Explaining health and healthcare utilisation of ethnic minorities in the Netherlands: A longitudinal perspective
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General discussion
This final chapter discusses the main findings of the studies presented in this thesis. This general discussion consists of five parts: Part 1 provides a summary of the studies; Part 2 discusses some methodological issues encountered in the data collection and the analyses; Part 3 offers a reflection on the conceptual model presented in the introduction and highlights some of the main findings; Part 4 formulates recommendations and implications for future research and policies following these findings and, finally, Part 5 presents the main conclusions of this thesis.

Part 1  Summary of the main findings

This thesis contributes to the understanding of the mechanisms underlying changes in health and healthcare utilisation among ethnic minorities, as presented in the introductory chapter (chapter 1). The changes over time in health and healthcare use of ethnic minorities originating from labour migration and of refugees resettled in the Netherlands were examined and related to factors potentially contributing to those changes. Other potential determinants of variation in healthcare utilisation were studied in a cross-sectional way. The first three studies focused on the explanation of GP healthcare utilisation of traditional migrant groups, whilst the two following studies focused on the changes in health of resettled refugees.

Explaining the use of GP health care among traditional immigrant groups

In the first study presented in this thesis (chapter 2), we examined the mechanisms underlying differences in the perceived quality of primary health care. Ethnic minorities in the Netherlands perceive the quality of GP care as poorer than their Dutch counterparts do (1). Poor perceived quality of care can form a barrier towards health care utilization. Therefore, the mechanisms underlying perceived quality of care among ethnic minorities should be examined. The corresponding 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?
We examined the factors that play a role in the perceived quality of general practitioner (GP) care among ethnic minorities. We specifically looked at the importance given to several quality aspects of GP care (i.e. medical treatment, language, accessibility, equity and cultural sensitivity) by several ethnic minority groups. We looked at how ethnic differences in rating the importance of those aspects could be explained. We therefore focused on the influence of cultural aspects, language fluency and differences in healthcare organisation in the country of origin on the individual ratings. This was examined among respondents from Turkish, Moroccan, Surinamese, Antillean origin, Western immigrants and respondents from Dutch origin. We saw that, first, respondents who attached more importance to the accessibility of the GP services and to the quality of the medical treatment had less modern/egalitarian cultural attitudes, but also a better Dutch language mastery. Second, respondents who attached more importance to translation services were having a lower mastery of the Dutch language. Finally, we saw that respondents who attached more importance to the accessibility of the GP and of specialist care were accustomed to a broader access to the health system in the country of origin. Therefore, these results indicate that cultural factors, language mastery and the health system considered as the reference all influence the importance given to several aspects of GP care quality among ethnic minorities.

The second study (chapter 3) focused directly on healthcare utilisation. The study examined the influence of experienced feelings of discrimination of ethnic minorities in society at large on the use of one of its main institutions, i.e. healthcare. The corresponding research questions were:

*Is healthcare utilisation of 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?*

We hypothesized that perceived discrimination in society at large would influence the extent to which people make use of GP healthcare for similar health needs. We also hypothesized that this relationship would be mediated by the perceived quality of GP care. Respondents with higher discrimination feelings would also experience a lower quality of GP care, and would therefore use GP services less for similar needs. These
hypotheses were examined at two time points (i.e. in 2001 and 2005) among a sample of respondents of Turkish and Moroccan origin. For the entire group, non-attendance to the GP healthcare utilisation was positively associated with perceived discrimination in society at large. Contrary to our hypothesis, perceived quality of GP care was not a mediator in this relationship. We found no evidence for substitution of healthcare in the home country to healthcare in the host country, as GP non-attenders had lower odds of having used healthcare in the home country during their last stay than GP attenders. Over time, a lasting feeling of discrimination was related to persistent non-attendance at the GP practice. Therefore, these results indicate that experienced discrimination feelings in society at large may constitute a barrier to the use of GP healthcare.

The third study (chapter 4) of this thesis linked changes in healthcare utilisation and changes in health status. It measured health and healthcare utilisation of labour immigrants simultaneously and repeatedly at two time points, and examined ethnic differences between Turkish and Moroccan respondents in this relationship. It considered health status as an indicator of need for healthcare and related this to changes in the utilisation of GP health care. Specifically, this study addressed the following research questions:

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?

