eastern European. In this sense future research should look at advancing and bringing together epidemiological and qualitative findings through a capabilities framework that takes into consideration structure and health agency as to their role in health inequalities among temporary migrants.

References

Abel, T. and Frohlich, K.L. (2012), ''Capitals and capabilities: linking structure and agency to reduce health inequalities'', *Social Science & Medicine*, Vol. 74 No. 2, pp. 236-44.

Anand, P. and Dolan, P. (2005), ''Equity, capabilities and health'', *Social Science & Medicine*, Vol. 60 No. 2, pp. 219-22.

Antoniadou, M. (2005), ''Can Cyprus overcome its health-care challenges?'', *The Lancet*, Vol. 365 No. 9464, pp. 1017-20.

Braun, V. and Clarke, V. (2006), ''Using thematic analysis in psychology'', *Qualitative Research in Psychology*, Vol. 3 No. 2, pp. 77-101.

Charmaz, K. (2008), ''Grounded theory'', in Smith, J.A. (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods*, 2nd ed., Sage, London, p. 81.

Chen, X., Chen, C., Zhang, Y., Yuan, R. and Ye, J. (2011), ''The effect of health insurance reform on the number of cataract surgeries in Chongqing, China'', *BMC Health Services Research*, Vol. 11 No. 1, p. 67.

Coast, J., Smith, R.D. and Lorgelly, P. (2008a), ''Welfarism, extra-welfarism and capability: the spread of ideas in health economics'', *Social Science & Medicine*, Vol. 67 No. 7, pp. 1190-8.

Coast, J., Flynn, T.N., Natarajan, L., Sproston, K., Lewis, J., Louviere, J.J. and Peters, T.J. (2008b), ''Valuing the ICECAP capability index for older people'', *Social Science & Medicine*, Vol. 67 No. 5, pp. 874-82.

CYSTAT (2011), *Preliminary Results of Population Census, 2011*, Cyprus Statistical Service, Nicosia.

Department of Labour Relations (2010), ''Minimum wage ordinance with effect from April 1, 2010'', available at: www.mlsi.gov.cy/mlsi/dlr/dlr.nsf/0/6A4286AC9BC7ED46C225782D003E22D4?Open Document (accessed 1 April 2010).

European Migration Network (2011), *Temporary and Circular Migration: Empirical Evidence, Current Policy Practice and Future Options in EU Member States*, European Union, Brussels, October.

Gasper, D. and Truong, T.D. (2010), ''Movements of the 'We': international and transnational migration and the capabilities approach'', *Journal of Human Development and Capabilities*, Vol. 11 No. 2, pp. 339-57.

Hennig-Schmidt, H., Selten, R. and Wiesen, D. (2011), ''How payment systems affect physicians' provision behaviour – an experimental investigation'', *Journal of Health Economics*, Vol. 30 No. 4, pp. 637-46.

Huddleston, T., Niessen, J., Chaoimh, E.N. and White, E. (2011), *Migrant Integration Policy Index*, British Council, Migrant Policy Group, Brussels.

HUMA Network (2011), *Access to Healthcare and Living Conditions of Asylum Seekers and Undocumented Migrants in Cyprus, Malta, Poland and Romania*, HUMA Network, Madrid.

ILO (2010), *International Labour Migration: A Rrights-based Approach*, International Labour Office, Geneva.

Lenard, P.T. and Straehle, C. (2010), ''Temporary labour migration: exploitation, tool of development, or both?'', *Policy and Society*, Vol. 29 No. 4, pp. 283-94.

McLoughlin, S., Munz, R., Bunte, R., Hultin, G., Muller, W. and Skeldon, R. (2011), ''Temporary and circular migration: opportunities and challenges'', Working Paper No. 35, European Policy Centre, Brussels, March.

Michael, M.S., Hatziyiannis, C., Stephanides, M., Christofides, L. and Klirides, S. (2005), *The Economic Impact of Foreign Workers in Cyprus*, University of Cyprus, Nicosia.

Mou, J., Cheng, J., Zhang, D., Jiang, H., Lin, L. and Griffiths, S.M. (2009), ''Health care utilisation amongst Shenzhen migrant workers: does being insured make a difference?'', *BMC Health Services Research*, Vol. 9, pp. 214-22.

Panayiotopoulos, P. (2005), ''The globalisation of care: Filipina domestic workers and care for the elderly in Cyprus'', *Capital & Class*, Vol. 88, pp. 1-36.

Patton, M.Q. (2002), *Qualitative Research and Evaluation Methods*, Sage, Thousand Oaks, CA.

Risse, M. (2009), ''Immigration, ethics and the capabilities approach'', Human Development Report No. 34, United Nations Development Programme, New York, NY.

Robeyns, I. (2005), ''The capability approach: a theoretical survey'', *Journal of Human Development*, Vol. 6 No. 1, pp. 93-117.

Robeyns, I. (2006), ''The capability approach in practice'', *Journal of Political Philosophy*, Vol. 14 No. 3, pp. 351-76.

