Chapter

GENERAL INTRODUCTION
Numerous studies in various fields have documented differences between ethnic population groups regarding their access to good quality health care services [1-7]. Such findings are widely considered disturbing and unwanted, coming from the idea that equal access to health care is in fact a key-characteristic of quality of care itself, and that both adequate access to and quality of care are necessary - though not sufficient - preconditions for equal opportunity to health [8-11]. Equal opportunity to health, then, is important from a human rights point of view [8,11]. As Braveman and Gruskin state:

“Equity in health is an ethical value [...] grounded in the ethical principle of distributive justice and consonant with human rights principles. [...] equity in health can be defined as the absence of disparities in health (and in its key social determinants) that are systematically associated with social advantage/disadvantage. [...] Equity in health [thus] implies that resources are distributed and processes are designed in ways most likely to move toward equalising the health outcomes of disadvantaged social groups with the outcomes of their more advantaged counterparts.”

In other words, equal access to good quality care for social groups is important because it may contribute to equity between social groups regarding their health status, and thus prevent that groups that are already disadvantaged are put at further disadvantage [11,12].

Inequities between ethnic groups

One way to define social groups is by focusing on their ethnic backgrounds. However, ethnicity is a fairly complex concept which is believed to represent a number of characteristics, including country of birth, language, religion or religious tradition, and social background [13]. Although ethnicity is preferably defined using a combination of these factors [14], it is not uncommon to measure it by using country of birth alone [15]. As such, country of birth can be seen as a proxy-measure of ethnic background [16,17]. In that sense, large parts of the general population in western countries nowadays have non-western ethnic backgrounds, in that either they or their parents were born in a non-western country [18-20]. There are at least four developments in recent history that have greatly influenced the demographic composition of western societies in this respect [21]. These are the process of decolonisation (e.g. of nations in Africa,
the Middle East, Asia, Latin America and the Caribbean), refugee movements following conflicts and civil disturbances (e.g. from South East Asia, the Balkans, and Central Africa), labour migration after the Second World War (e.g. from Morocco, Turkey and Tunisia), and the collapse of the Soviet Union.

There is a large body of research showing considerable variations between all these ethnic groups regarding their health status [22-27]. These variations tend to differ between ethnic groups, with some doing well and others doing worse than the host population, while differences within ethnic groups are present as well (e.g. across generations or health outcomes) [26-28]. Either way, variations like these pose important challenges for public health care in determining whether uptake of health services by ethnic minority groups adequately meets their needs. As far as mental health problems are concerned, there are various indications that this is currently not the case [29].

**Focus: anxiety and depression**

This thesis will address the presence of possible differences between ethnic groups regarding their access to good quality health care in relation to anxiety and/or depression. Anxiety and depression were selected for a number of reasons. Firstly, both disorders have a high prevalence in the general population, as a result of which they are often referred to as common mental disorders (CMD) [30-33]. Secondly, the burden of disease in CMD is enormously high, especially if depression and anxiety are present at the same time, or in case of comorbidity between anxiety or depression with other medical illnesses [34-39]. Both types of comorbidity occur frequently [38,40,41]. Thirdly, studies have quite consistently shown that certain non-western ethnic minority groups run a higher risk for developing CMD [29,42,43]. As far as ethnic groups can be considered to have a migration background, explanations for ethnic differences in mental health are often divided into pre-, peri- and post-migration factors. Pre-migration factors include differing base-line risks for developing a mental illness in the country of origin, possibly as a result of poor socioeconomic status or living conditions, or some genetic predisposition [31,33]. The process of migration itself (peri-migration) can be stressful or even traumatising and thus contribute or lead to mental illness [44,45]. Finally, there are numerous post-migration factors that are associated with the prevalence of CMD. Apart from socioeconomic disadvantages in host countries [9], large parts of the migrant population in western countries are confronted with discrimination [46-49]. The association between perceived racism and health appears to be strongest for negative mental health outcomes, including anxiety and depression [50]. A final reason to focus on CMD is that their treatment has advanced considerably
over the years. What is more, the available evidence suggests that, with some exceptions, ethnic minority patients can be treated successfully with existing interventions [51-57].