First, we saw that mental health improved between 2001 and 2005, but only for the Moroccan group. Physical health remained unchanged for both groups. On the other hand, healthcare utilisation (number of GP contacts) decreased for the Turkish group, and remained unchanged for the Moroccan group. This was not expected, based on our hypothesis and assumption: decrease in health needs of the Moroccan group over time did not seem to lead to a decrease in healthcare use. Moreover, this picture was different for the Turkish group, for whom healthcare use decreased while health needs did not. The explanatory statistical models confirmed this finding: once adjusted for changes in mental and physical health and other differences, the Turkish group had a slightly larger decrease in GP
contacts between both measurements than the Moroccan group. These results therefore show that changes in health needs explain changes in GP healthcare utilisation, but not in the same extent for both groups: the Turkish group showed a larger decrease than the Moroccan in healthcare utilization over time when taking changes in health needs into account.

**Explaining health changes among resettled refugees**

The fourth study (chapter 5) also examined changes in health over time, and specifically addressed this question among resettled refugees in the Netherlands. This study focused on the role of changes in the social environment on health improvement. Newly resettled refugees experience abrupt changes in their social context when granted a residence permit. Therefore, we examined the influence of a change in residence permit status on changes in health, and its underlying mechanisms. The questions addressed in this study 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?*

The outcome measures were changes in mental and physical health between 2003 and 2011 among refugees from Afghanistan, Iran and Somalia resettled in the Netherlands. Those refugees recently receiving a residence permit had a larger decrease in PTSD symptoms and anxiety/depression symptoms, and a larger improvement in self-rated general health over time as compared to longstanding permit holders. There was no significant association between type of permit holder and change in the number of chronic conditions. Health improvements were influenced by the fact of getting a residence permit through the subsequent improvement in the experienced living conditions, in particular employment and the presence of family/social support. Therefore, the change in social context seems to be the main mechanism underlying health improvements accompanying the receipt of a residence permit.

The fifth study (chapter 6) focused on changes in symptoms of post-traumatic stress disorder (PTSD) among refugees resettled in the
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The study addressed the following research questions:

How do symptoms of 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?

This study focused on refugees recently resettled in the Netherlands. Our findings show that the PTSD prevalence remained high among resettled refugees during a 7-year interval (around 15%, compared to 7% among the Dutch general population (2)). This seemingly unchanged rate has two main explanations. The first concerns the onset and persistence of the PTSD symptoms. Only half of the respondents with PTSD during the second measurement already had PTSD during the first measurement. The other half concerned new cases, for which PTSD developed later on, i.e. between the two measurements. The second explanation concerns the comparatively low use of mental health care during the first wave. It was observed that, during the first wave, only 21% of respondents symptomatic of PTSD reported contact with a mental healthcare provider at the same time point. This latter explanation is all the more important given the results of the analyses on the effectiveness of previous mental healthcare use: respondents with PTSD who made use of mental health care during the first wave were more likely to see an improvement in PTSD symptoms during the second wave compared to those who did not, regardless of differences in other pre- and post-migration factors. Therefore, these results indicate that having previously used mental health care in the Netherlands is beneficial for PTSD recovery.

Part 2 Methodological considerations

This section offers an overview of the main strengths and limitations of these studies for the internal and external validity of our general findings.

Internal validity

To start with, the longitudinal approach chosen for the design of these
studies can be considered a strength of our studies. It offered the possibility
to elucidate the mechanisms involved in the pathway towards health and
healthcare utilisation among ethnic minorities over time. The studies
examined changes over time at the individual level (e.g., changes in
employment, experienced living difficulties or healthcare utilisation) and
related these to the relevant outcomes, rather than merely comparing
groups with regard to the current associations between these factors and
potential outcomes.

The data used in this thesis were based on two waves of cohorts (the
migrant survey of the DNSGP-II, and ‘Gevlucht-gezond?’). The response rate
for the first wave (T1) of both studies was around 50% for the interviews of
the migrant survey of the Second Dutch National Study of General Practice
(DNSGP-II), and around 70% for the interviews of ‘Gevlucht-gezond?’

