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Somali Immigrants and Health Care: Neo-Liberal Globalization in the United States and Holland

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I. Introduction

Proper health care is important for everyone. According to Article 25 of the Universal Declaration of Human Rights, everyone has the right to a standard of living adequate for the health and well being of himself and of his family.[1] It states that health care is an essential right for everyone regardless of their social, cultural, and economic status. However, recent studies have shown that providing proper health care has not been well addressed, especially with regard to immigrants.

One of the problems that societies face regarding immigrant workers is providing effective and sufficient health care. Neo-liberalism led to the liberalized "free" market economy, which in turn resulted in an increased number of privatized industries and diminished state power to make economic decisions.[2] Due to the neo-liberal approach to the market economy, many public services have been converted into privatized services. With this change, the government no longer guarantees everyone proper health care, including many immigrants to the United States. Dutch society also faces problems when integrating the immigrant population. Because the host country does not perceive immigrant groups as equal to their native citizens, this results in a degree of inequality. One example of inequality appears through health care. As a result, immigrants in the Netherlands on average are in a poorer health condition than the native Dutch population.

To better address and examine the issues regarding health care, I have chosen the Somali immigrant population in the U.S. and in the

Netherlands as a case study, since many Somalis immigrated to both countries as refugees when civil war erupted in Somalia. The Somali immigrants that I studied are legal immigrants and therefore have a complete right to every medical service the host countries offer.

Globalization in Comparative Perspective, a program designed by the Institute for Global Citizenship at Macalester College, provided me with an opportunity to explore the health care system in the United States as well as in the Netherlands. This essay is the product of research conducted during the 2007–2008 academic year. Most of the work took place in St. Paul, Minnesota, and Maastricht in the Netherlands. During the first semester, my project was composed of extensive library research and interviews in St. Paul, Minnesota. The second semester, which took place in the Netherlands, extended and examined the research done in the first semester. During the spring semester, I focused on article reviews and personal interviews, which took place in Rotterdam as well as in Maastricht. As a foreign national attending a post-secondary institution in the United States, I was always interested in understanding the extensive medical care provided to foreigners/immigrants in the United States. Therefore, my goal for this essay lies in understanding the health care systems in the U.S. and the Netherlands when they provide an adequate medical service to their citizens, including minorities in society.

This paper consists of two parts. The first is descriptive and provides background information. It includes a brief explanation of the neo-liberal influence on the health care systems, as well as an outline of the health care systems in the U.S. and in the Netherlands. The second section explores various Somali immigrants' personal experiences with the health care systems in their host countries—the United States and the Netherlands. The essay attempts to respond briefly to these questions: (1) Even when governments provide immigrants with some level of health care, how extensive is it, and how will the immigrants be able to access the system?, (2) What kind of difficulties do immigrants face in terms of language and cultural barriers?, and (3) What kind of impact/reactions does providing health care have on the host nation's citizens? The findings of the two case studies will help answer whether providing adequate health care to minority citizens is well addressed in both countries.

II. Overview of the Health Care Systems

A. Neo-Liberal Globalization and its Impact on Health Care

The impact of globalization is represented in every society. With scientific and technological development, communication across national borders has become more facile. This has aided in the creation of a global community, in which nation-states are interrelated and interdependent. However, the kind of globalization that we have witnessed in the last two decades has not been a neutral process. It has further disadvantaged the poor and weak. Globalization, as Robinson defines it, is "the integration of the economies of the whole world into the liberal capitalist market economy controlled by the Group of Seven."[3] The definition acknowledges the controlling power of the advanced capitalist countries comprising the G-7 (Japan, the U.S., France, Germany, Great Britain, Canada, and Italy) in the "creation of policies that ensure the survival of monopoly capitalism."[4] This process, according to Sklair,[5] requires a "transnational elite class" as well as a market that brings abundant sources of cheaper human labor that can work towards meeting the best interests and greatest margins of the transnational elites. In the end, such a process results in a neo-liberal economy, in which a few international corporations dominate the world and the responsibility of the government to provide basic services to everyone diminishes. One can ask whether globalization has serious impacts on current health care systems. If so, in what ways does neo-liberal globalization shape the current policies in regard to public health?

