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

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Summary
Introduction

The purpose of the studies presented in this thesis was to gain insight into the determinants of health and healthcare utilisation of two different types of immigrants currently living in the Netherlands. We focused on traditional immigrant groups (originating from labour and decolonisation migration) and refugees who resettled in the Netherlands (fleeing countries at war, or from persecution). Both immigrant groups differ regarding their migration history and the circumstances in which they have been received in the Netherlands. Their current health state differs from that of the general population; however, this does 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. Likewise, ethnic groups show differences regarding their use of health care services. Like for health status, these differences do not follow a consistent pattern. Also, little information exists on how these differences develop over time. Knowledge on how health and healthcare utilisation develop over time offers insight into causal relations between health and its determinants.

Therefore, we examined the mechanisms underlying health and use of healthcare services of ethnic minorities in the Netherlands in a longitudinal perspective. In chapter 1, we developed a theoretical model for understanding differences in health and healthcare utilisation for migrant groups. We made a distinction between different types of explanatory mechanisms. When examining the use of GP healthcare for traditional migrant groups, we focused on perceived quality of care and its determinants, perceived health needs and perceived discrimination in society at large. When examining health status of refugees, we focussed on living conditions and prior healthcare utilisation. This model guided our analyses throughout the various studies.

Explaining health and healthcare utilisation of ethnic minorities
Explaining ethnic differences in the use of GP among traditional immigrant groups

Perceived quality of GP care
Previous studies have shown that ethnic minorities more frequently consult the GP than the host population, even when differences in health need are taken into account. In chapter 2, we focussed on one possible explanation of these higher rates, i.e. the way quality of GP care is perceived by 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 which factors could explain the importance given to those aspects. We therefore focussed on the influence of cultural aspects, language fluency and differences in health care 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/equalitarian cultural attitudes on the one hand, and a better Dutch language mastery on the other hand. 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 the specialised health services were those accustomed to a broader access to the health system in the country of origin. Therefore, cultural factors, language mastery and the health system considered as the reference all influence the importance given to several aspects of GP care quality.

The role of discrimination on health care utilization
Although the use of GP is generally higher among ethnic minorities, we also know that within ethnic minority populations, some people have higher GP utilisation rates than others, independently of health needs. We hypothesized that GP use is partly depending on the amount of discrimination people experience in society at large. More specifically, we expected discrimination feelings to be a barrier to the use of GP health care. Our assumption was that this relation would be partly explained by a lower perceived quality of GP care by those who feel more discriminated. In
chapter 3, we examined this hypothesis at two time-points (2001 and 2005) among a sample of respondents of Turkish and Moroccan origin. For the whole group in 2001, respondents experiencing higher discrimination feelings were making less use of GP health care for similar health needs. Contrary to our hypothesis, this relation was not explained by differences in perceived quality of GP care. We further found no evidence for substitution of health care in the home country to health care in the host country for GP non-attenders. Over time (both in 2001 and in 2005), a lasting discrimination feeling was related to persistent non-attendance at the GP practice. Therefore, experienced discrimination feelings in society at large form a barrier for using GP care.

**Health changes and subsequent changes in healthcare utilisation**

One might hypothesize that the rate of GP contacts among ethnic minorities is, among others, directly depending on the health needs of those ethnic minorities. Therefore, one might expect increases in health needs over time to lead to increases in GP contacts, and reversely. The assumption is that this relationship is similar across ethnic groups. We tested this hypothesis in chapter 4. We focussed on changes in mental and physical health of labour immigrants and related those to changes in GP healthcare utilisation. This association was examined among a sample of Turkish and Moroccan respondents at two time-points (2001 and 2005). First, we saw that mental health improved between the two measurements, 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 health care use. Moreover, this picture was different for the Turkish group, for whom health care use decreased while health needs did not. The explanatory models confirm 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. Therefore, changes in health needs explained changes in GP healthcare utilisation, but not in the same extent for both groups.
Explaining health changes among resettled refugees

The new context and prior healthcare utilisation

Across the globe, refugees show in general a poorer mental and physical health than the local populations amongst which they resettle. However, upon resettlement, and after obtaining a residence permit in a wealthier and economically and politically more stable country, health improvements over time are expected. Also, newly resettled refugees experience abrupt changes in social and physical context when granted a residence permit. In chapter 5, we examined developments in health of resettled refugees, and the factors explaining health changes. More specifically, we looked at the changes in mental and physical health of refugees, and at how a residence permit and subsequent improvements in social and physical context affect these changes. This was examined at two time-points (2003 and 2011) among a sample of refugees from Afghanistan, Iran and Somalia resettled in the Netherlands. First, we saw that recent residence permit holders had larger decreases in post traumatic stress disorder (PTSD) symptoms and anxiety/depression symptoms, and larger improvements in self-rated general health over time as compared to longstanding permit holders. There was no significant association between type of permit holders and change in number of chronic conditions. Second, we saw that health improvements were not directly influenced by the fact of getting a residence permit, but rather by the subsequent improvement of the experienced living conditions, in particular employment and the presence of family/social support. The changes in social context are therefore the mechanism underlying health improvements accompanying a residence permit.

