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MIGRATION AND INTEGRATION IN FLANDERS

Multidisciplinary Perspectives

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4. Key Problems in Primary Health Care – Qualitative Research on Prevention amongst Physicians Working in a Superdiverse Context*

David De Coninck, François Levrau and Falke Tibax

Introduction

Like most Western European regions, Flanders has entered a new era of migration described by Vertovec (2007) as a ‘transformative diversification of diversity’. ‘Super-diversity’ is the term that he has coined to underline the level and kind of complexity that has not previously been experienced in Western societies. In this chapter, we examine the impact of this new demographic reality for primary health care in Flanders. The Flemish Government recently restated that its policies should place ethno-cultural minorities at the centre of its attention since these groups continue to struggle with issues of equal opportunities *and* full participation in mainstream society (Flemish Government, 2014). And, as there are significant health differences between the native population and ethnic minorities in Flanders, the Flemish Government has forcefully stressed the importance of health services and the need for a culturally competent health care. Particular emphasis is placed on the achievement of health gains in the Flemish population based on preventive health care.

‘In order to strengthen individuals in their well-being we aim to prevent health issues, and we will realise this by having easily accessible primary health care, embedded in society.’ (Flemish Government, 2014, p. 13, our translation.)

The attention being paid to primary health care is of crucial importance, since elements of these health care services, such as prevention, can reduce mortality related to cancer, cardiovascular diseases and chronic illnesses, hence all sorts of diseases which dominate the current Flemish mortality pattern (Beaglehole et al., 2008; Mendis, Puska, & Norrving, 2011; Noppe, Vanderleyden, & Callens, 2012; Statistics Belgium, 2012; Stewart & Wild, 2015). However, since ethno-cultural minorities might suffer from different kinds of diseases, or at least might be prone to different health risks, it is important that primary health care is adjusted to the needs, lifestyles and symptoms of these 'new population groups'. For example, several studies have illustrated that these groups participate significantly less in prevention activities (Derluyn, Lorant, Dauvrin, Coune, & Verrept, 2011; Levecque, Lodewyckx, Vandeneede, & Timmerman, 2006; Vassart, 2005; Wilkins et al., 2012).

In this chapter, we aim to highlight the perceptions of physicians. What do they think are the key problems in primary health care in a (super-diverse) area? We focus on the situation of ethno-cultural minorities in the primary health care of the Greater Antwerp area, which is the municipality of Antwerp with its nine districts. Antwerp is currently not only a very diverse area when it comes to a multicultural population; demographic prognoses have also illustrated how Antwerp will become even more diverse so that it will eventually become a 'majority-minority city', a region where ethno-cultural minorities make up the majority of the local population. In order to have a clear view on how preventive health care works and could/should work, and to what extent the super-diverse population poses particular challenges in the field of primary health care, we have conducted qualitative research in the form of semi-structured interviews with physicians working in the Greater Antwerp region. It is commonly accepted that physicians are key agents in primary health care, since they are the most accessible providers of health services for a great part of the population (de Maeseneer, Aertgeerts, Remmen, & Devroey, 2016).

We start with a brief demographic description of our research area. We illustrate how the Greater Antwerp area is marked by super-diversity and will become a 'majority-minority city'. In the next section, we formulate and explain the 'social gradient'. According to a body of epidemiological findings, there is a correlation between socioeconomic inequalities and health inequalities within the population. The lower the socioeconomic status, the worse the health outcome. In the following section, we elucidate the methodology. We explain why we have conducted semi-structured interviews with physicians in the Greater Antwerp

region and describe some basic features of the respondents. We continue with an overview of the main results of these interviews. We consider general problems as well as ethno-cultural specific problems and suggest some solutions. In the conclusion, we recapitulate what we believe are the key findings of this study and also propose some suggestions for future Flemish policy concerning primary health care for ethno-cultural minorities.

Super-diversity in Flanders, the case of Antwerp

In 2007, Steven Vertovec coined a term to summarise the increasing diversity in Western Europe; 'super-diversity'. The term was quickly adopted and became very popular in all kinds of migration and integration studies. Super-diversity mainly refers to the growing awareness that the demographic, socio-political, cultural and socio-linguistic face of Western societies has drastically changed as a result of (1) ever faster and more mobile communication technologies and software infrastructures, along with (2) ever expanding mobility and migration activity related to major geo-political changes around 1990 (Blommaert, 2012). In that sense, Flanders has indeed become super-diverse.