For the second wave (T2), the retention rate for both studies was around 40%.
In most cases, respondents did not participate in the second wave because
the registered home address was no longer valid. In the case of ‘Gevlucht-
gezond?’ this was mainly explained by the fact that part of the asylum
seekers did not obtain a residence permit and/or had left the Netherlands.
Therefore, at T2, there were proportionally more respondents who already
had a residence permit at T1 than respondents who were still in the asylum
procedure at T1. For the migrant survey of the DNSGP-II, the main reason
for the non-valid addresses is less clear. Many respondents could not be
reached because they had moved away, or were not found at the registered
contact address. For this sample, a non-response analysis (presented in
chapter 4) showed that respondents in the first wave only did not differ
from the respondents in both waves regarding most of the socio-
demographic characteristics and health outcomes, with the exception that
the respondents in both waves were slightly younger. Both studies focused
on changes between the waves, and on the underlying determinants.
Therefore, longitudinal analyses used a paired-samples technique. This
approach limits the issues regarding retention rates that would otherwise
influence the results, because the data are compared over time within
individuals.

Measurements
Data on health status and healthcare utilisation were based on self-report.
Most data on health and healthcare utilisation were collected during face-
to-face interviews in the language chosen by the respondents. Self-reports
on healthcare utilisation are subject to recall bias, implying that participants can be biased in recalling how many times they actually visited a GP or another healthcare provider. In order to reduce this bias to a minimum, the time frame used for assessing healthcare utilisation was limited. Information on GP healthcare utilisation was asked over the past 2 months, and mental health care over the past 12 months. An earlier study on the accuracy of self-reported healthcare utilisation concluded that self-report may be used as a proxy when administrative data is unavailable, particularly for shorter recall periods (3).

Health status was also assessed by means of self-report. Self-reports on health status are also subject to bias, and therefore not the exact equivalent of professionally defined health status. Therefore, when possible, we made use of validated, multi-items instruments for assessing mental and general health. The mental health of refugees in ‘Gevluchtgezond’, used instruments such as the Harvard Trauma Questionnaire and the Hopkins Symptom CheckList-25 for PTSD and anxiety/depression. The 36-item Short Form Health survey was used to measure general health status for the migrant surveys of the DNSGP-II (SF-36, or Rand-36). However, the translations of these instruments into various languages were not validated. At the time of our study, the translations of the SF-36 into Turkish and Moroccan-Arabic were in the process of being validated (4). Nevertheless, at that moment they were the best available option for assessing mental and physical health status in a survey form, given the multi-item approach of these instruments, and the careful development and validation of the original versions.

In some chapters (chapters 2 and 3), the analyses of healthcare utilisation or perceived quality of care are adjusted for an approximation of health care needs. For these studies, health care needs are operationalised by the first item of the SF-36. Although this 1-item assessment is not used as a dependent variable, but only as one of the possible confounders for the analyses, we are aware of the weakness of this type of measurement. In the specific case of cross-cultural comparisons, the 1-item measurement of self-reported health has shown to be ethnic-dependent (5). Therefore, a type of measurement that depends less on the subject’s own assessment (e.g., clinical measures, or a multi-item approach) would have been better. However, this variable was used only to adjust analyses for health care
needs and, therefore, directly related to healthcare utilisation or perceived quality of care. Moreover, the single item measurement of self-reported health has shown to be a good indicator for morbidity among several ethnic groups (6).

Finally, another important limitation of the data on healthcare utilisation concerns the last study in this thesis (chapter 6). In that study, the use of prior mental health care is related to improvements in mental health (PTSD). However, specific information on the reason for contacting a mental healthcare provider was not available. Assessing the treatment effectiveness would at least require specific information on the reason for the contact with mental healthcare providers at baseline, and the treatment-specific outcome at a later measurement. Therefore, these results constitute a first indication of the influence of healthcare utilisation on mental health changes of refugees.