Theoretical and conceptual framework

There are multiple explanations why differences between ethnic groups regarding mental health care utilisation may exist. Two popular models are especially useful in this context. The first one is the Behavioural Model by Andersen and Newman [58]. The Behavioural Model first appeared in the 1960s and has been adjusted several times since then [58,59]. A simplified version of the model is depicted in figure 1. Essentially, the behavioural model discriminates between three types of individual characteristics that are related to health behaviours. First, there are predisposing factors, or sociodemographic and cultural characteristics of subjects, which can be divided into demographic factors (age, gender), health beliefs (attitudes, values, and knowledge in relation to the health care system) and social structure characteristics. Among the latter are, besides ethnic background, educational level, occupation, and quality of social network. The second group of determinants consists of enabling factors, which represent the ‘logistical aspects’ of obtaining care. Obviously, these include the availability of care, but also personal factors like the means (e.g. having an income and a health insurance) and knowledge (e.g. health literacy) to access health services. Key-determinants in the help-seeking process, however, are the need factors, which the model regards as the most reliable predictors of actual health care utilisation. Typically, two types of need are distinguished, namely perceived (or subjective) need and evaluated (or objective) need. [58,60-62]. Both need factors are important, considering that variations in the prevalence of mental disorders (evaluated or objective need) are often not sufficient to explain variations in care utilisation; greater perceived need for care is associated with higher use of services, less dropout and better compliance with treatment [63,64]. Conversely, the disbelief that problems require treatment (or no perceived need for care) is an important reason for people not to seek help [65,66].

The aforementioned individual characteristics are supposedly related to so-called health behaviours, which includes personal health practices (e.g. self-care, diet, exercise), the process of medical care (i.e. the behaviour of providers interacting with patients in the delivery of medical care, as expressed in quality of provider-patient communication) and people’s actual use of health services. In the end, both individual characteristics and health behaviours will have an effect on patient outcomes. Again, the model acknowledges that these outcomes have both objective elements (evaluated
health) as well as subjective elements (perceived health and consumer satisfaction). Moreover, the model includes a feedback loop showing that these outcomes may have an effect on predisposing, enabling, and need characteristics of the population, and on health services utilisation.

During the last phase of the process of model development, Andersen and Davidson [67] argued that in understanding health services use on a population level, it is also important to take into account contextual factors. For the sake of interpretation, these factors are not depicted in the model below. According to Andersen and Davids [67], contextual characteristics are to be measured at an aggregate level and include health organization and provider-related factors as well as community characteristics. Like individual characteristics, contextual factors are divided into predisposing (e.g. community age structure), enabling (e.g. supply of medical personnel and facilities), and need factors (e.g. mortality, morbidity and disability rates).

An additional model that is useful for gaining insight into barriers and obstacles to health care, and which was consequently included in the theoretical framework, is the filter model by Goldberg and Huxley [68]. The filter model is highly applicable to health care systems in which general practice plays a central role, as is the case in countries like Great-Britain, Denmark, Ireland, and the Netherlands [69]. The filter model can be used to describe pathways through health care by distinguishing different stages by which mentally ill individuals become diagnosed and treated accordingly. It discriminates between five levels, each of which is separated by a so-called filter. These filters provide insight in various selection mechanisms that may act between different levels, and which may be biased in several respects [70]. Figure 2 is a graphic presentation of the filter model as adapted from Goldberg & Huxley [68] and Bhui et al. [71]. According to the model, individuals in the general population may or may not have a mental illness. Only some individuals who have a mental illness decide to seek help for it (illness behaviour; filter A) and may eventually decide to visit a general practitioner (GP). These individuals subsequently have to present their mental health problems to the GP. This is the second filter, which then leads to the third level (i.e. ‘action by the GP’). GPs may or may not detect and identify cases that are presented to them, and may or may not decide to treat these cases in general practice. Eventually, a part of these cases will be referred by the GP for treatment in outpatient mental health care (fourth level). Finally, the most severe cases may have to be admitted to a psychiatric hospital or other inpatient mental health care facility. Since admission to inpatient or
Figure 1. A simplified behavioural model of health services use (adapted from Andersen et al. [58,59])

Figure 2. Filter model as adapted from Goldberg & Huxley [68] and Bhui et al. [71]
forensic facilities will not be a topic in this thesis, the final steps in the filter model are not displayed in the figure.