Generally speaking, the number of people of foreign origin in Flanders' has greatly increased since 2009. However, as Table 1 shows, this trend varies by ethno-cultural group. The number of people with a non-EU origin (+ 135.441) rose more sharply than the number of people coming from one of the EU countries (+ 75.186).² The largest increase is observed in the group with EU12 origin. During 2009 and 2013, their number has increased by 71% (31.316 individuals). During this period, those with European non-EU origin and the group 'other countries' have also increased considerably (respectively 21.110 individuals or 29% and 63.262 individuals or 35%). The number of people coming from one of the western and northern EU countries remained stable.

In 2013, around 230.000 people of foreign origin lived in the Greater Antwerp area.³ This number corresponds to 45% of the total population, turning Antwerp into one of the most diverse areas of Flanders (Van den Broucke et al., 2015). The area is also quickly evolving into a majority-minority city, meaning that a majority of the population consists of several groups of ethno-cultural minorities (Crul, 2015; Geldof, 2013). It becomes clear that the population in Antwerp is unique in terms of diversity compared to the rest of Flanders: the share of people of foreign origin in Antwerp is substantially higher and is growing more rapidly. In 2013,

Table 1 Population of foreign origin per origin group. Number of persons of foreign origin per origin group, Flemish Region, beginning of the year

Origin	2009	2010	2011	2012	2013	% of the total population
Total EU	463.580	480.400	499.980	519.856	538.766	7,4
Neighbouring countries	272.033	277.576	283.157	288.200	292.471	4,4
Western- and Northern-EU ₁₅	31.601	31.887	32.170	32.543	32.493	0,5
Southern-EU ₁₅	104.577	107.720	111.237	114.853	119.117	1,7
EU ₁₂	55.369	63.217	73.416	84.260	94.685	0,9
Total non-EU	506.410	539.241	575.962	613.423	641.851	8,1
Europe non-EU	71.691	77.511	85.537	91.577	92.801	1,1
Turkey	108.994	113.124	117.709	121.658	125.097	1,7
Maghreb	146.609	155.432	164.539	173.600	181.575	2,4
Other countries	179.116	193.174	208.177	226.588	242.378	2,9
Total	969.990	1.019.641	1.075.942	1.133.279	1.180.617	15,6
						18,4

Source: Van den Broucke, et al. (2015) p. 101.

45% of residents in Antwerp have a foreign origin, while the Flemish Region has only 18% of residents with a foreign origin (Crossroads Bank for Social Security, 2016; Van den Broucke et al., 2015). In addition to the sharp and recent increase of people with a migration background, another feature which is characteristic for super-diversity is the 'diversity within the diversity'. Moreover, it is precisely this increased complexity on the ethnic, linguistic, cultural, religious, legal and economic levels that forms the core of the demographic super-diversity (Geldof, 2013). Currently, Antwerp has 170 different nationalities residing on its territory (City of Antwerp, 2016). Table 2 illustrates how the 'diversity within the diversity' results in a growing fragmentation in terms of migration backgrounds. In both the Flemish Region and in Antwerp, most inhabitants of foreign origin hail from a country outside the EU27. In Antwerp however, the proportion of people with non-EU origin is much higher compared to the Flemish Region. Of the 227.599 people of foreign origin in Antwerp, 31.6% (161.659 people) are of non-EU origin. The proportion of residents with non-EU origin relative to the total population located in Antwerp is 21.6% higher than in the Flemish Region. Within the non-EU origin group, people mainly come from the 'Maghreb' and 'Other countries'.

Table 2 Number and percentage of persons of foreign origin⁴, by ethnic origin, 2013

Origin	Antwerp		Flemish region	
	Number	Percentage	Number	Percentage
Total EU	65.940	12,9	538.766	8,4
Neighbouring countries	29.908	5,8	292.471	4,6
Western- and Northern-EU15	5.836	1,1	32.493	0,5
Southern-EU15	12.224	2,4	119.117	1,9
EU12	17.972	3,5	94.685	1,5
Total non-EU	161.659	31,6	641.851	10,0
Europe non-EU	20.467	4,0	92.801	1,4
Turkey	20.415	4,0	125.097	2,0
Maghreb	61.826	12,1	181.575	2,8
Other countries	58.951	11,5	24.2378	3,8
Total	227.599	44,5	1.180.617	18,4

Source: Crossroads Bank for Social Security, (2016); Van den Broucke, et al. (2015), p. 101.

