



VII

General Discussion



In the first part of this book, we focused on the scale of cross-border healthcare utilisation in the country of origin by minority ethnic people resident in the Netherlands and on their reasons for seeking such care (chapter II). We found that cross-border healthcare use in our sample varied by ethnic group and by migration generation, with the ethnic Turkish group, and to a lesser extent the ethnic Moroccan group, reporting relatively high rates of utilisation in the countries of origin. Although new symptoms or deteriorations of pre-existing illnesses were amongst the main reasons for consulting an outpatient clinic during a stay abroad, other strong motives included dissatisfaction with care in the Netherlands and desires for a second opinion. Turkish participants reported a larger perceived cultural distance to the Dutch healthcare system than Moroccan participants. We therefore anticipated that their expectations and experiences with respect to the healthcare system in the Netherlands would be important push factors for seeking healthcare in the country of origin.

On the basis of these findings, we turned our focus to underlying motives and contextual factors that influenced Dutch residents of Turkish origin in their decisions to seek healthcare in Turkey (chapters III and IV). We found that many utilised healthcare in Turkey on an opportunistic basis, motivated by beliefs about what constitutes 'good care', by perceived unmet needs for specialist care, and by influences from their social network. They frequently reported that their needs had not been met by their Dutch general practitioner due to the latter's restrictive attitudes towards referrals to specialist care and/or conservative attitudes towards treatment (such as non-intervention). The Turkish healthcare system appeared to them to fill a void with regard to their expectations, health beliefs and perceived needs for specialist care. The degree in which it provided familiarity, trust and personal attention was instrumental in triggering their use of healthcare in Turkey.

We expanded our analysis with a further qualitative study, conducting open-ended interviews based on the biographic-narrative interpretive method. These explored how and to what degree both the Dutch and Turkish healthcare systems shape the values upheld by Dutch residents of Turkish origin, employing the system perspective as proposed by Arthur Kleinman (1978). We found that the explanatory models of illness and consequent healthcare-seeking behaviours of respondents in fact reflected the 'cultural rules' of both the Dutch and the Turkish healthcare systems.

However, if differences in cultural values (cultural mismatches) arose between respondents and their Dutch general practitioners which the respondents perceived as unbridgeable, they might 'bypass' the Dutch healthcare system by obtaining specialist medical care in Turkey. More specifically, the gateway function of the Dutch primary care system was perceived as one of the major motivating factors for seeking transnational healthcare. In this way, ethnic Turkish cultural values that were perceived as not matching the 'cultural rules' of the Dutch healthcare system in terms of health, illness and when to seek healthcare could still be upheld through this 'escape route'. After returning home, patients often presented the outcomes of their healthcare use in Turkey to their Dutch general practitioners in order to get recognition for their health problems. In such cases, healthcare use in the country of origin might be said to increase medicalisation – with more health symptoms becoming labelled as disease – as well as increasing the number of visits to the Dutch healthcare system.

In the final part of the book, we explored in quantitative analyses whether a high tendency to cross-border healthcare use by Dutch residents of Turkish and Moroccan origin in fact showed associations with the frequency of their healthcare utilisation in the Netherlands, as well as with patient outcomes in the management of two chronic conditions, diabetes and hypertension (chapters V and VI). We found no indication of avoidance of Dutch healthcare by those using healthcare in the country of origin. Instead we found, as our qualitative study had suggested, that people using cross-border healthcare had greater odds of being frequent attenders in the Dutch system. We found no evidence for inferior diabetes or hypertension management in participants who used healthcare abroad. In fact, patients taking hypertension medication who obtained cross-border healthcare had a greater likelihood of adequate blood pressure control than their counterparts who used Dutch healthcare only. For diabetes management, we observed no difference between the two groups of patients.

Methodological reflections

One strength of this book lies in its mixed-methods approach, which allowed us to quantify the phenomenon of healthcare utilisation in the country of origin while qualitatively explaining mechanisms behind the phenomenon. We had access to a wide range of self-reported data from Dutch ethnic minority groups which could be linked at the individual level to

healthcare reimbursement data. We supplemented that with qualitative data collected from Dutch participants of Turkish origin at several private and state-run hospitals in Turkey, as well as at primary care surgeries with ethnicity-concordant general practitioners in the Netherlands.

