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Publication date

2008

Document Version

Final published version

Published in

Saúde e Migrações na UE = Health and Migration in the EU: better health for all in an inclusive society: conference proceedings

[Link to publication](#)

Citation for published version (APA):

Devillé, W. (2008). Access to Health Care: do Migrant Groups need Specific Attention? In A. A. Fernandes, & J. Pereira Miguel (Eds.), *Saúde e Migrações na UE = Health and Migration in the EU: better health for all in an inclusive society: conference proceedings* (pp. 107-112). National Institute of Health, Ministry of Health, Portugal.
<http://www.insa.pt/sites/INSA/Portugues/Publicacoes/Outros/Paginas/HealthMigrationEU.aspx>

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Access to Health Care: do Migrant Groups need Specific Attention?

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Inequalities in health do include inequalities in access to health care caused by many different factors at different levels: micro level – the clients or patients themselves, medium level – the means to get health care, and macro level, the health care system itself. I will address all issues involved at the hand of a model and I will illustrate the findings by the evidence coming from the literature and by taking the situation in the Netherlands as a case study.

Last fall in 2006, the Council of Europe came with an explanatory memorandum titled “Adapting health care services to cultural diversity in multicultural Europe”. They identified several barriers to health care and addressed accessibility as an aspect of quality of care. Besides other recommendations they emphasised the lack of data in most Member States. When searching the literature in the international databases it becomes clear indeed that the evidence about this subject is coming from a limited number of countries in Europe. From quite a number of countries we do not know much in relation with the health of and the use of health care by their migrant groups and ethnic minorities. In another paper that Allan Krasnik and colleagues wrote for the WHO European Healthy Cities Networks meeting in Turku in Finland last year, they divided the factors effecting access to health care in formal and informal ones.

If we agree that equity should exist in the services we deliver to our citizens, going for equity in health care and health services should mean going for equity in accessibility of those health services for anybody of our population, old or young, men or women, native or not, poor or rich, refugee or labour migrant. People with the same needs should have equal access to health services, should be able to use health services at the same level and receive the same quality or treatment. Receiving the same level and quality of services by equal needs signifies horizontal equity. When the level of services corresponds the level of health needs we are talking about vertical equity.

To address the subject of health care use we refer to one of the models that is often used in this situation, the model of Andersen, the last update published in 95. Under the label environmental factors associated with health care use, Andersen grouped the health care system as such and others factors belonging to the environment in the large sense. Population characteristics were regrouped as factors resulting in predisponibility, means to get health care and needs. Health behavioural factors are clustered under personal health behaviour – for instance the lifestyle factors, and eventually use of health care itself. All those factors finally have their impact on health, perceived or measured, and on user’s satisfaction with the health service delivered. Let us first look at the macro level, the health care system.

A systematic review looking at differences in the use of primary care services in western countries by non-western migrant groups compared to native populations shows us quite a heterogeneous picture: in 44% of the outcomes there were no differences between the migrant groups and the local population, 20% showed a higher use, 27% a lower use of primary care services. There was a significant difference between on the one hand the US and on the other hand studies coming from Canada, Denmark, Netherlands, Norway, Sweden and UK, that met the selection criteria for the review. This might be a sign that primary care services and as such the health system in the US are less accessible than in the other countries. But still, also in the European countries there was a lot of heterogeneity in the outcomes: 50% showed no differences, 25% showed a higher use, 12% a lower use. So, it is quite impossible to give a general picture or to make general conclusions about the use of health care services by various migrant groups in various countries within Europe for instance. Of course these figures don't say anything about quality of care and may also hide outcomes in specific groups or outcomes for specific needs as we will see later.

Going back to the model, a number of factors are clustered under predisponibility: a group of factors called demographic factors, including psychological and genetic factors, factors belonging to the social structure of an individual, among others factors indicating the socio-economical position of somebody and factors belonging to health beliefs, including knowledge fuelled of course by information. Under means come income, health insurance and the level at which health care services are available – infrastructure, coverage, etc. Eventually all these factors lead to felt needs by the person self or by the health care providers, what might be not the same.

If differences in health care use are based on differences in needs or demographic characteristics mentioned in the model (age, gender, genetic or psychological factors), than still equity in health care use can be present. But if factors related to social structure, to health beliefs or to income are determining health care use than inequality is prevalent.

