

Perception of the Ecuadorian population living in Barcelona regarding access to health services

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Abstract

Objectives To analyse the factors that influence access to health services from the point of view of the Ecuadorian population living in Barcelona.

Methods A qualitative, descriptive and phenomenological study was carried out by semi-structured individual interviews on a sample of Ecuadorians (18) with maximum variation in age, sex, time since arrival and administrative status. The analysis was conducted according to Colaizzi's method. The study area was Barcelona.

Results Access was considered to be easy for personal health-care card (PHC) holders. However, interviewees identified few factors that facilitated access related to the Ecuadorian population (PHC holder, language, social networks) and the health system (free care, opening hours). In contrast, a number of hindering factors related to both the Ecuadorian population (insufficient knowledge of the system, problems with the documentation in obtaining the PHC, working conditions) and to the system itself (information availability, resources, organisation, attitude of staff) were also identified.

Conclusions Although access was perceived as easy, the Ecuadorian population has to overcome a number of barriers to obtain care. These obstacles may have consequences on immigrants' health and on the efficiency of the system.

Keywords Perception · Health services accessibility · Immigration · Barriers · Qualitative studies

Introduction

The rapid rise of the immigrant population in Spain, which in 2008 represented 11.4% of the total population (Instituto Nacional de Estadística 2009), has modified the profile of the population to be attended by the health services, which must adapt to respond to the new needs of this population (Departament de Salut 2006). Catalonia, an autonomous region of Spain, has experienced the same increase as the rest of the country, but with higher figures; the migrant population makes up 14.9% of the region's total population (Institut d'Estadística de Catalunya 2009). As in the rest of Spain, there is a wide range of countries of origin, with Ecuadorians forming the third largest group at 8.29% (Institut d'Estadística de Catalunya 2009).

Studies in countries with a greater tradition of immigration and a national health system, such as the UK and Canada, report worse health in the immigrant population (lower life expectancy and higher mortality rates for certain causes) (Health Canada 2008; Szczepura 2005). This is related to worse socioeconomic conditions and the inability of the services to adapt to this group's specific linguistic and cultural needs, which act as barriers to access, particularly during the process of adaptation (Health Canada 2008; Stronks et al. 2001).

General Health Act of 1986 (Ley General de Sanidad 1986) established the right for all Spanish and foreign citizens residing in Spain of access to free health care. Later on, a new decree explicitly granted access to health care to people without economic means (Real Decreto 1989). In addition, in 2000, foreigners without a residence

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permit but registered at the city council were granted the same right to health care as Spaniards. Those not registered were guaranteed emergency care as well as care for pregnant women and minors under the age of 18 years (Cortes Generales 2000). In spite of this, inequalities in access to care have been signalled as a determining factor of health inequalities in this population (Berra et al. 2004; Chauvin et al. 2007; Salinas et al. 2002). In this context, empirical studies that analyse access to services are mainly quantitative and descriptive and generally evaluate actual access (use of services) by the immigrant population, compared to that of the native population, particularly to hospital emergency services (Burón et al. 2008; Pérez et al. 2006; Rué et al. 2008). On the other hand, and to a lesser extent, few studies examine the determining factors of use, focusing on predisposing variables (level of education, knowledge of the language, time since arrival in the country, administrative situation, cultural differences) or enabling variables (job precariousness, housing conditions) associated with the population (Rodríguez et al. 2008; Torres-Cantero et al. 2007). Furthermore, research into access from the perspective of the social actors, quantitative surveys (Esteva et al. 2006; Plaza et al. 2008) or qualitative studies (Burón et al. 2009; Ramos et al. 2001; Vázquez et al. 2009) focus on the difficulties in providing care for this group and mainly consider the situation from the perspective of health professionals.

In short, there are very few empirical studies that analyse access by the immigrant population to health services in Spain, and even fewer that explore how population and contextual factors influence access, from the point of view of the immigrants. The objective is to analyse the perception of access to health services of the Ecuadorian population living in Barcelona, to identify factors that facilitate or hinder their access.