Globalization, which helped to shape a neo-liberal global market economy, has a complex influence on the health care system.[6] According to Immanuel Wallerstein, neo-liberal globalization implies that the governments of the world should not get in the way of large efficient enterprises in their efforts to prevail in the world market.[7] Neo-liberal globalization also implies that the international corporations should be able to freely cross national borders with capital and goods. In turn, all governments must relinquish some of their main powers to private corporations to suit the latter's economic activities. It also suggests that all governments in the world must minimize or eliminate all kinds of social welfare for their citizens.[8] Therefore, globalization results in minimal social services provided by the government and an unequal distribution of wealth, which influences the ability to afford personal medicines and other social services. In short, privatization of numerous

social services is a direct influence of the neo-liberal form of globalization. Reinforced by economic liberalization and market deregulation, privatization passes on public health needs to private capital.[9] Once this happens, the notion of "public" health loses its meaning. The public good must stress that the benefits cannot be individually calculated, but must be seen in the context of well being that accrues to the public.[10] The current neo-liberal economic approach views health care as a private good that is accessed through the market.[11]

Surely, consequences of privatizing health service are, to a degree, problematic. First of all, privatized health care will charge an increased amount for the services provided to the public, which will limit access to medicine, especially for the poor. Secondly, NGOs that focus on less well known diseases will have lesser chance of survival. For instance, health services mainly concentrate on treating HIV/AIDS, as it receives greater attention from the international community, undermining the treatment of other diseases. Third, there will be a longer waiting list for patients needing to receive treatment. When we introduce a privatized health care system, health care providers, such as doctors, will be expected to generate more money for their practice, resulting in the disruptive mobility of doctors. Doctors that are more talented than their peers will search for better paying opportunities, creating chaos that will result in longer waiting lines for patients. With the privatization of health care, the government minimizes its responsibility for providing optimal health care opportunities. Government will have less say in regulating hospitals and providing health insurance to everyone, with serious neglect for the poor.

In order to examine the impacts of neo-liberal globalization in the health care field, especially concerning a disadvantaged population, it is necessary to look at how medical care is provided to minorities. In this essay, a Somali immigrant group has been studied. In the following section, the history of Somali immigration to the U.S. and to the Netherlands is outlined. This will be succeeded by analyzing further the access to health services by Somali immigrants in each country.

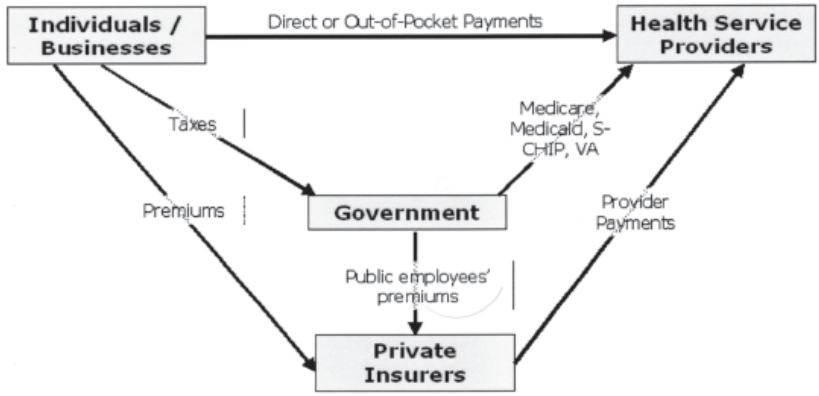

Figure 1: Multi-Payer System[14]

B. Health Care System

1. The United States

The United States is one of the wealthiest countries in the world. Yet in the U.S. there are 47 million citizens who are uninsured and, therefore, cannot access medical services.[12] There is a growing concern that the rising cost of insurance fees makes access to the health care system difficult for everyone. U.S. health services work best for individuals who are employed, enrolled in public insurance programs such as Medicaid, or who have the financial capital to purchase private insurance personally, without outside assistance.[13] Those not belonging to any of these categories would have a difficult time receiving proper medical services.

In the United States, the responsibility of providing health care is shared by the government and private insurance companies. The U.S. government collects money to pay insurance companies. Then the health service providers receive money from individuals, the government, and private insurers, all shown in the diagram above.