Several limitations require attention. While we had information on healthcare use abroad (both through self-report and register data), we did not have information on the objective, medically defined need for consultation, on the timing of consultations in relation to the time of arrival, or on the duration of stay abroad. We also lacked reliable information on diagnoses resulting from healthcare consultations in the Netherlands and in the country of origin. Such data would have enabled us to further differentiate between the types of participants using healthcare. Participants may obtain healthcare cross-border after a corresponding diagnosis in the Netherlands, prompted by dissatisfaction with Dutch healthcare provision or by a desire for a second opinion. Alternatively, the need for healthcare consultation may have arisen from new health problems developing during periods of stay in the country of origin. We also lacked detailed comparative information about the quality of provision in the country of origin and in the Netherlands, as quality indicators differed between the two.

A further limitation is that healthcare use in the two countries was assessed throughout the 2010–2015 period, whereas the self-reported health status data of participants was assessed at one point in time during the participant's inclusion in the HELIUS study. As a result, we may have overadjusted or underadjusted for health status. Adjustment with multiple health status measurements at different time points would have enabled better evaluation of our findings against the level of healthcare needs. In any case, our qualitative data did confirm a pattern whereby frequent healthcare users in countries of origin were also frequent users in the Netherlands.

A final possible limitation was that we confined our comparison of users and non-users of cross-border care to the clinical outcomes in two chronic conditions; our finding that cross-border care was not detrimental to disease management would not necessarily apply to patients with other chronic conditions.

In one qualitative study, we recruited Turkish participants only. For our second qualitative study, we found no Moroccan participants who had communicated outcomes of clinical encounters in Morocco to their Dutch primary care provider. Even though Moroccan participants were found to give similar reasons for seeking cross-border healthcare to those of Turkish participants (including dissatisfactions with Dutch healthcare and desires for second opinions), they may have perceived different cultural mismatches to those of Turkish participants. Theoretically one might wish to avoid seeking treatment in the Dutch system and acquiring the label of patient.

Interpretation of the findings

Evaluation of the phenomenon of transnational healthcare use

The overall findings suggest that healthcare consumption in the country of origin is highly prevalent amongst individuals of Moroccan and Turkish origin who are part of ethnic minorities residing in the Netherlands. In part this may be inevitable, as health issues may arise during stays abroad. To another degree, especially in patients of Turkish origin, cross-border healthcare consumption may be predictable in that it reflects cultural mismatches experienced in the Dutch healthcare system. Some respondents attributed the benefits of the Turkish healthcare system to a better match with their own explanatory models of illness (based on cultural values) in comparison with Dutch healthcare. Some perceived downsides were also reported. The lack of a 'central case manager', like a Dutch GP, for discussing treatment options was seen as a disadvantage after travelling to a faraway country for healthcare. Respondents had to rely on themselves and their social networks in interpreting medical information, and by starting a suggested treatment they risked medicalisation as well as adverse iatrogenic outcomes and insufficient aftercare. Some reported foregoing a suggested Turkish treatment due to a limited duration of stay, then returning to their Dutch general practitioner for a 'third opinion'.

Transnational healthcare may have its benefits and its drawbacks. Cross-border services may enable people to circumvent certain restrictions in the Dutch system, such as mandatory GP referral to specialist diagnostics. In other cases, however, patients may wind up feeling lost, as when medical information obtained abroad conflicts with that provided by their Dutch GP, leaving them doubting which healthcare system to believe.

Hence, there are reasons why tackling the phenomenon of transnational healthcare use could be in the interest of patients of Turkish and Moroccan origin. That might be achieved by improving the compatibility of the Dutch healthcare system with cultural values of patients of foreign origin.

Migrants and their offspring

We found that the phenomenon of cross-border healthcare utilisation was not limited to the first generation of migrants, specifically in the Turkish group. Even though second-generation people had good mastery of Dutch and were familiar with the Dutch healthcare system, some reported cultural mismatches and motivations similar to those of their parents. We therefore suspect that cross-border healthcare use may not fade quickly with time.

Migrant-specific phenomenon?