The models applied

Differences between ethnic groups - or ‘ethnic differences’ - in health care utilisation, can be found at different stages in the help-seeking process. A primary concern is that non-western ethnic minority patients with a mental health problem, including CMD, are less likely to seek treatment at all (i.e. illness behaviour; the 1st filter). Stigma and taboo are important predisposing factors, especially among elderly migrants, referring to the negative belief that mental illness should be considered as a sign of personal weakness and that having a mentally ill family member brings shame to the whole family, which influences attitudes toward service use negatively as well [72]. For example, Das et al. [73] reported that African Americans face a number of specific barriers in the recognition and treatment of major depression including stigma about diagnosis. Attitudinal differences are also presented in a study by Cooper et al. [62], who found that African Americans were less likely to find antidepressant medication acceptable than White persons. Hispanics were less likely to find antidepressant medication acceptable, but more likely to find counselling acceptable than white persons.

If ethnic minority patients decide to seek professional help for a mental health problem, the problem is supposedly less likely to be detected and diagnosed as such [74]. For example, recognition of depression among non-Western patients by primary care physicians is believed to be less likely, since non-western patients are supposedly more likely to somatize psychological distress (i.e. to present psychological symptoms with a focus on physical symptoms) [75]. Other problems involve the quality of communication between patients and physicians. For example, communication is more complex if a patient and provider do not speak the same language, have different ideas about illness, or have prejudices towards each other [76]. Such problems may negatively affect the perception of patients of the quality of the patient-provider relationship, and his/her trust in the physician [77,78].

Thirdly, there are concerns that non-western ethnic minority patients who attend general practice or primary care are less likely to receive treatments that are in agreement with professional guidelines [79-81]. For example, Lagomasino et al. [82] found that Latinos in the U.S. were less than half as likely as Whites to receive any depression care and guideline-level depression care in primary care, even after they controlled for several predisposing, enabling and need factors (e.g. age, educational level, current
unemployment, comorbidity of medical illness, and a diagnosis of CMD). Comparable results have been found by Wang et al. [51], who established that being White in the U.S. was a predictor of receiving guideline-concordant care for CMD, and by Young et al. [83], who found that patients who were Black were less likely to receive appropriate care for CMD.

With respect to GP-referrals to outpatient mental health care, patients with non-western ethnic minority backgrounds living in western countries appear to receive outpatient mental health care less often than members of the ethnic majority [84-86]. Regarding the quality of outpatient mental health care, the process of treatment is considered to be more complex, and outcomes to be less favourable for ethnic minority groups; differences have been reported regarding waiting and consultation times, follow-up rates, the ability to understand physician’s explanations, patient satisfaction, non-compliance, and early dropout from treatment [87-92].

**Knowledge gaps**

While the information above is generally supportive of the widespread and rather persistent idea that non-western ethnic minority groups are considerably disadvantaged in terms of access to (good quality) mental health care, one should be aware that the existing body of scientific literature has a number of limitations. The most important limitations will be discussed here.

First and foremost, the empirical evidence on differentials in health status between ethnic groups mostly comes from studies that have been conducted in the U.S. and the U.K.. The extent to which the results of these studies are applicable to health care settings in (other) European countries is uncertain [93], since there is considerable variety between countries in the ethnic populations they host [18]. Furthermore, there are variations between countries and studies with respect to the historical background of migration to the host countries (e.g. slavery, decolonisation, or labour migration), the definition of ethnic minority status (e.g. based on self-identification, religion, or country of birth), and health care systems (e.g. with or without general/family practitioners serving as gatekeepers to specialised mental health care, and with or without mandatory health insurance). For example, it was established by Uiters et al. [94] that studies conducted in the US more often reported lower primary health care utilisation by migrant groups than studies from Europe and Canada, and hypothesised that this reflected a weaker primary care system in the US compared to Europe and Canada. Finally, there are important differences in the operationalisation of equal access to
health care. Examples of definitions that have been proposed (and applied) are ‘equal inputs per capita’ ‘equal input for equal need’ ‘equal access for equal need’ and ‘equal utilisation for equal need’ [25,95].