The individuals and businesses pay income tax in addition to a payroll tax, which is designed to finance Medicare for both employers and employees. Businesses pay most of the premiums to the private insurers and the employees pay the remainder. From the money generated by taxes, the government reimburses the cost of Medicare, Medicaid, S-CHIP, and the VA to health care providers for the services to people who are enrolled in these programs. In addition, the private insurer

receives money from the government as well as individuals and businesses. The system is able to provide health insurance to numerous companies' employees. It also explains why unemployed citizens have a difficult time accessing the health care system.[15]

Due to the expensive nature of health insurance, many immigrants, as well as the U.S. born natives who belong to a poorer social class, do not receive decent medical care. But the health care coverage for refugees in the U.S. is different. When they first arrive, their health care is provided for eight months, free of charge. After that period, refugees are required to pay for their insurance. According to the Minnesota Department of Health, many Somali immigrants lack health insurance and the three primary reasons for this are (1) some could not find jobs that provide health insurance, (2) some are self-employed and do not earn a sufficient income to purchase health insurance individually, and (3) due to cultural and language barriers, some do not have the knowledge of where to find and how to access the system.[16] Financial burdens, which prevent access to health services, are a big obstacle even for those American citizens who were born and raised in the U.S. Thus, the U.S. health care system has failed to provide satisfactory health services for everyone. Therefore, a large proportion of people are not able to meet the financial requirements that assure access to the medical service they need.[17]

According to the World Health Organization, the characteristics of a good health care system include: (1) comprehensive coverage and good health conditions—the system must be able to provide a good health status throughout all age groups and across the whole life cycle; (2) responsiveness—the system should be able to respond to the client/patient's needs and expectations, and must treat the patient with respect; and (3) fairness—the system must ensure financial protection for everyone, so that everyone is able to pay the cost.[18] Based upon these measures, in order to qualify as providing good health practices, the U.S. health care system must reflect responsiveness to all people, regardless of their social class, and provide a financially affordable insurance policy to everyone. Many have long debated about whether the U.S. medical care system is a good and a fair one, in the sense that the system is financially accessible to everyone. It has been shown that health service in the U.S. has not been able to meet these criteria, especially for certain classes in the society.

2. Dutch Health Care System

This section discusses the availability of health care in the Netherlands, the government's responsibility with regard to health care insurance, and the individual's responsibility in accessing medical care. Following this is an examination of the extent to which health care is available to people of lower social class in Dutch society.

Health care in the Netherlands is more comprehensive in comparison to that in the United States. The Dutch government is responsible for the quality and accessibility of health care. Two types of insurance systems make up the Dutch health care system: basic health care insurance supported by the government and private health insurance. Since January 2006, the government has put forward a different kind of insurance system. If one pays an income tax and lives in the Netherlands, then one is required to purchase the basic health insurance from a private health insurance company. It costs about €100 per month, and the company is required to provide basic coverage.[19] If one is not a Dutch citizen, the length of stay determines whether or not one is required to purchase the basic health insurance plan. People who stay in the Netherlands temporarily are not bound by these requirements. However, foreigners that become long-term residents and those that earn a salary in the Netherlands are obliged to buy basic insurance from a Dutch health care insurance company.[20]

The health care coverage for refugees in the Netherlands is very different. When they first arrive in the Netherlands, their basic health care is provided for four years, free of charge. After the four years, refugees obtain the status of "regular" Dutch citizens and therefore are required to pay for the basic insurance. The insurance companies are obliged to at least provide the basic package and are not entitled to reject anyone who applies for it. The basic package covers medical care that includes general practitioners, medical specialists, dentists, various medicines and appliances, prenatal care, usage of an ambulance, and hospital stay.[21] If the basic coverage does not include a specific treatment that one needs, it is possible to purchase additional private insurance. However, the insurance companies have the right to reject their customers and determine the cost of the plan.

The fees for the basic package are decided annually by the health insurance companies and are charged on a monthly basis. Those that earn regular salaries also contribute a supplement from their income to their health insurance companies (4.4% for self-employed individuals

and 6.5% up to the first 30,000 Euros). On the other hand, all residents' children below the age of 18 are insured under their parents' insurance policies. The Ministry of Health usually establishes a standard of minimum fees for insurance, but insurance companies determine additional fees for the basic health care insurance.[22]

For those who earn a lower net income, the government provides subsidies for the cost of the basic insurance plan. According to Waynand, about two-thirds of the entire Dutch population receives some level of government subsidies. Less than 1.5% of the entire Dutch population is uninsured.[23] Therefore, meeting the cost of Dutch health care is not as difficult as it is in the U.S. As indicated by the measurements set by the WHO, the Dutch health care system is considered to be a comprehensive one, as it covers all age groups. It is also a fair system since it protects everyone from high prescription costs. Part two of the essay looks more closely at these findings with two case studies: the Somali communities in the U.S. and in the Netherlands.