Although literature is limited on migrants' cross-border use of healthcare, some studies suggest that migrants of various origins have experiences similar to those of our Turkish and Moroccan participants with regard to healthcare services in their countries of residence. Korean migrants residing in Canada and New Zealand, for instance, gave reasons for cross-border care that reflected desires for strong and definitive treatment and for healthcare providers with a shared language and culture. Waiting times and limitations on specialist referrals have also been noted as push factors for transnational healthcare generated by the healthcare system in the country of residence (Wang & Kwak, 2015; Lee, Kearns & Friesen, 2010). Pull factors in the South Korean healthcare system were primarily the swiftness of healthcare provision, the extensive diagnostics and the perceived high quality of delivered services (Oh, Jun, Zhou & Kreps, 2014). Most participants of Korean origin reported no perceived negative health-related outcomes resulting from using transnational care (Wang & Kwak, 2015; Oh et al., 2014; Lee et al., 2010).

Mexican migrants residing in the United States have reported perceiving healthcare use in Mexico as characterised by better personal attention due to shared cultural expressions, the prescription of stronger medical treatments and the greater speed of provision (Horton & Cole, 2011). In contrast, US healthcare was perceived as too focused on treatment according to protocol, which felt impersonal (Wiking, Saleh-Stattin, Johansson & Sundquist, 2009; Horton & Cole, 2011). Indian migrants residing in Australia wanted their healthcare providers to take on authoritative roles and saw shared decision-making as an indication of lacking medical knowledge (Gilbert, Antonides & Brijnath, 2019). Powerful treatments and enticing hope were valued as strong aspects of the Indian system. Similar results have been found for migrants of European origin in western Europe.

Russian migrants in Finland and Polish migrants in Scotland saw the structure of the healthcare systems in their countries of residence (characterised by primary care gatekeeping and long waiting times) as indications of low quality of care. Preferences were expressed for healthcare in the countries of origin (Kemppainen, Kemppainen, Skogberg, Kuusio & Koponen, 2018; Sime, 2014).

As the summarised literature suggests, migrants in many high-income countries give similar reasons for using healthcare in their countries of origin; these relate to language, cultural differences and socioeconomic barriers (Priebe et al., 2011). Our studies tried to deepen such insights by providing evidence on motivations for transnational healthcare use from a system perspective and on possible consequences of cross-border utilisation for healthcare outcomes.

Information on the perceptions of migrants of Western origin who utilise healthcare in their country of origin is sparse. However, the available literature does suggest that similar considerations to those highlighted here may apply when migrants from high-income European countries return to their countries of origin to obtain healthcare. Several studies have investigated cross-border healthcare use in European border areas with limited healthcare services (Vallejo & Sunol, 2009; Starmans, Leidl & Rhodes, 1997; Glinos, Doering & Maarse, 2012). Another study found that 72 per cent of students of German origin studying in the Netherlands opted for healthcare in their hometown in Germany, mainly citing familiarity with the German healthcare system (Glinos & Baeten, 2014).

Implications

The implications of healthcare utilisation by minority ethnic people in their countries of origin may be relevant for at least three types of stakeholders: Dutch healthcare providers, Dutch policymakers and researchers of transnational healthcare.

For Dutch healthcare providers, and general practitioners in particular, patients using healthcare in their countries of origin may pose numerous challenges in day-to-day practice. They may have to interpret foreign medical information, explaining to patients the treatments they have been prescribed for certain health problems or why particular test results or treatment interventions are not suitable or are not available in the Netherlands. For dealing with such patients, Arthur Kleinman and colleagues proposed eight clearly defined and structured open-ended questions to aid GPs during consultations in understanding a patient's explanatory model of illness and consequent

cultural mismatches in relation to the healthcare offered by the GP (Kleinman, Eisenberg & Good, 1978). Such mismatches should be approached in culturally sensitive ways, through patient education, professional explanation of test results and diagnoses, and negotiation on whether further diagnostics and treatment are needed (Kleinman 1978; Suurmond, Uiters, de Bruijne, Stronks & Essink-Bot, 2011; Priebe et al., 2011; Seeleman, Suurmond & Stronks, 2009).