Methods

A qualitative, descriptive and phenomenological study was carried out (Marshall and Rossman 1990; Patton 1990; Wojnar and Swanson 2007). The purpose of the study was to describe, from the point of view of the Ecuadorian population, the structure and essence of a phenomenon, that is, access to health care. To analyse access, the theoretical framework used was that proposed by Aday and Andersen (1974), which distinguishes dimensions related to health policies and the characteristics of the population and health-care services that influence access to care. Its further adaptation for immigrant population was as in Scheppers et al. (2006).

The research took place in the city of Barcelona, which was chosen due to its high proportion of immigrant

population from Ecuador. The field work took place between October and December of 2008.

The study population comprised Ecuadorians living in Barcelona, who had used or tried to use health services of the national health system. A maximum variation sample was taken (Patton 1990) with regard to the criteria of age, sex, time since arrival, administrative status (documented/undocumented) and reason for migration. Contact was first made with Ecuadorian associations in Barcelona, but as no results were forthcoming, a snowball sampling was used to reach informants. The final sample size of 18 individuals was determined by saturation: that is, when a new interview provided no additional information for the study's objectives (Valles 1997). The characteristics of informants are shown in Table 1.

Individual semi-structured interviews were conducted, with a topic guide (Patton 1990) of the themes to be addressed during the interview: the opinions and perceptions on information on the health system; the experience in the use of health care; and elements related to the access to health services. All themes were addressed as they came up during the interview. In addition, all emerging themes relevant to the study objectives were followed up during the interview. These interviews, which lasted between 50 and 80 min, were recorded and then fully transcribed.

Analysis was conducted according to Colaizzi's method (Wojnar and Swanson 2007) for elucidating interviewees' understanding of the phenomenon, with the support of the software Atlas-ti 5.0. The process of generation categories was mainly inductive. Data were segmented by themes, with a mixed generation of categories from the topic guide and those emerging from the data (Table 2). Themes were identified, coded, re-coded and classified identifying common patterns by looking at regularities, and convergences and divergences in data, through a process of constant comparisons, going back and forth between data and conceptual framework. To ensure data quality, the information obtained was triangulated by the participation of four analyst members of the research team, with different personal and professional backgrounds (a foreign public health student; three national researchers including a health economist, a medical doctor and a public health specialist with experience in using qualitative research and analysing access to care) and an in-depth knowledge of the context (years of work and research) (Patton 1990; Vázquez et al. 2006). To make the researchers aware of their assumptions and preconceptions, bracketing was accomplished in three ways: (a) revision of the literature on the subject, (b) seeking critique of the investigators' insights from methodological experts and other researchers with experience in the subject under investigation; and (c) taking note of their observations and assumptions and discussing them all along the process of research.

Table 1 Characteristics of the sample of informants (Barcelona, 2008)

Informants	Age	Status		Children		Personal health-care card		Time since arrival		Education level			Reason for migration			Total			
		20-30	31-37	Documented	Non-documented	Yes	No	Yes	No	<3	3 or >3	Primary	Secondary	Vocational training	University		Economic	Studies	Family unification
Male	4	6	8	2	1	9	6	4	4	6	4	-	2	3	3	5	3	1	10
Female	3	5	7	1	3	5	8	-	3	5	5	1	3	1	3	3	4	2	8

Source author's own

Table 2 Categories and sub-categories that emerged in data analysis (Barcelona, 2008)

Analysis categories	Analysis sub-categories
Factors related to Ecuadorian population	Knowledge of the health system
	Obtaining personal health card
	Working conditions
	Attitude of the population
Factors related to health services	Health care needs and use of services
	Provision of information
	Documentation required to obtain personal health card
	Organisation of provision
	Perceived technical quality of staff

Source author's own

Participants were informed of the objective of the study and that they were free to leave at any point. Participants gave their oral consent for the interviews to be recorded. The recordings and transcripts were codified in such a way that the individual origin of each one could not be identified, before being appropriately stored.