III. Case Studies

A. Brief History of Somali Immigration

Until the middle of the 17th century, Somalia was not recognized as an actual state.[24] Before the land was taken over by Europeans, various kin groups, who considered themselves Muslims, ruled the region.[25] However, after nearly eighty years of the colonial experience, Somalis started to express their collective anger against foreign rule. This sentiment matured into organized resistance against their colonizers, Italy and Great Britain. The first leader that recruited an army and challenged the colonial presence in Somalia was Sayid Muhamad Abdile Hasan.[26] He demanded that people act against the foreign powers that dominated their land. Even though this resulted in little success, the struggle brought Somalis a step forward in establishing a sovereign state.[27]

Achieving independence in Somalia took a long time. Right after World War II, Somalia was placed under the protection of the United Nations. The U.N. believed that establishing a state in Somalia would require some time since the Somalis had no experience of self-governance due to the extensive presence of colonizers in their land. Finally, in July 1960, two territories joined as the Somali Republic.[28] The new republic developed a democratic parliament and the representatives

from the two former colonies participated in the process of establishing a democratic government in Somalia.[29] Somalis enjoyed their newly created democratic order and the freedoms that came with it. But this period was brief, for the government failed to sustain stable institutions.

In 1969, General Siad Barre and his cohorts took military action and established a military dictatorship. Barre's oppression generated hundreds and thousands of Somali refugees, who sought asylum around the world. After two decades of harsh rule, Barre's regime finally collapsed into full-scale civil war. Even after Barre's dictatorship was over, Somalia was not able to find peace. As the civil war continued, the country suffered from a power struggle between numerous different clan militias. Various clans tried to take control over Somalia, and violent lawlessness became the norm.

Due to this instability, more than 250,000 inhabitants fled the country and 20,000 were killed or gravely wounded during the last months of the year 1991.[30] As of this writing, nearly a million Somalis have sought resettlement in almost every continent. To this day, Somalis have been unable to reconstitute their national identity and the institutions that will manage the affairs of their society. Many continue to seek refuge in other countries.

The following section will focus on Somali refugees in the United States and the Netherlands. I will explore their access to medicine and their difficulties in accessing the health care systems.

B. Somali Refugees in the United States

Beginning in the late 1980s, a considerable number of Somalis started migrating to the United States. According to the Immigration and Naturalization Service, in 1985, only 139 Somalis were admitted to the United States. In that period, Somalis migrated to the United States due to the favorable immigration legislation as well as increased acceptances to American colleges.[31] Subsequently, however, a great number of Somali immigrants came to the U.S. due to political and social turmoil in their homeland. In 1986, more than 4,300 Somalis entered the United States as refugees, and more than 31,000 individuals have entered the country from 1985 to 2003.

Many migrants were highly skilled and thus able to take advantage of what had been offered to others by the immigration legislation.[32] Due to the continuing civil strife in Somalia, people are still coming to

the United States. Nowadays, many Somali refugees come to the U.S. as immigrants, supported by their relatives who already have U.S. passports or green cards.

Even though some Somali immigrants can ask for assistance from family members who have already settled in the United States, many still experience difficulties in setting up their new home in the U.S. There are a number of reasons for the problems. First, many Somalis have already experienced serious traumas, which can last for the rest of their lives. Second, some cannot speak English and are not familiar with the customs of their host country. Third, some are exposed to prejudice and discrimination for being an ethnic minority. Fourth, the majority of Somali immigrants are Muslims, which can act as another barrier for their integration due to the negative sentiments that exist in the U.S. toward Islam, especially after the 9/11 attacks. Lastly, expensive health insurance payments discourage Somali people in the U.S. from accessing the health care system.