**Analyses**

The sample size of the two cohorts did not allow for an analysis which would help to thoroughly unravel the causal relationships (e.g. path analyses). Also, a third measurement would be needed to further test trends in developments in health outcomes and healthcare utilisation. However, the repeated-measures approach used in the analyses for the studies with a longitudinal design does contribute to the understanding of the factors related to changes in health and healthcare utilisation. It also contributes to understanding the causal relationships underlying health changes, e.g. when linking prior healthcare utilisation to posterior health outcomes (chapter 6).

**External validity**

Both studies present some limitations concerning the external validity of the results. For example, ‘Gevlucht-gezond?’ included three different ethnic groups initially selected for several reasons (7), including the representation of these groups of refugees in the Netherlands at the time of the start of the study (2003). However, due to the small sample size and the retention rate at the second measurement, analyses could not be made per ethnic group. The same limitation applies to the sample size of the migrant survey.
of the DNSGP-II. A larger sample would allow to stratify the analyses per ethnic group, and would also shed light on the reasons for the differences between the Turkish and Moroccan groups with regard to their respective developments over time in health and healthcare utilisation (as reported in chapter 4). However, the conceptual framework outlining this thesis approached ethnicity at a general, non-cultural level. It examined the mechanisms that play a role among all groups of immigrants coming to a new country. The extent to which those mechanisms play a role for each ethnic/cultural group could still be discussed and, in our opinion, would also deserve to be addressed in an anthropological perspective. However, this was not the primary aim of this thesis.

Another limitation concerns the limited possibility for further interpretation of the ethnic differences in healthcare utilisation, even when taking healthcare needs into account (as in chapter 4). Adjusting the statistical analyses on healthcare utilisation for health status (whether used in a longitudinal or cross-sectional study design) presents a major problem when attempting to draw conclusions in terms of equity in healthcare utilisation between different groups. If information on health status is used to assess the need for healthcare, it does not disclose information about the outcome of healthcare utilisation for the populations concerned (8). Therefore, we did not draw conclusions about the overall equity of treatment, but rather on the possible determinants affecting this relationship.

Part 3 Reflections on the main findings

In the introductory chapter (chapter 1), we offered a conceptualisation of the possible determinants of ethnic differences in changes in health and healthcare utilisation. This model guided our analyses throughout this thesis. Hypotheses were formulated in the different studies following this outline. In this concluding chapter, we reflect on this framework in the light of our results.

Figure 7.1 presents the revised model based on our findings. This figure is the amended version of figure 1.1 (chapter 1). The associations presented in figure 1.1 were tested throughout the chapters of this thesis, and figure
7.1 presents the confirmed and non-confirmed associations resulting from the different studies.

Starting from the right side of this figure, mental and physical health has several determinants. On the front line, both healthcare utilisation and the social and physical environment have a direct influence on the mental and physical health of ethnic minorities. This was illustrated in chapters 5 and 6 of this thesis. Chapter 6 showed that the use of mental health services had a positive effect on the mental health development of resettled refugees. This same study also investigated the independent effect of the physical and social environment on the mental health development of resettled refugees, and showed the positive effect of an improvement in living conditions on the improvement of mental health. Chapter 5 also suggested that improvements in living conditions directly affect improvements in mental health and general health among resettled refugees.

However, the direct independent association between migration history and mental and physical health developments was not confirmed in this thesis. Although it can be stated that migration history statistically explains cross-sectional health differences between groups, when approximated by residence permit (9, 10) or past traumatic events (11), the studies presented in this thesis show that these factors lose their explanatory power when considering individual changes over time. For instance, chapter 6 showed that the number of traumatic events did not predict the way mental health develops after resettlement, after taking healthcare utilisation into account.
Figure 7.1  Social determinants of the mental and physical health of immigrant groups: revised conceptual model

Adapted from R.M. Andersen Revisiting the Behavioral Model and Access to Medical Care: Does It Matter? Journal of Health and Social Behavior, 1995, 36 (1)
Similarly, chapter 5 showed that the benefits of having a residence status on health improvements actually transited through the social and physical environment.