(Primary) health care and diversity

Since World War II, health care has become an increasingly important policy area in Belgium. Throughout the second half of the 20th century, the Belgian Government attempted to develop a compulsory health insurance system based on independent medical practice, free choice of health care provider by the patient, fee-for-service payment of providers and reimbursement for the patient. Since 1980, health care has become a competence of both federal and regional authorities. The Federal Government remains responsible for the regulation and financing of compulsory health insurance and hospitals. Regional authorities, such as the Flemish Government, are responsible for most of the day-to-day organisation of health services, such as health promotion and prevention in their region (Gerkens & Merkur, 2010). The universal principle from which Flemish health care operates is that every individual, regardless of residential status, has a right to equal access to health care (Levecque et al., 2006). This might sound good in theory; however, the reality shows a somewhat different picture. Health surveys conducted between 1997 and 2013 in Flanders have pointed out that ethno-cultural minorities generally have a worse health status than the native population, and that this gap is only increasing (Detollenaere, Vos, De Maeseneer, & Willems, 2014; Noppe et al., 2012; Van Oyen et al., 2005). This inequality is a clear example of a so-called Matthew effect. The health status of individuals in Flanders decreases as they descend the social ladder, despite the fact that the intended principle is to help all people, and in particular these disadvantaged groups (Deleeck, 1989).

A whole host of national and international literature has shown that ethno-cultural minorities become more vulnerable to illness since they experience reduced access to health care. Hence, it is not entirely surprising to observe that these groups are more frequently confronted with chronic conditions compared to the native population. These groups also report worse subjective and mental health (Anson, 2000; Levecque et al., 2006; Lorant, Van Oyen, & Thomas, 2008; Van den Broucke et al., 2015; Van Oyen et al., 2005). An illustration of this reduced access can be found in the fact that prevention initiatives do not affect the entire population equally. It is mainly those who run the biggest risk of illness that do not participate sufficiently in preventive efforts such as the adoption of a healthy lifestyle (Derluyn et al., 2011; Levecque et al., 2006; Vassart, 2005). As Table 3 illustrates, citizens with a different nationality demonstrate more unhealthy

behaviour. When it comes to healthy food, the proportion of Belgian nationals that eat the daily recommended amount of vegetables and fruit is higher than non-Belgians. However, the percentages are low for all groups. People with EU nationality (excl. Belgium) and who are born in the EU (excl. Belgium) smoke much more (almost 50%). Belgians and people born in Belgium engage a little more in daily exercise than the other groups.

Table 3 Health behaviour by nationality. Percentage of the population that consumes the daily recommended amount of vegetables and fruit, exercises 30 minutes a day, non-smoking, by current nationality and country of origin, 16 years and older, Flemish Region, 2013 (in %)

	Healthy food	Exercise	Non-smoking
<i>Current nationality</i>			
Belgian	11	40	79
Non-Belgian EU	5	37	52
Non-EU	6	34	83
<i>Country of origin</i>			
Belgian	11	41	79
Non-Belgian EU	10	34	55
Non-EU	11	31	85

Source: Van den Broucke, et al. (2015) p. 216-217.

Here, another Matthew effect is at play, since prevention campaigns mainly benefit the so-called ‘worried well’s (Krogsbøll, Jørgensen, Larsen, & Gøtzsche, 2012; Van De Kerkhof et al., 2010; Zeliadt, Etzioni, Ramsey, Penson, & Potosky, 2007). If left unaltered, this situation will serve only to widen the health gap between the native population and ethno-cultural minorities in Flanders. An important aspect of primary health care is prevention. This type of health care, which aims either to prevent illness or treat it as early as possible, has become increasingly important in recent decades. This is due to the fact that cancers, cardiovascular diseases and chronic illnesses have become a major part of the mortality pattern in Flanders (Noppe et al., 2012; Statistics Belgium, 2012). These conditions can be combated with prevention, be it with vaccines, a healthy lifestyle or regular check-ups (Beaglehole et al., 2008; Mendis et al., 2011; Stewart & Wild, 2015).

A first factor which explains why ethno-cultural minorities have more health problems is related to their socioeconomic status (Mehta, House, & Elliott,

2015; Nandi, Glymour, & Subramanian, 2014). Studies concerning poverty and socioeconomic exclusion have shown that ethno-cultural minorities can usually be found in the lowest income categories (Van Haarlem, Coene, & Lusyne, 2011). As Table 4 illustrates, 56% to 62% of these groups can be found in the first quintile, while ‘only’ 17% to 19% of the natives are in the lowest (Belgian) income category (Van den Broucke et al., 2015; Van Haarlem et al., 2011). Moreover, the risk of poverty in Flanders for migrants born outside EU borders is three times as great as that of the native Flemish population (Van den Broucke et al., 2015). Having a favourable health status generally comes with a financial cost, making this even harder to achieve for ethno-cultural minorities given their low income and high risk of poverty (Kant & Graubard, 2013; Van den Broucke et al., 2015).