1. Extensiveness of the Health Care System in the U.S. for Somali Refugees

I focused on the health care coverage for Somali immigrants in Minnesota because more than half of the Somali refugees in the United States reside in this state.[33] Upon their arrival, Minnesota provides health care to people with refugee status. The Immigrant and Nationality Act of 1980 for the state of Minnesota entitles refugees to receive services such as immunizations and health assessment updates; screening for Hepatitis B, intestinal parasites, malaria, and sexually transmitted diseases; lead screening for children age 5 or younger; vaccinations; and assessments and referrals for other health problems.[34] Any Board-certified health care provider in Minnesota can perform the examination and the Minnesota Department of Health (MDH) reimburses the cost.[35]

When Somali refugees arrive in Minnesota, they are automatically insured by the government with Straight Medical Assistance, also known as the Pre-paid Medical Assistance Program.[36] This program provides newly arrived refugees with medical services free of charge, since they do not have personal insurance that can pay for medical care in the U.S. The MDH repays health care providers up to $505.32 for the services that they provide to refugees within 90 days of their arrival.[37]

Other specific health coverage for Somali refugees includes medical assistance, which is guaranteed for an eight-month period from the date that they arrived in the United States.[38] Once that period is over, one must be responsible for his or her personal medical care, which leaves many Somali immigrants with no health insurance.

2. Difficulties

There are many challenges that face the Somali community regarding access to the health care system in the United States. Language barriers can be a problem for those that have immigrated to a new country that uses a different language.[39] However, the language barrier associated with accessing health care in the United States is manageable. This problem can be solved by translation agencies, which have connections with most major hospitals in Minnesota.[40] The major problems that Somali refugees deal with in the U.S. health care system are cultural differences that exist between the U.S. and Somalia and the degree of financial burden.

First, the concept of health care is new to many Somali immigrants.[41] Due to the social unrest in Somalia, they barely experienced any medical care system there.[42] Moreover, there is a lack of awareness about the types of available health insurance as well as the importance of health insurance.[43] Also, some may be aware of existing health care options, but are not familiar with ones that are affordable. Even if cognizant of affordable medical insurance, the complexity of the system acts as an obstacle for many desiring access to the system.[44]

Second, many members of the Somali community also experience clashes between their cultural beliefs and the United States' health care practices. For instance, birth control, HIV/AIDS, and the prevention of HIV/AIDS are not easily discussed in the Somali community. Influenced by the Islamic religion, people in the Somali community are expected to have a sexual relationship only after they are married.[45] Thus, mentioning birth control methods as well as HIV/AIDS indirectly imply that the Somali cultural values are not being respected. A further cultural conflict between U.S. medical practice and the Somali community is the different gender norms. Male Somali patients prefer to be treated by male doctors and female Somali patients prefer female doctors, especially when visiting an OB/GYN.[46] Since gender-based medical practice is not being practiced in the United States, Somali

patients and U.S. health care providers experience some level of frustration.

However, the greatest hardship faced by a majority of the Somali population in the U.S. is the financial burden of purchasing the insurance. Many people in the Somali community are not employed with major companies that cover their health insurance, and their income is not sufficient to afford a comprehensive health care package.[47] Therefore, many choose to minimize their visits to doctors, only seeing health care providers when it is completely necessary. According to a personal interview, "doctors are rather seen as evils with no hearts in the Somali community."

3. Quality of Health Care Satisfaction in the U.S.

Many Somalis find the financial burden involved with accessing the system unbearable and the general perceptions of U.S. health care are no more encouraging. Since many Somalis do not have inclusive and comprehensive health care coverage, they choose to use a sliding fee system, which is a plan that requires payment according to the number of visits to the doctor. When one visits medical providers frequently, the sliding fee cost increases accordingly. Therefore, many do not choose to see doctors unless it is a life-threatening situation.[48] In addition, they feel that the price of prescription drugs is expensive. This economic difficulty is a major hindrance.

However, the overall sentiment of the Somali community is that when one can meet the costs associated with the U.S. health care system, the service that the hospitals can provide is superb.[49] Many of the major U.S. hospitals, such as Johns Hopkins and the Mayo Clinic, are also known for their fruitful medical research on top of their world renowned medical services. The state of Minnesota specifically has been ranked as the second best state with respect to the quality of hospitals in the United States.[50] This clearly conveys a contradiction in U.S. health care: the U.S. has top rated hospitals, but 47 million of its citizens cannot benefit from them.