When patients inform their GP about intended healthcare utilisation in the country of origin, the GP should focus on the safe use of transnational healthcare, on ensuring adequate medical information transfer to avoid unnecessary repetition of diagnostics, on drug interactions in treatments and on monitoring whether treatment aftercare is available (Crooks, Kingsbury, Snyder & Johnston, 2010; Jun & Oh, 2015). GPs should be aware of medicalisation in transnational healthcare patients. Daily ailments and slight differences in test results may get turned into diseases. Excessively powerful treatments may be given when more specific, less intrusive options are available. And particular diagnostic methods may be overmarketed as the only possibility for ruling out certain severe diseases, such as cancer (Moynihan, Heath & Henry, 2002).

GPs should be sensitive to possible feelings in ethnic minority patients of not being taken seriously or of not getting recognition for their symptoms; discussing the roots of such feelings may help to forestall transnational healthcare use (Kemppainen et al., 2018). At the same time, as our data suggest, the management of some chronic conditions may actually benefit from transnational care, as it may improve patients' understanding of their illness and enhance treatment adherence. In such cases, GPs might consider recommending seeing a doctor in a patient's country of origin.

For policymakers, various challenges may arise from the use of transnational healthcare by residents of the Netherlands. While patients might perceive benefits from such care, it can have an undesirable impact on Dutch healthcare availability. As our results suggest, it may be associated with increased healthcare uptake in the country of residence, some of which may be redundant. As cross-border healthcare use sometimes continues in the second and later generations, policymakers can help develop schemes to spend healthcare resources more efficiently. They can play key roles in organising and formalising cost-effective transnational healthcare services, including pre- and post-treatment care and mechanisms for timely medical information transfers to help monitor the quality of care and patient safety in transnational care (Kifmann & Wagner, 2014).

One viable option would be for Dutch health insurers to contract only a limited number of healthcare institutions abroad, which would then have to meet certain standards of healthcare quality. That could bring about more alignment and harmonisation between healthcare services in the countries of origin and residence, and thereby reduce the risk of medicalisation, adverse iatrogenic outcomes and lack of treatment aftercare.

Another task for Dutch policymakers would be to ensure that healthcare in the Netherlands allows for culturally sensitive care. It needs to be adaptive to a changing population with increasing diversity and differences in cultural values with regard to health, illness, healthcare and healthcare-seeking behaviour (Phillimore et al., 2015; Seeleman et al., 2009).

Researchers of transnational healthcare could seek evidence for which types of patients and diagnoses are best suited to cross-border care and how to assess effectiveness. They might also compare transnational healthcare in terms of quality and patient safety with local care provision for patients with migrant and non-migrant backgrounds. A major step in knowledge could be achieved by a prospective study with a mixed-methods approach with the aim of formulating appropriate cross-border healthcare pathways that can minimise unwanted outcomes from the perspectives of patients, providers and policymakers. Such a study could perform individual medical record reviews to analyse data on total numbers of healthcare visits, the diagnostics used and the disease outcomes over a certain follow-up period, while also conducting in-depth interviews with healthcare providers and patients. The study should include a number of different transnational populations with their unique sets of health issues, such as ageing immigrants and their chronic conditions, refugees and high-skilled immigrants

CONCLUSION

In summary, we found that cross-border healthcare utilisation varied by ethnic group and by migration generation, with the Moroccan group, and especially the Turkish group, reporting relatively frequent use of healthcare in the countries of origin. We found that healthcare utilisation in the country of origin often reflected perceived cultural mismatches with the Dutch healthcare system. These, in turn, were shaped by differences between the Dutch and the foreign healthcare systems. We also found that ethnic minority people, regardless of their degree of perceived cultural distance to Dutch society and to the Dutch healthcare system, did not avoid Dutch healthcare; nor were disease management outcomes in two common chronic conditions inferior in patients who used healthcare in their country of origin. Our results may have implications for Dutch primary care providers and policymakers, and they also may be relevant for other European countries with similar migrant populations, in particular those countries with gatekeeping healthcare systems. Our findings may support the implementation of culturally sensitive care for patients who are inclined to seek healthcare abroad. The findings could also help foster the development of transnational healthcare pathways in which patient safety, quality of care, medical information transfer and aftercare provision are adequately formalised and safeguarded between countries.

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