Secondly, there is a lack of cross-culturally validated instruments which are suitable for measuring inter-ethnic differences in need for health care [96-98]. For example, researchers need to question whether translated items have a meaning similar to the original, and if measures assess the same concept cross-culturally [99-101]. The lack of cross-culturally validated instruments is one of the reasons why respondents who do not sufficiently master the dominant language in host countries tend to be excluded from large-scale epidemiological studies, thus severely reducing the representativity of these studies [98]. The resulting lack of population-based prevalence estimates of psychiatric disorders in various ethnic groups poses an important problem in that it is consequently difficult to establish if observed differences in health care utilisation are truly indicative of inaccessible institutions, rather than these differences being an expression of inter-ethnic differences in health care need.

The external validity of previous studies is being compromised in an additional number of ways. For example, it is important to mention the systematic non-response among ethnic minority groups, which is typically higher than among members of the ethnic majority population [102,103]. Finally, an important shortcoming in this field of research is the lack of information on cultural/ethnic background in the registration databases of health care institutions, preventing health services researchers to study potential dissimilarities between ethnic groups at all. To some extent, this informational gap is related to the lively and ongoing discussion about whether ‘race’ and ‘ethnicity’ truly are important variables in epidemiological research, and how we can best define and measure them [13,16,104-106].

If one takes these limitations into consideration, it is all the more important to note that the existing body of literature on ethnic differences in mental health care utilisation is in fact not as homogeneous as is often suggested. That is, there are studies which have found results that are not in line with the widespread view that non-western ethnic minority patients lag behind in terms of access to good quality mental health care. For example, Shim et al. [107] found that African Americans and Hispanics or Latinos had more positive attitudes toward mental health treatment seeking than non-Hispanic whites. In addition, Golberstein et al. [108] found that Asian and Pacific Islanders in the U.S. were more likely to perceive stigma towards mental health care use, but...
among those with probable depressive or anxiety disorders, there was no evidence that perceived stigma was associated with service use. Kirmayer, finally, has argued that, contrary to the claim that non-Westerners are prone to somatize their distress, recent research confirms that somatization is ubiquitously present in all ethnic groups [109].

**Setting: the Netherlands**

The studies presented in this thesis were conducted in the Netherlands, where the four largest non-western ethnic minority groups are from Turkey, Morocco, Surinam and the Netherlands Antilles. These four groups are best represented in the urban agglomeration in the West of the Netherlands, which is roughly composed by the municipalities of Amsterdam, Rotterdam, The Hague and Utrecht (also known as ‘de Randstad’). On January 2010, the proportions of Surinamese, Antillean, Turkish and Moroccan inhabitants in the general population of Amsterdam were 9.3, 1.6, 5.4 and 9.3 percent, respectively. Migrants from Turkey and Morocco are among the largest non-western migrant populations in western (mainland) Europe [110]. Labour migration from both countries started halfway the 1960s, when Western Europe’s economy recovered rapidly and large labour shortages appeared. Like France, England, Belgium and Germany, the Netherlands actively hired labourers from poor countries such as Turkey, Morocco, Spain and Italy. For Spanish and Italian migrant workers their stay in the Netherlands was mostly temporary, while many people from Turkey and Morocco became permanent Dutch residents when it became clear that the situation in their countries of origin did not improve sufficiently. During a more recent immigration peak, which started halfway the 1970s, citizens from Surinam and the Antilles migrated to the Netherlands as well. Surinam and the Netherlands Antilles are former Dutch colonies 1. Surinam became an independent state at that time, and the economic circumstances in both Surinam and the Netherlands Antilles were unfavourable. Because of the colonial history, by far most of the migrants from Surinam and the Netherlands Antilles master the Dutch language.