Table 4 Median income and income distribution. Median standardised net household income in euros and distribution over 5 income quintiles (in %) by current nationality and country of origin, 16 years and older, Flemish Region, 2013

	Median income	Lowest quintile	2 nd quintile	3 rd quintile	4 th quintile	Highest quintile
<i>Current nationality</i>						
Belgian	23.260	19	21	20	20	21
Non-Belgian						
EU	21.029	28	19	18	10	15
Non-EU	12.960	62	22	7	1	8
<i>Country of origin</i>						
Belgium	23.659	17	20	20	21	21
Non-Belgian						
EU	21.109	25	22	18	12	23
Non-EU	14.725	56	20	10	5	9

Source: Van den Broucke, et al. (2015) p. 203.

The living arrangements of an individual are also proven to have an effect on their health status. Studies have shown that unfavourable living conditions can contribute to several health issues (Tilborghs, Wildemeersch, & de Schrijver, 2009; World Health Organization, 2000). ‘Het Grote Woononderzoek’ (the Great Housing Research), a Flemish study, has illustrated that people of foreign

origin often reside in neglected neighbourhoods, which increases certain health risks (e.g. air pollution) in Flanders (Heylen, 2015). It is also indicated that ethno-cultural minorities are frequently confronted with 'housing deprivation'. This phenomenon is characterised by at least one of the following shortcomings in a residence: a structural problem in the residence (e.g. leaky roof, rotting windows or doors), a lack of elementary luxury (e.g. no shower or bath) or a lack of (natural) light (Kunst et al., 2005). For the Flemish Region, 18% of the native population was faced with this type of deprivation in 2013. 34% of individuals born outside EU borders live with this housing deprivation, as well as 22% of non-Belgian EU-citizens (Van den Broucke et al., 2015).

Aside from socioeconomic status and living arrangements, a third factor that impacts on the health status of an individual relates to certain convictions that may have an ethnic, cultural or religious character. These convictions not only influence the lifestyle of people, but also their sick role (Shilling, 2002). Elements such as the supernatural and the existence of stigma concerning psychological conditions or sexual (health) issues may clash with the Western image of evidence-based medicine (Rousseau & Kirmayer, 2011; Vassart, 2005). Certain 'cultural' or 'religious' convictions, such as the idea that one has to endure pain or illness as these are signs or, even worse, punishments from God, will prevent a person seeking medical help. Individuals who believe that psychological problems are only for the weak – or are socialised in a culture where these convictions are widespread – will also not (openly) seek help for these issues (Bhugra & Gupta, 2010; Kirmayer, Weinfeld, Burgos, & du Fort, 2007; Lindert, Schouler-Ocak, Heinz, & Priebe, 2008).

Methodology and description of research population

The main objective of this study is to map the perceptions of physicians concerning problems in primary health care in a society characterised by super-diversity, with particular attention to the perception of prevention efforts for ethno-cultural minorities. Between October and December 2015, 18 semi-structured interviews were held with 18 physicians located in the Greater Antwerp area. This region was chosen because Antwerp is a prime example of super-diversity in Flanders, and because it will become a majority-minority city within the next few years (Geldof, 2013; Van den Broucke et al., 2015).

We have worked with semi-structured interviews and not with focus groups, since bringing together physicians for a focus group would have been difficult given their busy time schedules. Furthermore, given that all physicians work in the same area, the chances were high that they would have known each other, which might negatively influence the way they respond to the questions. The possibility of socially desirable answers is reduced when face-to-face conversations are utilised (Morgan, 1993). Interviews with 'ethno-cultural patients' could also have been an interesting option but, given the limited time frame of the study, this was not really an option. Finding ethno-cultural patients willing to talk would probably have been more time-consuming, and would also have posed additional difficulties in terms of communication (language). However, by focusing on the perceptions and attitudes of those who have a direct responsibility in primary health care, we had the opportunity to draw a clear picture of how they experience the super-diverse society and its impact on prevention.

