Explaining health and healthcare utilisation of ethnic minorities in the Netherlands: A longitudinal perspective

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Citation for published version (APA):

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Introduction
Introduction

The aim of the work presented in this thesis is to gain insight into the determinants of health and healthcare utilisation among ethnic minorities in the Netherlands, in a longitudinal perspective. This thesis examines changes in health and use of healthcare services of two different types of ethnic minority groups currently living in the Netherlands, namely traditional immigrant groups (originating from labour and decolonisation migration) and refugees who resettled in the Netherlands (fleeing countries at war, or persecution). In each of the different chapters, the factors underlying these changes over time are examined.

In this chapter, this first section provides a short historical overview of recent flows of migration to the Netherlands, followed by a summary of the empirical evidence on ethnic differences in health and healthcare utilisation in the Netherlands. Subsequently, the main research questions addressed in this thesis are presented, followed by the general outline of the thesis and an overview of the data used in each of the studies.

Migration flows to the Netherlands

The Netherlands have a rich and longstanding history of immigration. The relative prosperity and tolerant social climate were important factors that attracted immigrants to the Netherlands throughout the past four centuries. In recent decades, much attention has been paid to the ‘immigration question’ in this country. However, it is often forgotten that large-scale immigration and resettlement were considerably greater in the period 1580 to 1800 (1) in relation to that of today. In the twentieth century, the reasons and goals for immigrants to travel to the Netherlands had become particularly diverse compared with earlier periods. For example, World War I, decolonisation, the shortage of labour from the mid-1950s, wars in other parts of the world and political regimes, were the main causes of several migration streams to the Netherlands, with or without permanent resettlement.

Currently, the largest groups of ethnic minorities in the Netherlands originate mainly from decolonisation of the Netherlands East Indies shortly
after World War II, followed by flows of guest workers from Southern Europe, Morocco and Turkey in the 1960s and 1970s, and immigrant flows from Suriname and the Netherlands Antilles, which were at their highest in the years before the independence of Suriname (early 1970s) and in the early 1980s. Nowadays, (children of) immigrants from Suriname, Turkey, Morocco, the Netherlands Antilles and Aruba account for 7.3% of the total population in the Netherlands (2010) (2).

From the 1980s onwards, asylum immigration played an important role in both the European and the Dutch landscape. The number of immigrants from Africa, Asia, Latin America and Eastern Europe (Balkan) increased sharply until the mid-2000s, when the Netherlands started to apply a more restrictive asylum policy. Nowadays, nearly 70,000 residents hold a permit as a refugee (3), while 13,820 are residing in reception centres across the country whilst waiting for a decision on their asylum application¹ (4).

The context for migration of the various groups which nowadays compose the ethnic minorities in the Netherlands is therefore very diverse. First, the reason for migration differs between the groups: although it can be stated that immigration is generally not solely a result of individual choice, a distinction can be made between voluntary and involuntary migration. Labour migration, such as for Turkish and Moroccan guest workers, or migration from the former Dutch colonies in the Caribbean, is considered to be voluntary because the main underlying reason was an economic one. Involuntary migration refers to the flux of refugees from the 1980s looking for asylum and fleeing countries at war, or groups that are persecuted for political, ethnic or religious reasons.

Secondly, the policies of the receiving country, in this case the Netherlands, differ between categories of immigrants. Labour immigrants and immigrants from former colonies were attracted or received in the Netherlands under bilateral treaties, actively recruiting workers from abroad, or offering settlement opportunities for study or work to nationals from former colonies. Generally, asylum seekers were not actively recruited or invited to the Netherlands, but looked for resettlement in a region where their personal safety could be guaranteed. They undergo a (sometimes

¹ Counted between 1 January 2012 and 1 July 2012.
lengthy procedure which examines the safety situation in the country of origin before granting a residence permit for the Netherlands. In 2010, around 56% of the decisions regarding a residence permit were in fact rejections (3). Until the moment asylum seekers obtain a residence permit, they are not fully entitled to work or to housing.

Thirdly, on average, the groups differ in their length of stay in the Netherlands: immigrants from the 1960s are currently reaching retirement age and their children, referred to as the “second generation”, are adults who are often born and educated in the Netherlands. The “third generation” is still growing. In 2011, there were approximately 1,900,000 legal inhabitants from non-western countries in the Netherlands. Of them, 829,000 were second generation; 98% of them were younger than 45 years. Except for the East Indians, the third generation of immigrants is still very young and a relatively small group. In 2010, 80% of them were younger than 15 years and half of them were of Surinamese descent (2).

Resettlement of asylum seekers and refugees shows a different pattern. Emigration to other European countries is more common (e.g. for family reunification) as compared to traditional immigrant groups. The ethnic composition of this group is also continuously renewing itself; immigrants looking for asylum come from diverse countries, following geopolitical circumstances. Refugees from the 1980s are still taking part in the labour market, and a “second generation” is not yet visible.