Taking one step backwards in this model, healthcare utilisation and the physical/social environment are both influenced by one or more factors. First, healthcare utilisation is directly and independently influenced by need factors, ethnicity and the subjective social position in the host country. Need factors were indicated by perceived health status (chapters 4 and 6). The higher the perceived health problems, the higher the use of healthcare services. However, as shown in chapter 4, ethnicity influences the extent to which participants made use of health care irrespective of their needs. For similar changes in perceived health needs over time, ethnic groups show differences in their propensity to adapt their health care use. The subjective social position (here approximated by perceived discrimination in society at large) of ethnic groups also directly and independently influences their healthcare utilisation. This was shown in chapter 3, where participants with stronger feelings of discrimination in society at large were less inclined to use health care for similar health needs. Initially, we expected the effect of feelings of discrimination to be explained by a subsequently lower perceived quality of GP care. However, this was not the case: feelings of discrimination were not linked to a lower perceived quality of GP care and its related influence on GP healthcare utilisation.

Second, the social and physical environment are directly influenced by migration history (here approximated by their permit situation at a given moment); this was shown in chapter 5. When obtaining a residence permit, the experienced living conditions of refugees improve considerably. Therefore, migration history (operationalised as the stage in migration history, i.e. before and after getting a residence permit) is important for the conditions it creates which, in turn, affect health developments.

Regarding the upper part of the model, and taking another step backward, the need factors, predisposing characteristics and enabling resources (12) determining healthcare utilisation are influenced by a set of social, economic and cultural factors on the one hand, and by the healthcare system of reference on the other. The findings on the hypothesised role of subjective social position (feelings of discrimination) on one of the
predisposing characteristics (perceived quality of GP care) are described above. Chapter 2 shows that language and cultural factors directly and independently influence the predisposing characteristics, by their action on perceived quality of care. Chapter 2 also shows the direct and independent influence of the healthcare system of reference (i.e. the organisation of healthcare in the country of origin) on this predisposing characteristic. Ethnic minorities tend to judge the healthcare system of the host country through the norms established within the healthcare system in the home country. Employment is one of the factors influencing changes in needs (perceived health). As shown in chapter 4, being employed vs. unemployed was related to an improvement in mental health. In addition, for those who are employed, having lately obtained a paid job had an additional positive effect on mental health.

This ends the description of the associations found in the causal path towards health. Although some associations were not confirmed by our studies, most of them were. Therefore, health is the product of a stepwise causal chain, encompassing socio-economic and cultural factors on the one hand, and factors related to the physical and social environment on the other, which in turn influence health directly, or indirectly, through healthcare utilisation. At this point, we consider that the following factors in the causal chain need to be highlighted, either because they have been relatively under-investigated until now, or because the nature of their relationship with health needs more in-depth examination.

The healthcare system of reference

Immigrants to a new country do not only bring along their language and cultural characteristics, but also norms and ideas concerning society’s institutions. Opinions about how health care should be organised and should function is also part of these norms. These opinions are formed during the contact with the healthcare system in the country of origin, before and after migration. They influence the way health care in the host country is judged, and remain the frame of reference of the groups coming in regular contact with health care in the country of origin. Some studies have examined the specific role of the healthcare system in the country of origin of immigrants on their assessment of the new system (13-15), and its
effects on health-seeking behaviour. They commonly show that the characteristics of the healthcare system in the country of origin influence the way immigrants judge and use healthcare in the host country. This was examined in chapter 2 of this thesis for Turkish, Moroccan and Western immigrants in the Netherlands. The differences in the reference framework might influence the overall judgement of quality of care, and may impede utilisation. Immigrants coming from countries with a non-regulated access to specialised care, might judge the highly regulated access to specialised services as a barrier to good quality of care (chapter 2). Similarly, if they are accustomed to a broad accessibility of the GP practice in the home country, the Dutch GP system with regulated opening hours, telephone reception and limited home visits might be considered as an obstacle to the good quality of GP care. The specific role of the healthcare system of reference was not investigated for the refugee groups in this thesis, but we hypothesised that frameworks concerning the functioning of health care would be more active for groups of newcomers than for groups resettled for at least two generations (13). We believe that taking the healthcare system of reference into account in future research among immigrants will provide more insight into ethnic variation in healthcare utilisation. This path has not yet been explored in any depth.