Finding physicians willing to talk was certainly not an easy job. We started with looking up all contact data of all physicians – the contact data are listed in a book called *'List of the registered physicians in Antwerp'*, and hence could be rapidly found (Provincial Council of Antwerp, 2014) – and contacted all 300 physicians by email. In the email we asked the physicians to fill in a short questionnaire that covers some socio-demographics, as well as specifics about their professional context (payment arrangement, kind of practice, % of ethno-cultural patients). We also asked them whether or not they would agree to a semi-structured interview in order to grasp their ideas on primary health care. Finally, we asked them if they were using the *Global Medical File Plus* (GMD+), a short list of questions available to Flemish physicians aimed to institutionalise preventive efforts for patients aged 45-75. This instrument, developed by Domus Medica,⁶ has been used since 2010 and contains questions concerning blood pressure, family history, smoking behaviour, vaccines, weight and mental health. The GMD+ was amended in 2014, which resulted in the mental-health section being removed from the questionnaire. We contacted some 300 physicians via email, asking them to participate in the study. Forty of those completed the short questionnaire, and only ten agreed to the interviews. To further increase our response rate, we contacted the presidents of several health-related organisations in Antwerp. Two of them were prepared to send an email to their members in which they were asked to participate in a study conducted by the University of Antwerp. This resulted in five extra respondents. One additional physician was gathered using snowball sampling, since we asked every interviewee if they knew

of colleagues that might want to participate in the study. Finally, two physicians were convinced to participate after we simply entered their surgeries and asked them directly if they would participate.

Table 5 summarises the profiles of the practitioners. Most of the respondents were female (13 out of 18), worked in a group practice (15 out of 18), and worked in the fee-for-service arrangement (11 out of 18). The practitioners were located in 5 different districts of the Greater Antwerp area. In Flanders, the fee-for-service is the most popularly used payment system, and this is reflected in our study. Fee-for-service implies that patients pay a fee to the physician for each service provided, and are partially reimbursed at a later date by their health insurance agency (Art & De Maeseneer, 2005; de Maeseneer et al., 2016; Hurst, 1991). Since 1994, 'capitation' has become an alternative payment arrangement in Flanders. The reason for the development of this payment arrangement lies in the aforementioned ideology of the Flemish health-care system which is to make health care as widely accessible as possible. In this system, physicians are paid a set amount for each person assigned to them for care, per period of time, regardless of whether or not that person actually seeks care in this timeframe. There is no financial cost for the patient, which makes health care in this payment arrangement more accessible to individuals in lower socioeconomic positions (Annemans et al., 2008; Art & De Maeseneer, 2005).

The semi-structured interviews with physicians were carried out in Dutch, and transcribed verbatim. The analysis of the gathered data was performed by means of the NVivo software programme. In order to use quotations, we have translated them as literally as possible. However, some minor alterations were necessary to ensure legibility and readability.

Main results

We summarise the main findings of our qualitative research below. From the very outset, it became clear that according to the respondents primary health care – and especially prevention for ethno-cultural minorities – is not straightforward. The interviews indicated that physicians perceive at least five key obstacles related to (prevention in) primary health care in the Greater Antwerp area: time constraints, financial difficulties, the payment arrangement, cultural differences and difficulties related to language. These obstacles will be split up in general and ethno-cultural specific problems and their solutions.

Table 5 Overview of practitioners that have participated in the study

Id	Gender	Birth year	Practice	Payment arrangement	Country of origin	District of employment
R1	Male	1963	Group practice	Fee-for-service	Belgium	Deurne
R2	Female	1972	Group practice	Fee-for-service	Belgium	Hoboken
R3	Female	1955	Solo practice	Fee-for-service	Belgium	Antwerp
R4	Female	1980	Solo practice	Fee-for-service	Morocco	Wilrijk
R5	Female	1982	Group practice	Fee-for-service	Belgium	Antwerp
R6	Male	1952	Group practice	Capitation	Belgium	Antwerp
R7	Male	1985	Group practice	Fee-for-service	Belgium	Borgerhout
R8	Female	1985	Group practice	Capitation	Belgium	Borgerhout
R9	Male	1955	Group practice	Fee-for-service	Belgium	Deurne
R10	Female	1982	Group practice	Capitation	Belgium	Hoboken
R11	Female	1984	Group practice	Capitation	Belgium	Antwerp
R12	Male	1951	Group practice	Capitation	Belgium	Hoboken
R13	Female	1959	Group practice	Fee-for-service	Belgium	Antwerp
R14	Female	1976	Group practice	Capitation	Belgium	Antwerp
R15	Female	1983	Group practice	Capitation	Belgium	Deurne
R16	Female	1970	Solo practice	Fee-for-service	Russia	Antwerp
R17	Female	1984	Group practice	Fee-for-service	Belgium	Deurne
R18	Female	1976	Group practice	Fee-for-service	Belgium	Antwerp