Health and healthcare utilisation of ethnic minorities in the Netherlands

Refugees and traditional immigrant groups differ regarding their migration history and the circumstances in which they were received in the Netherlands. Additionally, their current health state differs from that of the general population; however, study results do not show a consistent picture. Compared with the majority population, for some health outcomes ethnic minority groups are advantaged whereas for other outcomes they are disadvantaged. This also depends on the way health outcomes are measured and analysed, and on the ethnic groups investigated. For instance, higher rates of mortality for males are registered among the most
Chapter 1

traditional immigrant groups (i.e. issuing from labour and decolonisation immigration) in the Netherlands after controlling for age structure, with the exception of Moroccan males who show a lower risk. However, mortality among females at the start of the 2000s did not show important ethnic differences (5). Prevalences of cardiovascular diseases and cardiovascular risk factors (6) are higher among several traditional immigrant groups. Similarly, general self-reported health status is often poorer among both traditional immigrant groups (7) and refugee populations (8) than among the general population. Studies on mental health show a higher prevalence of common mental disorders among Turkish men and women, and Moroccan men, than among the Dutch population (9). The prevalence of common mental disorders is also high among refugees in the Netherlands (8, 10), although no studies have compared this prevalence between refugees and the Dutch population and/or traditional immigrant groups.

Regarding the use of health services, important differences have been found between ethnic groups in the Netherlands. Again, these differences do not follow a consistent pattern. Turkish, Moroccan and Antillean groups show a higher propensity of using general practitioner services. However, when examining patterns of utilisation (combination of primary and secondary health services) no differences are found between ethnic groups regarding their use of any professional health care (11). Mental health services are used less by ethnic minorities for similar levels of need (12, 13), although this is not confirmed in all studies (14). For youth, a recent report from the Health Council of the Netherlands indicate that youth from several ethnic minority groups (Moroccan, Turkish and Antillean) do not use child and youth mental services as much as could be expected based on the frequency of mental problems within these groups, and the size of the groups (15). Use of internal medicine outpatient care is higher among traditional immigrant groups than among the Dutch population (16). Specialist care is used less by ethnic minority groups than for the majority population with comparable health status (17).

Understanding ethnic differences in health and healthcare utilisation

The explanation for ethnic differences in health often focuses on
differences in socio-economic status. This is an important determinant of ethnic variation in health outcomes (18, 19, 5). However, even when analyses are adjusted for socio-economic variation between ethnic groups, some differences still remain, e.g. the lower self-reported general health among Surinamese, Antillean, Turkish and Moroccan groups compared with the Dutch population (11), or the higher mortality among Turkish, Surinamese and Antillean/Aruban males compared to the Dutch (5). It should be noted that adjusting analyses for socio-economic differences does not imply that ethnic differences disappear. The fact that socio-economic and ethnic variations overlap each other confirms the mainly socio-economic disadvantaged position of ethnic minority groups, and reveals the effect of this disadvantage on health compared to the majority population (20, 21).

Socio-economic disparities also partly underlie ethnic differences in healthcare utilisation, also when taking healthcare needs into account (11). Besides socio-economic status, other mechanisms have been studied when looking at ethnic differences in both health and healthcare utilisation. However, those social, cultural or environmental factors have received less attention until now. We conceptualised the role of these factors in the causal relation between healthcare utilisation and health by adapting the model of Andersen (22, 23) (figure 1.1).
Figure 1.1  Social determinants of mental and physical health of migrant groups: conceptual model

In this model, healthcare utilisation and the mental and physical health of ethnic minorities are given a central place. Mental and physical health is conceived as the final outcome at the end of the causal chain, and healthcare utilisation as one of the direct determinants of health, together with lifestyle factors. At the level of the individual, social characteristics such as socio-economic status, culture, language and subjective social position in the host country are influenced by demographic characteristics (ethnicity, age and gender) and migration history (e.g. labour or asylum migration). These characteristics, in turn, affect the predisposing characteristics, enabling resources and (perceived health) needs, which are themselves direct determinants of use of healthcare services. This suggests that people's use of health services is a function of their predisposition to use services, factors which enable or impede their use, and their need for care. Mental and physical health is directly influenced by the use of healthcare services, together with lifestyle, migration history, and the social and physical environment.

Finally, we should mention the factors at the level of the healthcare system that influence healthcare utilisation. The professional definition of needs (as distinct from the perceived health need at the individual level), the cultural competence of healthcare providers, financial accessibility and medical expertise affect the use of healthcare services, probably indirectly through their relationship with the predisposing factors and enabling characteristics at the individual level. In other words, the extent to which individuals are prone to use healthcare services also depends on the characteristics of the healthcare system (e.g. accessibility).

Originally conceived to guide reflection on differences in healthcare utilisation between groups, according to differences in individual and system characteristics, this model can also be applied with a time dimension. Changes in mental and physical health over time might follow the same causal path. The factors presented here are more or less prone to change over time. Generally speaking, the left side of the model (e.g. demographics and migration history) is more stable over time after migration, while the factors on the right side of the model are more prone to change (e.g. enabling, predisposing and needs characteristics and healthcare utilisation) over time, partly through the effect of changes in the preceding factors (e.g. culture, language mastery, socioeconomic status,
subjective social position in the host country). These latter factors are essentially dynamic. To start with, acculturation is the mechanism through which cultural elements change in the contact with a new culture. Also, the mastery of a new language develops over time for new immigrants, through the learning process. The subjective social position of ethnic minorities also varies over time with political and social developments. Socioeconomic status can shift upscale or downscale with educational achievements or employment possibilities. Changes in one or more of these factors affect changes in the other factors; these changes have repercussions throughout the causal chain presented in this model.