Ruger, J.P. (2006a), ''Health, capability, and justice: toward a new paradigm of health ethics, policy and law'', *Cornell Journal of Law and Public Policy*, Vol. 15 No. 2, pp. 403-82.

Ruger, J.P. (2006b), ''Rethinking equal access: agency, quality, and norms'', *Global Public Health*, Vol. 2 No. 1, pp. 78-96.

Ruger, J.P. (2006c), ''Toward a theory of a right to health: capability and incompletely theorized agreements'', *Yale Journal of Law and The Humanities*, Vol. 18, pp. 273-326.

Ruger, J.P. (2010), ''Health capability: conceptualization and operationalization'', *American Journal of Public Health*, Vol. 100 No. 1, pp. 41-9.

Sarma, S., Devlin, R.A., Belhadji, B. and Thind, A. (2010), ''Does the way physicians are paid influence the way they practice? The case of Canadian family physicians' work activity'', *Health Policy*, Vol. 98 Nos 2-3, pp. 203-17.

Scambler, G. (2011), '''Tackling health inequalities' and its pros, cons and contradictions: a commentary on Blackman, Wistow and Byrne'', *Social Science & Medicine*, Vol. 72 No. 12, pp. 1975-7.

Sen, A.K. (1992), *Inequality Reexamined*, Harvard University Press, Cambridge, MA.

Sen, A.K. (1985), *Commodities and Capabilities*, Oxford University Press, Oxford.

Sheikh, A. (2009), ''Ethnic minorities and their perceptions of the quality of primary care'', *British Medical Journal*, Vol. 339 No. 16_3, p. b3797.

Siddiqi, A., Zuberi, D. and Nguyen, Q.C. (2009), ''The role of health insurance in explaining immigrant versus non-immigrant disparities in access to health care: comparing the United States to Canada'', *Social Science & Medicine*, Vol. 69 No. 10, pp. 1452-9.

Sokolec, J.E. (2009), ''Health care for the undocumented: looking for a rationale'', *Journal of Poverty*, Vol. 13 No. 3, pp. 254-65.

Stanciole, A.E. and Huber, M. (2009), ''Access to health care for migrants, ethnic minorities, and asylum seekers in Europe'', available at: www.euro.centre.org/data/1254748286_82982.pdf (accessed 2009).

Trimikliniotis, N. and Demetriou, C. (2011), ''Labour integration of migrant workers in Cyprus: a critical approach'', in Pjnik, M. and Campani, G. (Eds), *Precarious Migrant Labour Across Europe*, Mirovni inštitut, Ljubljana, pp. 73-96.

van Ryn, M. and Burke, J. (2000), ''The effect of patient race and socio-economic status on physicians' perceptions of patients'', *Social Science & Medicine*, Vol. 50 No. 6, pp. 813-28.

Zuvekas, S. and Tallaferro, G. (2003), ''Pathways to access: health insurance, the health care delivery system, and racial/ethnic disparities, 1996-1999'', *Health Affairs*, Vol. 22, pp. 139-53.

Further reading

Betancourt, J.R., Green, A.R., Carrillo, J.E. and Park, E.R. (2005), ''Cultural competence and health care disparities: key perspectives and trends'', *Health Affairs*, Vol. 24 No. 2, pp. 499-505.

Krajic, K., Strasharpmayr, C., Karl-Trummer, U., Novak-Zezula, S. and Pelikan, J.M. (2005), ''Improving ethnocultural competence of hospital staff by training: experiences from the European 'Migrant-friendly Hospitals' project'', *Diversity in Health and Social Care*, Vol. 2 No. 4, pp. 279-90.

Laurie, M.A., Susan, C.S., Mindy, T.F., Jonathan, E.F. and Jacques, N. (2003), ''Culturally competent healthcare systems: a systematic review'', *American Journal of Preventive Medicine*, Vol. 24 No. 3, pp. 68-79.

WHO (2003), *International Migration, Health and Human Rights*, World Health Organization, Geneva.

About the authors

Dr Christalla Pithara has worked as a Research Associate with the Open University of Cyprus in the research project ''Migrants and health in Cyprus''. She has been involved in health care research and her research interests include the application of qualitative methodologies in health economics, evaluation of health care services, psychosocial consequences of health care services, and welfarist and non-welfarist approaches to economic evaluation. Christalla Pithara is the corresponding author and can be contacted at: Christalla.pithara@gmail.com

Dr Michalinos Zembylas is Associate Professor of Education at the Open University of Cyprus and Director of Curriculum Development for CARDET. His expertise lies in qualitative methodologies. His research interests are in the areas of educational philosophy and curriculum theory, and his work focuses on exploring the role of emotion and affect in curriculum and pedagogy. He is particularly interested in how affective politics intersect with issues of social justice pedagogies, intercultural and peace education, and citizenship education.

Dr Mamas Theodorou is Associate Professor in the Health Management Programme of the Open University of Cyprus. His background is in health economics and is an expert in the organisation and evaluation of health systems, quality of care and delivery of health care services. He has co-authored a number of books and articles in this area.