**Mental health through employment**

This thesis focused on changes in health and healthcare use of immigrants originating from both voluntary and involuntary migration. The reasons for coming to the Netherlands were different for both groups. However, some mechanisms on the pathway to health are common to both groups. Employment is one of the common factors underlying health benefits; this was shown in chapters 4 and 5. Employment is more than income alone. It has both a psychosocial and an economic dimension (16). It makes economic participation possible and meets a psychosocial need in a society where employment is the norm. The improvement in mental health due to employment is shown in chapter 4, where participants who found paid work between both measurement points also improved their mental health status. In chapter 5, refugees who obtained a residence permit (making employment possible), reported a decrease in living difficulties related to employment; this was beneficial for their mental and general health,
probably because of their social and economic integration into society. The positive influence of employment on health has been shown in large prospective cohort studies like the Whitehall study (17) for the general population, and the Refugee Resettlement Project (18) for South Asian refugees resettled in Canada. These studies also empirically tested the causal path between employment and health, showing the positive effect of employment on (mental) health. Although it can be argued that mental health affects employment (19), our study places itself in the line of these large studies when arguing that the opposite association also applies for labour immigrants and refugees. The economic and social participation provided by employment leads to improvements in mental and general health.

Healthcare utilisation and subjective social position

In this thesis, discrimination is seen as an indicator for the perceived social position of the ethnic minorities studied. Only a few studies have addressed the role of experienced discrimination in society at large on healthcare utilisation (20, 21), while several studies showed the role of experienced discrimination on various health outcomes (22, 23). Feelings of discrimination in society at large (i.e. not measured within a particular institution, like the healthcare system) showed to be part of the causal chain leading to health status in two ways. First, it influences the utilisation of healthcare services (as shown in chapter 3). Individuals with a strong feeling of discrimination tend to use GP healthcare less than those with a less strong feeling, irrespective of their need for health care. Second, perceived discrimination is directly associated with mental health; this is shown in chapter 5. Over time, a change in perceived social position mediates the relationship between obtaining a residence permit and changes in mental health. Obtaining a residence permit reduces feelings of discrimination, which is beneficial for mental health (chapter 5). However, it remains unknown whether or not the influence of discrimination feelings on mental health is mediated by mental healthcare utilisation. A lower level of mental healthcare utilisation for those with a stronger feeling of discrimination could explain the lower mental health status of this group of permit holders. As shown in chapter 6, refugees who did not use mental health care did not improve their mental health status, compared to those
who did use mental healthcare. The subjective social position of a group in society at large has important repercussions on their health-seeking behaviour which, in turn, can influence mental and physical health and possibly directly influence their mental well-being.

**Part 4  Implications and recommendations**

**Recommendations for future research**

The longitudinal approach adopted for some of the studies presented in this thesis is an asset for fostering reflection on social determinants of health and healthcare utilisation of ethnic minorities. To some extent, it helps to unravel the causal relationships. However, the relatively small size of the samples in our studies did not allow the use of path analysis and other techniques that may further support the conclusions regarding the causal direction of the associations. Therefore, we recommend conducting larger longitudinal studies on these topics. Especially the relationship between medically defined healthcare needs, subsequent healthcare utilisation and final health outcomes would benefit from large multiethnic prospective cohort studies combining survey data and medical registrations (8).

Taking the health system of reference into account could be another interesting path for explaining ethnic differences in healthcare utilisation. It would be interesting to further explore the consequences of experiences with health care in the home country on healthcare use and its development over time in the host country. Also, the use of healthcare in the home country and its consequences for treatment continuity and quality could provide useful and interesting data for policymakers and medical practitioners.

The influence of the healthcare system of reference could also play a role in the relatively low use of mental health services among refugees (as reported in chapter 6). Also, as shown by Morris and colleagues (24), the perceptions of resettled refugees of the healthcare in the host country result from past experiences in the country of origin. In addition, the stigma
around mental illness is another issue underlying the generally low use of mental healthcare services among refugees upon resettlement (24). In which way these two factors (and possibly others) explain the low use of mental healthcare among refugees resettled in the Netherlands remains unknown. Answers to this question require another research track to eventually improve the universal access to mental healthcare.