C. Somali Refugees in the Netherlands

A small trickle of Somalis started emigrating to the Netherlands in the late 1980s. However, by the early 1990s, this trend became a major flow.[51] Soon new and stricter rules were put forward by the Dutch

state. The Somali population, however, was still considerable: within five years (1990–1995), 10,000 refugees had come to the Netherlands. Among them, 85% arrived for political and personal security reasons. At present, the Somali population in the Netherlands is estimated to be around 21,000, of which 17,368 are first generation and 3,920 are second-generation immigrants. Even though the majority of the Somali population in the Netherlands is generally young (under 25), most do not continue on to higher education. According to survey results from 2003, 19% do not have any form of education at all.[52] Thirty-six percent have only an elementary school education. A mere 8% hold university degrees.

It is perhaps the low levels of education that serve to explain why people of Somali origin are represented substantially in the unemployed sector of the labor market (36%). The high rate of unemployment is not the only hardship that the Somalis experience in the Netherlands. Similar to Somali experiences in the United States, Somalis in the Netherlands also have difficulty adjusting to Dutch customs. Social norms and cultural differences reflect their respective views of adequate health care provision.

1. Extensiveness of the Health Care System in the Netherlands

In the Netherlands, the health care system for refugees is generous and extensive. After having received the status of refugee, Somalis enter the regular health care services for four years.[53] After that period of transition, they are expected to be responsible for paying for their individual health care packages.

When Somali people are recognized as refugees, many of them are first sent to a refugee camp. Although some people argue that many of the refugee camps do not provide a good environment for overcoming mental trauma, Logghe contends that these issues are sufficiently addressed in most of the refugee camps in the Netherlands, because the camps provide sufficient health care and counseling. Also, when Somali immigrants first enter the country, they receive several kinds of vaccines since they could have been exposed to malaria and tuberculosis. The Dutch government requires screening for tuberculosis within two weeks of arrival, and this check-up is provided for free.[54] When the four-year period of medical service is over, Somali immigrants have the equal right and opportunity to access the health care system. About two-thirds of Dutch households get an income-related subsidy, which

is called the care allowance from the government.[55] Stronks claims in his study that equal utilization of health care services for first-generation immigrant groups has been achieved in the Netherlands.[56]

2. Difficulties

Immigration is a difficult process because one is forced to accept and adapt to a different culture, language, and system in a short period of time. Even though the health care system in the Netherlands has been generous, especially with Somali refugees, adaptation is still not easy for them. This is due to the cultural differences, language barriers, diverse perceptions of medicinal practices, and the generational gap between older and younger Somalis. Also, the Dutch health care bureaucracy and some of the mistreatment create a less hospitable environment for them.

Most of the Somali immigrant population experiences a serious language barrier when they first come to the Netherlands.[57] Acquiring a foreign language becomes even more challenging when one leaves a home country at a later stage of life. Not being able to explain your symptoms makes it difficult to communicate with doctors. As a result, accessing medical care is more difficult for immigrant groups.[58] Several of my sources mentioned that some Somali children in the Netherlands are under stress and feel great anxiety, not only because they need to acquire a new language themselves, but they are also expected to help their parents and act as translators between their parents and the Dutch health care providers.[59] Another obstacle is the different gender norms and values in Somalia and the Netherlands. Klaske Kik, a 32-year General Practitioner (GP) in Rotterdam, outlined her experience in treating some male Somali patients who did not wish to be treated by her due to her female status. Klaske says, "In the Netherlands, it does not matter whether one's doctor is a male or female. I was disappointed to see that they (male Somali immigrants) refused to be treated, and I didn't feel good about dealing with the situation." Such misunderstandings and miscommunications caused by cultural frameworks make it harder for both parties involved.

Another misunderstanding that exists among the older Somali immigrant generation, according to Kadicha, is their conception of good medical service. Kadicha asserts that in the Somali community many believe that good medical service includes the prescription of drugs. Since many associate receiving drugs with good treatment, dis-

appointment and frustration ensue when doctors deem drugs unnecessary or inappropriate as a form of treatment.

3. Quality of Health Care/Satisfaction in the Netherlands

In general, people that participated in the interviews expressed a great appreciation for the health care service. Being able to receive medical service is not as forbidding as it is in the United States, since the financial burden of accessing health care providers does not exist to the same extent. This encourages people to see health care providers as freely as they are needed.

Yet, dissatisfaction with the process of receiving health care is at once technical and personal. For instance, the long waiting list to see a health care provider is one looming concern. Another technical problem is the financial difficulty of affording more comprehensive medical care beyond just basic attention. Most Somali immigrants in the Netherlands have a difficult time affording further private health care insurance that provides even more comprehensive coverage.[60] Consequently, many only receive the basic level of treatment.