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1 While the Netherlands Antilles are still part of the Kingdom of the Netherlands, they were dissolved as separate states within the Kingdom in 1986 (Aruba) and 2010 (Curaçao and St. Maarten). Bonaire, St. Eustatius and Saba (together the so-called ‘BES Islands’) acquired the status of extraordinary municipalities within the Netherlands in 2010.
As stated before, the Netherlands have a health care system in which general practice plays a central role, in that it is mandatory for patients to see their general practitioner (GP) before consulting a medical specialist. GPs subsequently have to suspect/recognise a condition before they can decide to refer to specialised services [111]. Subsequently, mental health care is organized into general, categorical, and specialised institutions. In addition, help can be sought from independently operating psychologists, psychotherapists, and psychiatrists. Since 2006, health care is financed by mandatory basic insurance packages, of which the content is defined by the government. Supplementary insurance packages are optional. Prior to 2006, everyone earning less than a threshold income had a public insurance, and those with higher incomes were obliged to have private insurances [112,113]. As a consequence, family practitioners are the most important caregivers to those who seek medical care, and have a crucial role in the recognition of mental health problems and need for mental health. Compared with other European countries, the Netherlands have had a leading role in the development of evidence-based clinical guidelines and guidelines implementation research, as is the case for CMD [114,115].

In the Netherlands, too, concerns exist that, compared with the ethnic Dutch population, access to and quality of mental health care by ethnic minority groups is less than adequate. These concerns have been summarised in a well-known report that was published by the Dutch Council for Public Health and Health Care (Raad voor de Volksgezondheid en Zorg; RVZ) [116,117]. Surprisingly, however, the Council also observed evidence to suggest that access to (outpatient) mental health care was improving for some ethnic minority groups, including the Turkish and Moroccan populations. In addition, they summarised a number of drawbacks of the existing literature, most of which were in agreement with the limitations that were summed up earlier in this chapter. Among these are the exclusion of respondents from large-scale mental health care studies and surveys (e.g. the Netherlands Mental Health Survey and Incidence Study; NEMESIS) if they do not sufficiently master the Dutch language, and shortcomings in the registration (incomplete, inconsistent) of ethnic background in medical files.

The RVZ-report was published at the end of the previous century, and at that time its authors already concluded that the report was based on partly outdated information. To date, the report of the council itself might be considered outdated as well. It is important that information on this subject is updated continuously, thus taking into account developments that have been taking place in mental health care, in society, and
Introduction

For example, concerns about accessibility of mental health services for migrants further stimulated efforts from Dutch mental health care institutions to adapt their services to suit clients from different cultures, and to achieve equity in access to good quality health care [18,118]. The Dutch government even implemented a special taskforce on accessibility and quality of health care services for migrants and ethnic minorities in 2001 [119]. This process, which is often referred to as interculturalisation of (mental) health care, started about thirty years ago and includes numerous projects at various levels of the health care system. There are indications nowadays that accessibility of mental health care for ethnic minority groups in the Netherlands has been improving [120]. Additionally, on a societal level, it is important to acknowledge that current political and social developments, by some labelled as “Islamophobia”, have contributed to the discrimination and marginalization of Muslims in Western countries [121,122]. As a religious minority, Muslims nowadays constitute a large and increasing part of the migrant population in many Western countries. For example, the European Muslim population is expected to be doubled by the year 2025 [123]. In terms of mental health, marginalization may be considered as the most risky outcome of the acculturation process [124-126]. Finally, there have been several recent efforts to estimate the prevalence of CMD among non-western ethnic minority groups in the general Dutch population. For example, de Wit et al. [127] recently estimated that 25.7% of the Turkish population in Amsterdam fulfilled the DSM-IV criteria of an anxiety and/or depressive disorder in the previous year, followed by the ethnic Dutch (14.8%), Moroccan (13.3%), and Surinamese/Antillean populations (9.6%). These results are in line with similar studies conducted in Belgium and the Netherlands [128-131]. The availability of these data allows us to better estimate whether the migrant population in the Netherlands are adequately represented in mental health care.

Thus, this thesis seeks to address two questions, namely

1. Are there differences between ethnic groups regarding their mental health care need?
2. Are there differences between ethnic groups regarding their access to good quality mental health care?

Sources of information

In summary, the aim of this thesis is to examine differences and similarities between the main ethnic groups in the Netherlands (i.e. ethnic Dutch, Surinamese, Antillean, Moroccan and Turkish) regarding accessibility and quality of health care in relation to CMD. This is done using data that were derived from three different studies or
sources. These are the Amsterdam Health Monitor (AHM), the Netherlands Information Network of General Practice (LINH) and longitudinal data from a nationwide psychiatric case register (ZORGIS). I will briefly discuss each of them.