Finally, studying ethnic differences in health and healthcare utilisation as such, taking into account (but not limiting it to) socio-economic differences, remains worthwhile. Immigration is a phenomenon applicable in all times, and is certainly not limited to the waves of the 1960s and 1970s. With the broadening of the European borders and the labour agreements within Europe, new groups of economic immigrants (with a different profile from their predecessors) are arriving in the Netherlands and other north-European countries. They bring their languages, cultures, and expectations regarding healthcare and personal migration histories. European health systems rest on the idea that healthcare should be equally accessible for all. However, this ideal is being challenged by an increasing level of diversity. How responsive is our healthcare system in dealing with these (new) differences? Deepening our understanding of social determinants of healthcare utilisation for new groups offers tools for policymakers and practitioners to enable equal access by all groups.

**Implications for policy**

In our opinion, this thesis offers some agenda points for policymakers in the field of public health.

- **Health of resettled refugees**: mental health improvements among this group are within reach when focusing on the social and economic participation of refugees. At the time of these studies the asylum procedure offered little perspective for such participation, with limited possibility for paid work, and practical (e.g. geographic and economic) limitation to social participation outside the Dutch reception centres. Our findings reveal the key role played by these factors in mental health improvements. Therefore, the positive influence of social and economic participation on the mental health of refugees should be taken into account when considering the
effects of the circumstances of the asylum procedure. Intervention studies examining the possible health benefits of activities improving the economic and social participation of asylum seekers during the procedure could be set up to test this finding.

- **Use of mental health care**: policymakers in the field of public health should address the limited use made of mental health care by refugees, a group with a high prevalence of psychological problems. For this, a first step is the ongoing collaboration with research groups to establish the mechanisms underlying this low level of utilisation. A second step consists of paying specific attention to the ethnic targeting of information on mental health treatment possibilities.

- **GP health services**: GPs play a central guiding role in referring the health care demand towards other relevant disciplines. Therefore, their awareness about the possible barriers towards healthcare utilisation (discrimination, language, cultural attitudes or how health care is organised in the home country) is essential for overcoming them. GPs should also be aware of the relatively low use made of mental health services and the high prevalence of mental health problems among this group. Their quick referral to specialised mental health services deserves attention.

- **Diversity-responsive care**: Perceptions and expectations of healthcare influence the help-seeking behaviour of ethnic minorities. Language differences between patients and health providers are also a well-known barrier in relation to access to healthcare. Assuming that our healthcare system should be equally accessible for all, these aspects should be taken into account when designing policies related to healthcare. Professional interpreting services should remain available, and their use should be increased in the daily practice of health providers. The awareness of healthcare providers about the importance of using such services, and on their responsibility in crossing cultural barriers, should be increased. Embedding education on the determinants of health and healthcare utilisation in medical curricula would contribute to the diversity-sensitive approach of our health system, and this would
increase the responsiveness of this system to the growing ethnic diversity of its users. This follows the overall findings of this thesis, and the evidence that ethnic diversity is a growing, long-lasting phenomenon in our society. Therefore, diversity-sensitivity requires a sustainable, long-term approach. Education of future professionals is one of its instruments.

**Part 5 Main conclusions**

This thesis has elucidated some of the mechanisms underlying changes in health and healthcare utilisation among two types of immigrants. For traditional immigrants and their use of GP care, it stressed the importance of perceived discrimination, culture, language, organisation of the health system in the country of origin, and showed ethnic differences in the extent to which health needs explain healthcare use. For refugees, it showed the central role of living conditions (social and physical environment) in health improvements, and the importance of use of health care for the mental health of this group at risk.

The choice for juxtaposing research on voluntary and involuntary migration yielded insight into the role of the ‘baggage’ brought along by immigrants, which includes their culture, migration history or framework of reference concerning the healthcare system. Those factors are prior to immigration, but still play a role in how immigrants approach the healthcare system and how their health develops over time.

More work is needed to continue testing and amending the conceptual framework used in this thesis. We believe that future research can make a substantial contribution to the existing evidence by setting up large multi-ethnic cohort studies, including more ethnic groups, and the newer groups resulting from eastern European labour migration. Also, international collaboration may provide more insight into the role of the healthcare systems and their characteristics for similar groups of immigrants resettled throughout northern Europe.
Chapter 7

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