Results

Most of the participants consider access to health services to be easy when someone is in possession of the personal health-care card (PHC). However, factors that enable or hinder access emerged in the discourse relating both to the immigrant population and the health services alike, whereby barriers were clearly predominant.

Factors enabling access to health care

Three factors relating to Ecuadorians that facilitate access were identified: being a PHC holder, knowing the language and having a social network (Table 3). Some informants pointed out that having the PHC gave them a feeling of security and protection. In their discourses, the knowledge of one of Catalonia's official languages, which facilitates communication, also emerged along with the social support network as advantages to access health care. Support of friends and relatives are recognised as important to register with the city council, to obtain information on services and to receive assistance with family commitments.

Regarding health services, most of the informants know and value the fact that the services are free at the point of delivery, which makes them feel protected and included in the system (Table 4). Many participants also point out the accessibility of primary care, with its extensive opening hours and its proximity to their homes, as a factor that helps their attendance.

Table 3 Examples of verbatim quotations of the enabling factors relating to the immigrant population (Barcelona, 2008)

Enabling factors	Quotation
Holding an individual health card	“(…) that it was really good; you were protected, in terms of health; and then… I don’t know, after 2 or 3 months of being here, I got the card”
Language	“(…) But, well, I mean what I’ve seen is that, it’s just lucky that we have the same language”
Social network	“(…) since I got here, friends of mine told me that I should register with the council, they said: “go and register so you can get access to health care”, then afterwards I went to a friend’s house and that’s where they registered me” “(…) Sometimes my mother-in-law helps me, when I have to… I don’t have time, so my mother-in-law helps me out. She takes them, when I’m not getting, when I have to, they don’t give me the time off or something, then my mother-in-law helps me out”

Source author’s own

Table 4 Examples of verbatim quotations of the enabling factors relating to the health services (Barcelona, 2008)

Enabling factors	Quotation
Universal and free access	“So everyone has access to it, I think that’s great, because the first thing that people need is their health, and everything else comes afterwards” “Because when I arrived, they told me that health care services were free. How great! Right? Of course (….) Positive”
Geographical and organisational accessibility of primary health care	“Good, because (the centre) is just a street away” “(…) Those are the times, and they ask you, what time do you want (….) Sometimes in the morning and sometimes in the afternoon, I mean at whatever time I… that suits me, either in the morning, fine, or in the afternoon, fine”

Source author’s own

Access-hindering factors related to Ecuadorian population

The informants identify a number of elements relating to the immigrant population that hinder access to services, particularly upon arrival: knowledge of the system, living and conditions, and attitudes and use of services (Table 5).

Insufficient knowledge of the health system

Few informants know that in Spain health care is a right, whatever their administrative status. The majority also report not knowing at the time of arrival either the PHC as an access requirement or the health services available that they have a right to, referrals for specialist care and the need for a prescription for co-payment at pharmacies: “That’s my problem, I don’t know exactly how far the services go, and the rights that I might have within the health system”. According to the interviewees, the consequence of this is not obtaining or taking longer to obtain the PHC, meaning a limited service use and, in some cases, economic repercussions, as they have to pay for the total cost of medicines or contract a private insurance. The main source of information is word of mouth, but the participants feel that they receive partial and contradictory information. They had to gain knowledge through their own experience.

Lacking a registered place of abode

Most of the interviewees find the process involved in obtaining the PHC to be quick and easy. They state, however, that an essential requisite to be granted a PHC, i.e. registering with the city council, is the main difficulty, because of their inability to register a place of abode for a variety of reasons. These include: not having their own home or a rental contract; the owner not authorising their registering; not having utility bills in their name, “But there are people… who don’t have a flat, who live in a rented room, and the woman you live with doesn’t want to register you. That’s the problem for some of us, because there are people that rent you a room, but don’t want to register you”. To overcome the problem, they use different strategies, such as registering at the home of relatives or friends. All the informants with an undocumented status have obtained their PHC, but they point out the fear of “being recorded” on official databases amongst those with such a status as a barrier to obtaining their PHC.