The Amsterdam Health Monitor (AHM) is a general public health survey, carried out by the Amsterdam Municipal Health Service (GGD) every four years. In 2004, the AHM was designed to map the general health status of the Amsterdam adult population by means of a structured interview and a physical examination, with a special focus on migrant groups. A random sample was drawn from the municipal population registration, stratified by ethnicity (Dutch, Turkish, Moroccan and other) and age (18-34, 35-44, 45-54, 55-64 and 65 years and older). In 2005, this generic AHM was followed by a ‘second wave’, which consisted of a structured interview that was specifically aimed at mental health. All respondents from the first wave who consented with a second approach were asked to participate. Both phases provided data for this study. Both the first and second phases of the AHM, including their results, are more elaborately described elsewhere [127,132,133].

The ZORGIS database was introduced in 2000, and established to facilitate health care policy and health services research. In addition, ZORGIS was developed to establish benchmarks for the mental health care sector. All in all, ZORGIS contains information about 1,845,709 episodes of care for 1,345,660 clients from 2001-2005. In ZORGIS, an episode of care is defined as the time interval between registration with a service for a mental health problem and a final/last contact with that service. For this thesis, data were used from general mental health care, which includes integrated mental health care (GGZ), general psychiatric hospitals (APZ), and institutions for community based mental health care (Dutch acronym: RIAGGs). For these institutions ZORGIS covers the larger part of health care consumption among adults in the Netherlands between 2001 and 2005.

LINH, finally, is a sentinel network of family practices, of which the patient population is considered to be representative for the general Dutch population [134]. From these practices routinely recorded data from electronic medical records (EMRs) are made available for research [135-139]. The data holds longitudinal information on consultations, diagnoses, prescriptions and referrals of approximately 350,000 patients that are listed in these practices. Data for the present study were collected in 2007. Practitioners participating in LINH record diagnoses and complaints using the International Classification of Primary Care (ICPC) [140], which is related to the ICD-10 [141]. Dis-
ease episodes were constructed for each ICPC-coded health problem, defined as all encounters for the management of the same specific health problem [142].

**Outline of this thesis**

This thesis contains a number of chapters, divided into sections that correspond with the central research questions. The first section (chapters 2, 3, 4 and 5) can be placed in the context of the Behavioural Model, as it describes how ethnic background is related to a number of predisposing, enabling, and need factors. The cross-cultural validity of the Kessler Psychological Distress Scale (K10) [143,144], an instrument that is becoming increasingly popular as a screening tool for anxiety and depressive disorders, is examined in chapter two. Second, results will be presented of a study that investigates the relationship between acculturation (predisposing factor) and psychological distress (need factor), the latter established by the K10 (chapter three). Chapter four contains the results of a study that is concerned with differences between ethnic groups regarding their perceived need for mental health care. Finally, chapter five focuses on differences in attitudes towards self-reliance and (in)formal help seeking for mental health problems (predisposing factors) between Turkish, Moroccan and ethnic Dutch respondents. All chapters in the first section are based on data from the AHM.

The second section of this thesis contains three studies which describe how ethnic background may be related to accessibility and quality of mental health care at different levels of the filter model. Chapter six, which is based on data from the AHM as well, compares the degree of primary and specialised mental health care utilisation between various ethnic groups in the general population. This is done in confirmation with the Behavioural Model, accessibility of services is studied according to the principle of “equal access for equal need”. The following chapter seven focuses on the next level in the filter model, namely primary care/general practice, using data from LINH. The chapter addresses the questions whether there are differences between ethnic groups regarding the (1-year) prevalence of CMD in family practice in urban areas, and whether there are differences in the quality of care provided by family physicians. Finally, chapter eight moves to the third level in the filter model by reporting on a study on outpatient mental health care. More specifically, it is studied whether ethnic minority background was associated with lower depression treatment intensity and lower quality of depression care. Chapter eight is based on the ZORGIS data. Chapter nine consists of a general discussion of the main findings presented in the various chapters. This final chapter will also provide some implications for research and public health policy.