One source of the wide range of outcomes are the different foreign-born populations in our countries with their own languages, health attitudes and beliefs, and with different experiences related to the health systems in their own countries. This diversity of ethnicities and countries of origin is a reality in all our countries. It is one of the major challenges in addressing health care related problems in different population groups. The multicultural reality is a fact and our services addressing the population cannot afford any longer not to address 5 to 10% or more of our population. In these figures the second generation is not included, while they have their own specific problems. In the Netherlands 42% of the migrants of non-western origin belong to the second generation

A lot of those factors are of course not independent of each other and there may be quite some overlap between them. This generates the discussion if the main driver of inequality in these groups is income and socio-economical status, or if ethnicity – as a proxy-indicator for a lot of hidden information – is an independent discriminative factor determining use of care. Well, from the literature again we get mixed information. Ethnic differences may disappear in some situations when socio-economical status is taken into account, while in other cases it is not. Data coming from electronic patient

records in GP practices in the Netherlands compare the odds that 4 migrant groups had at least on contact a year with their GP to the odds in the native population. The univariate analysis just looking at ethnicity shows less use of GP care in the Surinam and Antillean migrant groups, while the people from Moroccan and Turkey show a significantly higher odds. But when taking a few factors as SES and age into account differences diminish: only Surinam has still a significant lower odd to contact a GP and Turkish migrants have still a higher odd. So, ethnicity here remains an independent factor for some groups, for other not.

And, those people making at least one visit a year to the GP, how often do they go? What is the burden for the health care provider? The mean number of contacts for those persons having GP Care is significant higher for the four migrant groups. But looking closer, those differences remain almost only among people who rate their health as good. So, persons from the four major migrant groups in the Netherlands, rating their health as good go more often to their GPs compared to those native Dutch who rate their own health as good! And that while we are aiming at improving self-care, making the patient responsible for her/his own health, aiming at self-management. So, these figures may signify that migrants in the Netherlands have still a lot of questions to ask their family practitioners in relation to their health. They may lack information as well about their health, the functioning of the body as about their position and responsibilities in the health care system in the Netherlands. They may try to leave these responsibilities in the hands of their GPs...only a few hypotheses trying to explain these figures, and the reader may have more ...

What about the other types of health care in the Netherlands? Again we have heterogeneous figures, not only between the various migrant groups, but also between the various kinds of health care. While all groups reported more that they had contact with a specialist outpatient department, most groups reported less often that they had contact during the last year with a physiotherapist. Persons from Moroccan origin reported less often that they had contact with ambulatory mental health care. From other sources we know that this group presents also less mental health problems to the GP. Does that mean that they have fewer problems indeed, or that they for one or other reason do not like to go for health care with these complaints or health problems?

General morbidity figures for all migrant groups together do not make sense as we know that for instance already genetic differences between the groups will result in different incidences for several diseases. But if we disaggregate the data, and look into the groups from different ethnic origin, we see that complaints they are presenting to the GP vary between the groups. Migrants from Surinamese, Moroccan and Turkish origin in the Netherlands are presenting gastro-intestinal complaints more than the Dutch patients and the difference seems to be of the same magnitude in all three groups. On the other hand, cardiovascular complaints are much more prevalent in patients from Surinamese origin, but in patients from Moroccan origin they are less prevalent. Patients from Moroccan origin present less complaints from a psychological order or related to sexual problems. Does this means that they have those specific complaints less than the other groups, or is there any cultural barrier in the access to primary health care in this group?

By not looking into specific ethnic groups, those differences would have been hidden and not easily addressed by health care.

Is there any evidence in explaining the differences we have seen, or differences seen in dental care, preventive care, and home care? Also in those sectors data are not straightforward. Vaccination levels in the main migrant groups are sufficient - I am not referring to newcomers, asylum seekers and so on – but among second generation and for instance influenza vaccination in older migrants. On the other hand breast cancer screening or cervical cancer screening programmes are less well attended by migrant women in general and by some ethnic groups specifically. Homecare seems less used by migrant groups. But the evidence is limited. Most research seems to be descriptive up to now, and less going into depth, looking for explanations. A lot of research is still quantitative and less qualitative, although there is quite some literature about the cultural needs of patients and competences of providers. Most research is not involving the study group self for instance by participation of their proper organisations, so that inside expertise is available when designing new research and new research tools. There is need for cultural validated research instruments and new instruments trying for instance to measure acculturation. Research is often excluding migrants, as it is expected to be too difficult to reach these groups, to get them involved or to keep them in the study or monitoring exercises. Research is often addressing only the major groups, because of the need for numbers in quantitative research or some groups are political less important or interesting as asylum seekers or undocumented migrants. Evidence about quality of care in migrants or about patient safety in these groups is almost not present in European studies.