Precarious employment and working conditions

Difficulties relating to temporary contracts, working in the black economy or having more than one job, fear of being fired, being refused time off to go to the doctor or long

Table 5 Examples of verbatim quotations of the hindering factors relating to the immigrant population (Barcelona, 2008)

Hindering factors	Quotation
Insufficient knowledge of the health system	“(…) It’s just that the few times that I go, it’s the GP. I don’t know if you can ask to see a specialist directly, for example”
	“For example, when there is pre-paid medicine; (…) I didn’t know that; because at first I started buying it and I was working; (…) and I went to the pharmacy and I bought it outright without taking the prescription”
	“What did happen to me was what happened more or less to other people, I mean they all had to get access, everybody was given different information (…)”
Lacking a registered place of abode	“Because they think that that’s how they can tell if they don’t have papers and because it’s an official place, which at the end of the day they’re entering your details and that’s how they can locate you, I imagine it’s because of fear”
	“(…) It’s difficult for someone without papers because they’re scared... of being put on file or being recognised as someone without papers and that not having papers might cause problems (…)”
Precarious employment and working conditions	“Sometimes it’s temporary; and like I say, because of, because of the actual job, here, eh... now we’re in a time when if you’re out of work, because of illness, the company might... might end your work; so in order not to lose your job, well, you stop going to the doctor”
	“No, no, just work. (...) but because of work I can’t... I mean I can’t leave (...) there are days that I just don’t ask, because there’s a lot of work”
	“Sometimes when I make an appointment and at times at work they don’t give me the time off; I have to stay and leave the appointment there hanging (...) because sometimes I ask the lady for the time off, and she tells me that as I work in this boys’ residence, that I can’t leave the floor stranded so sometimes I haven’t had time to go”
Submissive attitude of the Ecuadorians	“If you let your head drop, that’s where it stays (...) People who... I don’t know... who feel more insecure about being here or who arrived recently”
Perceived need and use of services	“Yes, I’ve felt poorly, but I haven’t been (...): Because it hasn’t been anything so serious, and that’s when I use my own little home-made remedies”
	“They can tell me what they like, but I go with my children, I don’t have anyone to leave my children with...”
	“It depends on how ill you feel, but if I see that; I mean I prefer curing medicine. I almost never take anything chemical unless I’ve already got an infection or something like that. Something that’s out of my hands, but if I can control it, well, prevention is best”
	“It was perhaps one of the first times that I went to the doctor here, to tell her, my GP, if she would do, or if she needed to do a check-up or something”

Source author’s own

working hours emerge strongly in the interviewees’ discourses. The main obstacle to using health services is the fear of losing their job, “Now we’re in a time when if you’re out of work, because of illness, the company might end your contract; so in order not to lose your job, well, you stop going to the doctor”. Only one informant felt that the distance from their place of work to the health centre would make it difficult to access. These difficulties led to them not requesting or not attending to health appointments made for them or their relatives, seeing the doctor only when their illness worsens, hastening medical discharge and using self-medication.

Submissive attitude of the Ecuadorians

Some informants considered Ecuadorians to be submissive and insecure in accessing health services. They attribute this attitude to having a rural background or a low

socioeconomic status, and consider that it can also lead to reports of unequal care.