Another dissatisfaction expressed by the Somali community was a level of distrust in Dutch doctors. One source mentioned during the interview that many adult Somali immigrants live in a close-knit community where gossip spreads quickly. Therefore, other people in the community find out immediately when one experiences bad medical service with a certain doctor or hospital. There have been some incidences that led them to believe that German health care was better suited for them, so many travel a long distance to Germany when they are seriously ill.

There is a general concern among Somali refugees that they do not feel they are being well taken care of by General Practitioners.[61] When a Somali woman was talking to me about her medical experiences, she mentioned that her GP did not even want to see her previous medical records, nor was there a physical examination. The doctor just listened to her complaints and prescribed a medication. She related that doctors in Somalia listen very well to what patients have to say and provide a thorough explanation of the diagnosis and treatment.[62] However, her encounter with the Dutch doctor was just the opposite.

Another disappointment that Somalis face is the degree of racism by the Dutch doctors. Oftentimes, GPs explain their patient's physical complaints as merely psychological. Sometimes the Somali immigrants

had to listen to explanations that they are sick because they come from Somalia, and Somalis have all these complaints because of the situation there.[63] These kinds of statements do not help patients recover. Even worse, one woman explained that she had to ask the health insurance agency for a new doctor. When she visited the clinic, the doctor asked her how long she was going to stay in the Netherlands and when she would return to her home country.

These kinds of attitudes of Dutch doctors make the Somalis' stay and access to the health care system stressful. To avoid these conflicts, many Somali patients go to Germany or Luxemburg for medical treatment. In Germany or Luxemburg, the Somali immigrants say that doctors take care of patients more thoroughly and they want to monitor the patients' progress toward recovery.

D. Reactions of the Host Countries

In both the United States and the Netherlands, there has been a public concern that immigrants remain a major burden on society. There is also the sentiment that native-born taxpayers have to take care of immigrants.[64] Especially in the Netherlands, the rise of right-wing populist politics reveals the current relationship between the host country and the newly arrived immigrants. Some taxpayers, who financially support the health care system in the Netherlands, say the system must be altered so that people who cannot pay must not be allowed to access the system.

In the U.S., similar opinions about immigration have appeared in public. The U.S. national borders have gotten much more secure in recent years. The cost of health care can become a major source of contention.[65] The existing conflict with regard to integrating immigrant populations and the hostility that exists in the host countries complicates the challenges of the new arrivals in making a life for themselves. In the end, the host country's attitudes and policies diminish the rate of successful civil belonging—the ultimate meaning within a society.

IV. Conclusion

Throughout the course of the January Seminar and two academic quarters of European Studies at Maastricht University, as well as my prior experiences at Macalester College in the United States, I learned important lessons from discussions on health care systems and the

influence of globalization on such matters. A main purpose for this research was to explore the impact of globalization, particularly the force of the global economy, on public health. Though public health ought to be accessible to all, neo-liberal arrangements make such an ethical position increasingly untenable. Still, the United States and the Netherlands are not the same. While the first is increasingly driven by a greater degree of privatization, in the Netherlands, nearly everyone is still able to access the health care system and receive basic care, without carrying a serious financial burden.

Nonetheless, as discussed already, the U.S. health care system offers high quality service and works well with many of those who can pay the cost. In contrast, there have been some complaints that Dutch doctors are not very attentive to their patients' needs, resulting in (among others things) longer recovery periods. Therefore, in order not to leave a particular group behind, both countries must upgrade their systems, revise their health policies so that the problems described can be improved, and find a balance between the quality and accessibility of medical services.

The U.S. health insurance policies must be changed so that the cost of insurance decreases and the greater public can access the system. The U.S. government should provide subsidies to the health insurance agencies so that insurance can be provided to every citizen. Also, the government must suggest a policy that sets and stabilizes payments for health care providers, especially doctors, so that they do not move around as much and patients can receive a higher standard of health care in every hospital without paying too much money. On the other hand, the Dutch health care system must work on upgrading their efficiency and quality of services so that patients do not wait for long periods or endure extended recovery times. Health care providers will need to treat their patients with openness and empathy so that visiting them can be done without stress and difficulties. ◉

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