That said, what we know about existing barriers limiting accessibility or quality of health care.

As informal barriers are known;

Communication between health care providers and patients: it is not only a language barrier, but also a cultural barrier. The language barrier is of course present everywhere and limits the initial contacts with health care. This is not limited to health care, but also a problem for other services in the society. But in health matters it is quite sensitive, where misunderstanding and lack of information can have important consequences for one's personal health, physical or mental. It remains a major challenge when in one city you have to deal with more than 100 different languages among migrant groups. But language proficiency is not limited to a basic knowledge of language .Expression of complaints can be limited by the limited knowledge of specific word and synonyms. Or some complaints are in one culture more prominent present that in other cultures, and may have different meanings. Health information and health promotion campaigns have to try to reach those vulnerable groups as migrants may be and address as well generic subjects as the functioning of the health system, the responsibilities of patients as well as health care providers. Just translation into another language is not sufficient, cultural differences at various levels have to be taken into account. The health care system in our Member States and its functioning , as well as the health insurance system has to be explained to persons coming from countries with complete other health systems and

no health insurance. Information and promotion have also to address specific health problems that may be more prevalent in these groups and absent in the native population. On the other hand it is known that some migrants – it might be the more educated ones – know alternative ways in their search for help and are travelling around Europe to get help in another Member States when they are not satisfied with the availability and access to care in the country where they are living and working.

Cultural barriers: as mentioned before cultural differences and different values have to be taken into account, or at least addressed if we want to limit cultural barriers to care. Cultural competence training and cultural sensitivity should become a mainstream part of educational training of all health professionals in their basic training. There is a lot of discussion going on how far cultural sensitiveness has to go. For instance what about the problem of pregnant women that don't accept to be helped by male health care providers? On the other hand at least the attitude of health care providers should be open for people coming from other cultures. Cultural sensitive training should be mainstreamed in professional training. Cultural mediator's original from the major migrant groups may support medical practices up to a certain level, but also here outcomes are mixed. Sustainability is often a problem in the long run. Health care providers from the same migrant groups may also help, although these health care providers do not want always to be seen as the solution for everything. Ethnic diverse health care teams may be a part of the solution, as long as only the health care providers of migrant origin are not the only ones always seen as the cultural experts...

I may also refer to the possible existence of structural discrimination as health care is part of the general society and if discrimination happens in some parts of the society it may happen in health care as well. This phenomenon is poorly researched up to now.

Among formal barriers we have to mention the legal restrictions in many member states in the entitlement to health care services for asylum seekers, refused asylum seekers and illegal migrants. Here of course aspects of human rights are coming in, as well as the possibilities/ willingness of coverage of costs of health care. As in most Member States the majority of migrants and ethnic minorities belong to the lower income groups, access of care is limited by financial resources, depending of the health care system and what is covered by basic health insurances. But therefore there should be access to affordable health insurances in the first place. Specific services might lack specific competences to deal with cultural expressions of specific health problems as mental health services, especially for asylum seekers in the short and long run, even after getting a status as refugee. Public health programmes, prevention programmes and health education or promotion programmes should make bigger efforts in trying to reach vulnerable groups in society and tailor their activities and approaches towards these groups.

Summarizing,

Use of health care varies over ethnic different groups, at different levels of health care and different health care systems;



There may be as well overuse as underuse of health care services in comparison with the majority groups in the local society;

Many factors determine health care use and accessibility; I refer again to the model of Andersen. Addressing socio-economical inequalities will increase accessibility only partly;

Culture sensitive health care services and communication may deal with some informal barriers;

Adapted health information also about the functioning of the health system and empowering migrant patients may address barriers at the patient side;

Taking away legal barriers will improve access of health care for specific population groups as asylum seekers and other vulnerable groups;

Addressing specific subgroups may reveal hidden problems of accessibility.

Do migrant groups need specific attention? I think so and at least at two levels: generally, addressing issues that account for all cultural groups, and specifically, to address specific problems of accessibility in specific subgroups.