Perceived need and use of services

Most interviewees report resorting to the available health services only when their illness worsens or develops complications, or when it interferes with their daily routine. Many use home-based remedies to avoid a continued utilisation of conventional medicines, as they feel that it could cause more serious harm. With children, however, they seek care each time they fall ill. The most frequent health problems for which they use health services are respiratory, dermatological, digestive and gynaecological in nature. Some use health services for the first time for routine checks or to obtain prescriptions (in the case of informants with chronic illnesses). The usual place to access health service is the primary care

Table 6 Examples of verbatim quotations of hindering factors relating to the health services (Barcelona, 2008)

Hindering factors	Quotation
Insufficient provision of information	<p>“Well, they should give you more information, you know? They... well, they give you the card, but what do you have then? What can you do with it? You didn't have it before; I mean, I don't know, it's a bit, you know? Straight away, I mean, your papers, you filled two in and that's it, nothing else; it was information, I think; making it easier”</p> <p>“I know people that have been before I arrived and they ask me, “hey, what did you do to get the health card”</p>
Variation in documentation required to obtain the PHC	<p>“Well... first I registered with the council, then I went to my designated health centre and they told me that I had to get my social security number, in order to get the health card”</p> <p>“I mean, I know that now, for example, they don't just give you the health card, just like that, if you don't have your social security number”</p>
Issues around organisation of provision	<p>Primary care</p> <p>“What I didn't like one time was that; because I went once and I said: “I've got a problem here” and the doctor took a look, and I also said that it hurts me here, and the doctor said: “I'm not going to look you over completely on the same day, because I've got people waiting outside and you have to make an appointment for each thing”, the doctor said, and I didn't like that”</p> <p>“So, that time the doctor replied, telling me: “the thing is that I've only got ten minutes to see to you and you're making three consultations in one”</p> <p>“It was quick, because the doctor that saw me asked me general questions, I answered and told her my symptoms, and she gave me a prescription, she told me what care I had to take and it was quick, she didn't take long”</p> <p>Specialist care</p> <p>“It's just that... to go to a hospital is much further (...) And with the little time that you have (...). And even to go to a hospital, the hospitals are sometimes a bit further away than from where we live”</p> <p>“But to the hospital, they just see you, I think it's from 9 to 1, or 1.30 or 1.15, so you have to go during that time, and you can't ask for any other time, to go at 5 or 6 o'clock”</p> <p>“For example, my wife was given a gynaecology appointment, in 6 months' time; so then if you ask for an appointment, it's presumably because you're ill that you go to the doctor, not for you to get an appointment in 6 months' time (...)”</p> <p>“The bad thing is, is the appointments, the appointments that you get for 2, 3 months' time, that's the bad thing (...) But to be seen, the time you have to wait, 2, 3 months, for one appointment, then another, that's what I think is wrong. And that's what I'd like to be improved, if you ask me as a user”</p>
Health personnel behaviour	<p>“I was going crazy, I mean, I said: “how can you say what I've got without looking?”, I mean apart from me turning up and saying what I've got, and she didn't even give me a check-up”</p> <p>“They're very quick to see you, mind. You go, say it hurts, you say: “I've got stomach pain, or my back hurts”, they just put something there on your back and they give you a prescription”</p> <p>“It's that I had to ask her what was going to happen to me, or rather I had to take an interest in my illness rather than her telling me what was wrong, you know?”</p> <p>“The people themselves... the people that are there, at the desks, to give you your appointment, it's not... I think that they're capable but they're a bit like... overwhelmed by their work, to tell you your appointment and then on top they have to be giving you all the information”</p>

Source author's own

centre. They report little experience in using secondary care services.

Access-hindering factors related to health services

Identified factors that hinder access to health services are the provision of information, requested documentation in obtaining the PHC, organisation of health care provision and perceived technical quality (Table 6).

Insufficient provision of information

According to most interviewees, the information provided by the health system to facilitate access to services was inadequate “I think it's a lack of information. I mean that the information isn't very visible for everyone, at least for those who come from elsewhere and don't know how the system works here. It's not much.... there's not much information”, particularly with regard to the PHC: what it

is, what it is for and how to get one. This led to delays in obtaining a PHC, or to not obtaining one at all. Some Ecuadorians who have spent a long time in Catalonia, do not have a PHC yet because they do not know how to obtain one.