Despite these health improvements over time among refugees, evidence shows that the prevalence of PTSD remains high, even several years after resettlement. Chapter 6 focussed on changes in PTSD symptoms among refugees and related those to prior mental health care utilization. This study also focussed on refugees recently resettled in the Netherlands. Our findings show that the PTSD prevalence remained considerably high among resettled refugees at a seven-year interval (around 15%, compared to 7%
among the general population\(^1\)). This seemingly unchanged rate has two main explanations. The first one concerns the onset and persistence of PTSD symptoms. Only half of the respondents having PTSD during the second measurement already had PTSD during the first measurement. The other half concerned new cases, for which PTSD developed later on, between both measurements. The second explanation concerns the low use of mental health care during the first wave. We saw that during the first wave, only 21% of respondents symptomatic of PTSD were reporting contacts with a mental health care provider at the same time point. This last explanation is all the more important given the results of the analyses on the effectiveness of previous mental health care 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. Having previously used mental health care in the Netherlands proved therefore to be beneficial for PTSD recovery.

**Discussion**

The last chapter (chapter 7), we start by discussing the strength and weaknesses of the data used for the internal and external validity of the research. To start with, the longitudinal approach chosen for the design of these studies can be considered as a strength of our studies. It offered the possibility of enlightening mechanisms playing in the pathway towards health care utilization and health of ethnic minorities through time. It examined changes through time at individual level (for instance changes in employment, experienced living difficulties or health care utilization) and related these to the posterior relevant outcomes, rather than merely comparing groups in the contemporaneous associations between these factors and potential outcomes.

However, some points can be considered as weaknesses of our studies. First, we used two two-waves cohorts (migrant survey of the second Dutch National Study of General Practice, (DGNSP-II) and ‘Gevlucht-gezond?’). For

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both studies, the retention rate was about 40%. However, both studies focussed on changes between waves, and on the underlying determinants. Therefore, longitudinal analyses used paired-samples techniques. This approach limits the retention rates issues that would otherwise influence results (for instance when using repeated cross-sectional analyses techniques), because data is compared through time within individuals. Second, data is based on self-report. Recall bias (healthcare utilisation) or lack of validated translations of measurement instruments (health outcomes) could be problematic. In this section we explain how we dealt with these two possible bias-inducing problems, in the study design or in the analyses. Finally, the sample sizes of both cohorts limited the extent to which analyses could be stratified per ethnic group. Likewise, this limits the scope of conclusions on ethnic differences. However, this was not the primary purpose of our thesis, which was rather to examine the possible mechanisms playing a role for all groups of immigrants coming to a new country regarding their health and healthcare utilisation.

In this chapter, we also reflect on the conceptual model presented in chapter 1 in the light of our results, and discuss some specific outcomes. On our model, we conclude that some associations were not confirmed by our studies, but that most of them were. Health is therefore 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 health care utilization. In this causal chain, we noted the specific role of discrimination in society at large, which forms a barrier to healthcare utilisation. We also noted the benefits of employment for mental and general health improvements. Finally, we underlined the role of the health care system in the country of origin, held as the reference from which the Dutch health care system is being judged upon. These factors are relatively little investigated until now, and these results add to the understanding of the path towards better health for ethnic minorities.

Finally, we formulated some recommendations for further research and for policy around health and healthcare use of ethnic minorities. Future research should pay ongoing attention to health and healthcare utilisation of ethnic minorities, in the first place because ethnic diversity will continue to increase in the coming decades, and that the question remains on how
responsive our healthcare system is to this challenge. Policies should be targeting at this a) by re-thinking the social and economical context in which refugees and all newcomers are placed upon resettlement in the Netherlands, specifically by promoting social support and employment possibilities. This recommendation follows our findings on the role of employment and of social and physical context on health improvements; b) by improving the information on mental healthcare for these groups, following our findings on the relative low use of mental health services by refugees shortly after arrival; c) by increasing the awareness of health care providers on possible barriers to care for ethnic minorities. GPs play a central role in guiding the health care demand towards other relevant disciplines. Therefore, their awareness about the possible barriers towards healthcare utilisation (being discrimination, language, cultural attitudes or organisation of healthcare in the home country) is essential for overcoming them. Finally, d) by re-thinking educational curricula of healthcare providers: imbedding education on the ethnic and socio-economic determinants of health and healthcare utilisation would improve the diversity-sensitive approach of our health system. This would be a first step in increasing 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-sensitiveness requires a sustainable, long-term approach.