Studying the relationships linking ethnic background and health and healthcare utilisation is needed to address ethnic inequities in health effectively. Finding out which mechanisms underlie these relationships forms the basis on which policymakers can build their policy agendas in an increasingly diverse population. Longitudinal study designs offer the opportunity to examine the contribution of social determinants over time to changes in health and healthcare utilisation of ethnic minorities.

This thesis

This thesis aims to contribute to the understanding of the mechanisms underlying ethnic differences in health and healthcare utilisation as presented in figure 1.1. The role of several factors in ethnic variations in health and healthcare utilisation is analysed, mostly in a longitudinal perspective. Changes over time in health outcomes and healthcare use of traditional migrant groups and refugees resettled in the Netherlands are examined, and related to factors potentially contributing to those changes in health and healthcare utilisation. One study (chapter 2) is based on cross-sectional data only, and examines factors explaining the variation in healthcare utilisation among traditional immigrant groups.

More specifically, this thesis can be divided into two different approaches in the operationalisation of our aim: understanding the use of healthcare of traditional immigrant groups on the one hand, and the change in health status of refugees on the other hand. We had at our disposal two main data sources, each of them addressing one of these two groups. We used the data on traditional migrant groups primarily for gaining insight into one
specific type of health services, i.e. the general practitioner (GP). We used the data on refugees primarily for understanding changes in health, with a specific focus on mental health.

When examining the use of GP healthcare among traditional immigrants, we focused on the following factors: perceived quality of care and its determinants, perceived discrimination in society at large and perceived health needs. When examining health status among refugees, we focused on living conditions and prior healthcare utilisation.

Research questions

Each of the studies presented in this thesis examines specific relationships presented in the conceptual model, either in a cross-sectional design (focusing on group differences), or in a longitudinal design (focusing on changes over time). The research questions addressed in the following chapters are as follows:

Explaining ethnic differences in the use of GP among traditional migrant groups
1. The first study examined the factors related to the perception of quality of GP care of ethnic minorities. The related research question was: “To what extent do cultural aspects, language fluency and differences in healthcare organisation in the country of origin play a role in the perceived quality of general practitioner care among Turkish, Moroccan, Surinamese, Antillean and Western immigrants and the Dutch population?” (Chapter 2)

2. The second study examined the role of discrimination in society at large on the use of GP care. The related research questions were: “Is healthcare utilisation among Turkish and Moroccan groups related to their reported feelings of discrimination in the Dutch society? Does the perceived quality of GP care mediate this relationship? Is perceived discrimination related to the use of healthcare in the country of origin during longer stays? Do the associations found persist over time?” (Chapter 3)
3. The third study examined the relation between health needs and use of GP care. The research questions were: “Does self-reported mental and physical health status change over time, and is there a difference between Turkish and Moroccan groups in this regard? Does the relationship between self-reported health and the frequency of GP contacts (healthcare utilisation) change over time and, if so, is the difference between 2001 and 2005 similar in importance and direction for both ethnic groups?” (Chapter 4)

Explaining health changes among resettled refugees

4. The fourth study looked at the role of living conditions and residence permit on health changes of refugees. The related research questions were: “How do mental and physical health indicators of ‘new’ and longstanding resettled refugees from Afghanistan, Iran and Somalia develop over time? Is there an association between health changes and change in residence status? Do experienced living difficulties mediate the relationship between change in residence status and mental and physical health changes?” (Chapter 5)

5. Finally, the fifth study looked at the role of prior healthcare use on mental health changes. The related research questions were: “How do symptoms of post traumatic stress disorder (PTSD) develop over time among resettled refugees from Afghanistan, Iran and Somalia? In which ways do pre- and post-migration factors and prior mental healthcare utilisation explain the course of PTSD symptoms among those groups of refugees resettled in the Netherlands?” (Chapter 6)
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Data and methods

Table 1.1 presents an overview of the studies presented in this book and the data used in each study. There were two main sources of data. First, data were collected during the second Dutch National Study of General Practice (DNSGP-II) (24). During this large study based on data from 104 general practices throughout the Netherlands, a survey was held in 2001 focusing on the health and healthcare utilisation of ethnic minorities among a sample of 1339 participants of Surinamese, Antillean, Moroccan and Turkish origin. This survey was repeated in 2005 among a sample of 210 Turkish and Moroccan respondents, who also participated in the 2001 survey. Data from either one, or both, of these surveys are used in chapters 2, 3 and 4. The second data source stems from the study ‘Gevlucht - Gezond?’ (25) which was conducted in 2004 and again in 2011 among 410 refugees from Afghanistan, Iran and Somalia in the Netherlands. In this survey, health and healthcare utilisation were extensively assessed. The second wave (2011) included 172 respondents who also participated in the first wave of the study. Data from both these surveys are used in chapters 5 and 6.
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