Variation in documentation in obtaining the PHC

Some informants state that the documentation requested at primary care centres to process the PHC vary from one to the other. In some cases, their social security number was asked for. Those who have spent the longest amount of time in Catalonia report a tightening up of requirements in processing the PHC by care centres. As a consequence, they do not obtain their PHC, or there is a delay in getting it, and are forced to take out private insurance.

Issues around organisation of provision

Most interviewees point out to the short duration of the primary care and specialist visits as difficulty in getting a detailed explanation of their symptoms. As a consequence, there emerges a feeling of mistrust of the care received, and as a result they do not arrange new visits or resort to self-medication. Morning consultation hours hinder their ability to attend appointments and lead to interruptions in the care received. For some participants, the long waiting times involved in receiving specialist care “The bad thing is, is the appointments, the appointments that you get for 2, 3 months’ time, that’s the bad thing” leads to a fear of possible complications of their illness and, consequently, they use emergency care. Informants who have used specialist care report having had difficulties due to the distance that they must travel to attend their appointments.

Health personnel behaviour

Most of the informants point out that the behaviour of medical staff (particularly in primary care) influences their use of services. Participants mistrust their doctors due to a scant or non-existent physical examination, being given a prescription following very little examination, little eye contact and no information given on their health condition, “I was going crazy, I mean, I said to myself: how can you say what I’ve got without looking at me? I mean apart from me turning up and saying what I’ve got, and she didn’t even examine me”. As a consequence, they do not make or fail to go to new appointments, they consult with their pharmacist or they self-medicate. In contrast, some participants state that the behaviour of the reception staff, although hard and distant, does not influence their use of the services. They attribute this behaviour to the staff’s workload.

Discussion

The results allow for a detailed analysis of the elements that Ecuadorian migrants identify as facilitating or hindering access to health services. However, when considering the results, it should be taken into account that the study focuses solely on the Ecuadorian population living in Barcelona. As such, it represents a specific context and the vision of only one of the immigrant populations of Spain. Nonetheless, similarities with the results of studies referring to other contexts and immigrant groups were also found.

Access to health care was perceived as easy with the personal health-care card, and some facilitating factors were identified. However, interviewees identified a number of barriers related to the immigrant population (poor knowledge of the system, poor working conditions) and to the system (insufficient information available, organisation, behaviour of health personal).

People from Ecuador share one of the official languages of the country to which they have migrated (i.e. Spanish), which led to language being considered a facilitator in accessing services, in contrast to the large majority of studies that point out to language as one of the main access barriers (Green et al. 2005; Ngo-Metzger et al. 2003). Another facilitating factor that emerged is the support given by social networks, which seems to be particularly relevant to the migrant population, as it has also been identified as an element that strengthens and facilitates the integration of immigrant populations in the country where they live (Lurbe 2005).

Taking into account the conceptual framework of Aday and Andersen (1974), barriers in accessing health-care with regard to migrant population seemed to be more compare to those referring to health services. However, some of them are directly related, for instance, to lack of knowledge, insufficient provision of information; labour conditions, pattern of use of health services and organisational barriers. The difficulties arising due to poor knowledge of the health system, which relates above all to not knowing the mechanism of access (the PHC and requirements to obtain one) and how the services are organised, emerge strongly in the first few months after arrival in Barcelona and whilst trying to make their first contact with the system. Studies carried out in Spain point out that the migrant population does not access information easily (Instituto de investigación en ciencias sociales 2005; Gabinete de Investigación Social y Estudios de Mercado 2005) and these initial difficulties are not exclusive to immigrants living in Catalonia, but occur in the rest of Spain and elsewhere (Jansa and Borrell 2002; Teng et al. 2007).

As in other studies, the main source of information amongst participants, is ‘word of mouth’, mainly from people of their own nationality who have lived longer in

the country (Gabinete de Investigación Social y Estudios de Mercado 2005; Simich et al. 2007; Vázquez-Villegas et al. 2000, Rodríguez et al. 2009). The lack of knowledge of the system directly relates to the insufficient provision of information by the health services, which emerges as a barrier in our results. Most of the health policy responses to the increase of immigrant population in Spain (amongst them, the Immigration Master Plan for Health (Departament de Salut 2006) in Catalonia) aim amongst others to disseminate information on the health system to the immigrant population to facilitate access to adequate care (Terraza-Núñez et al. 2010). The results of this study, however, indicate that dissemination has been so far insufficient to reach Ecuadorians and probably more so for other nationalities.

Work and employment conditions emerged as a main difficulty in receiving or continuing medical care. It has been already described in other studies that highlight precarious working conditions such as fear of losing one's job and not being given time off (Instituto de investigación en ciencias sociales 2005; Gabinete de Investigación Social y Estudios de Mercado 2005; Simich et al. 2007). The main consequence is the use of services only when an illness worsens or the utilisation of emergency services, which is in line with previously published systematic revisions (Ahonen et al. 2007; Scheppers et al. 2006). This would not only have consequences on the immigrant patient's health, but also on the adequacy of health services utilisation. However, available literature in our context is not conclusive in relation to the adequacy of the service use by the immigrant population. Whilst some show that immigrants use emergency services more than the native population (Plaza et al. 2008; Rué et al. 2008), others show the opposite (Burón et al. 2008).

In addition to insufficient provision of information, barriers related to health services or supply side refer to organisational factors and health personnel behaviour. According to Aday and Andersen (1974), organisational factors may generate barriers both before and once the patient has already entered the system. These two types of barriers appear in the informants' discourses, for instance geographical distance of specialised care, morning consultation appointments or waiting times in referrals to specialised care. These results signal structural deficiencies related to both the health services and to migrants, as morning consultations are incompatible with patterns of employment.

Informants considered health personnel behaviour as a barrier for the use of health services. Different studies indicate that migrants, especially Latin Americans, expect greater empathy from health professionals and relate it to the health culture in the country of origin. This would explain why expectations of Ecuadorian immigrants are not

met with regard to health personnel behaviour (Instituto de investigación en ciencias sociales 2005; Anderson et al. 2003). In our study, however, differences in health beliefs between Ecuadorian patients and health professional did not seem to be a barrier. Other studies show that ethnic minority patients' cultural perceptions of symptoms may act as a barrier because their needs may be differently expressed (Scheppers et al. 2006) or because of the different use of the language in Spanish-speaking groups (Vázquez et al. 2007). One question that emerges is how far underlying cultural barriers are insufficient communicational abilities on the side of the health personnel or even organisational barriers due to insufficient time for consultation.

It is important to note that these factors (poor communication between patient and health professional, not listening to patients' needs, inadequate or insufficient physical examinations) are attributes of quality of care and informants have valued them negatively. This could point to immigrants receiving lower quality of health care that needs to be further explored, as studies on this topic are scant, especially in Spain.

Finally, it is noteworthy that undocumented status in Spain and other countries is considered a hindrance in accessing any public service (Palmer and Ward 2007; Rodríguez and Lanborena 2006; Simich et al. 2007). In this study, it is not a factor that emerges as a barrier for the informants, as all those with undocumented status had obtained their PHC and had accessed health care. However, some do consider it to be a barrier for other Ecuadorians, linked to obstacles in registering with the city council and the fear of remaining registered in the host country, as described in other studies related to undocumented immigrants (PICUM 2007, HUMA Network 2009).

In conclusion, this study has provided an insight into the possible barriers that the immigrant population must overcome to access health services, which may have consequences on immigrants' health and on the efficiency of the system. They point towards insufficient implementation of the policies that aim to improve the access to health care of immigrants; they also highlight structural deficiencies of the system that need to be addressed through broader social policies. In addition, the study points towards an area where further research is needed: the adequacy of the care received by the immigrant population.

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