(1) General problems and their solutions

(1.1) Time constraints

In numerous publications, it has been argued that decent and tailored health care takes time (Rafferty, 1998; Wender, 1993; Yarnall, Pollak, Østbye, Krause, & Michener, 2003). A lot of the practitioners with whom we have spoken argued that both completing the GMD+ with a patient (which requires around half an hour) and processing the data afterwards demands too much time which they cannot or are unwilling to spend. This especially proves to be the case for physicians in the fee-for-service arrangement, since a higher frequency of patients generates higher revenue. However, physicians who work with capitation also struggle with a lack of time. Since physicians only have a limited amount of time per patient, prevention is usually the last item that comes up (if at all) during a consultation. Only after the patient has asked all their relevant (medical) questions will/can the physicians look at prevention, as shown in the following quotation:

R5: 'No, because there are people who only have one question and you think... Well, we have about twenty minutes per patient, yeah some only have one question and only then I'll say: Ah yes, I'll check your file.' (Female, 34 years old, fee-for-service)

These time constraints, which are often perceived to be a consequence of a lack of organisation in the practice, can be alleviated. One of the possible solutions which several respondents have mentioned is the employment of a doctor's assistant or nurse. Whilst this is often an extra cost the physician cannot or is unwilling to make, the employment of such an individual would be very useful for both patient and physician. These assistants or nurses could be responsible for (most of) patients' prevention, relieving the physician of additional work and stress. Reducing this workload is important, since physicians' busy schedules can result in an early burn-out. A recent study has shown that 17.8% of all Belgian physicians are at risk of a burn-out, with 5.4% actually experiencing one at the time of the study. The workload of these physicians appears to be one of the main determinants of their (possible) burn-out (Vandenbroeck et al., 2013). Policymakers could take this into account, and provide (financial) benefits to physicians who would like to work with an extra member in their practice.

(1.2) Financial difficulties

A second key item which regularly emerged during the interviews was the experienced financial barrier to prevention. This is in line with international research: although prevention is cheap, the very fact that one has to pay a little can already be too much for some patients, and can hence be a barrier to effectively utilising prevention (Gaus, Cooper, & Hirschman, 1976; Ho & Sandy, 2014; Schroeder & Frist, 2013). In Flanders, a prevention consultation with a physician in the fee-for-service arrangement costs €25, 75% of which is reimbursed to the patient through their health insurance at a later date, in an attempt to make prevention as widely available as possible. Nonetheless, the practitioners with whom we have spoken indicate that this amount is still too costly, especially for ethno-cultural minorities with a low socioeconomic status (see above). Physicians who work with capitation do not charge a fee for their consultations, which eradicates this financial barrier for patients. One possible solution would be that prevention consultations become free of charge for all patients, even when their physician works in the fee-for-service arrangement.

R6: ‘Yeah, that’s sort of the advantage of community health centres or a general capitation practice. The patients are registered, so they don’t have to pay anything when they come round for a consultation ... I think that if I worked in a regular practice, well it depends, if I’d ask the regular fee, that wouldn’t be too bad. Some don’t have to pay an awful lot, but I think there’s a bit more hesitation to make people come back for something like this. ... Or maybe the fee-for-service system initially inhibits the physician from asking the question and secondly of course whether it inhibits people from coming back.’ (Male, 54 years old, capitation)

Also the fact that patients have to pay any amount of money at all, even when they feel (currently) healthy, proves too much of an obstacle. They believe that one should only visit a practitioner if one is really sick.

(1.3) Payment arrangement

In Flanders, physicians can work with two types of payment arrangements: the fee-for-service and capitation arrangements. Based on the interviews, it becomes clear that there are substantial differences between these two arrangements in terms of prevention efforts. In capitation, physicians are more likely to undertake

personal effort and take into account patients' broader social context (e.g. living and working conditions) when analysing their health issues. They organise cooking courses, give lectures, undertake group exercises and send out letters or call patients to reach them for a prevention consultation. All of this indicates a strong motivation to stimulate prevention, which is made possible by the fact that the income of these physicians is not dependent on the number of patients they see per day. Physicians in the fee-for-service arrangement mostly point to a lack of time and financial means as explanations for their reduced preventive efforts.

R1: 'But it's an entirely different setting ... We're all self-employed, and you earn what you perform so you try to work as much as possible and in fact if they pay us through capitation, I think that would be perfect, then you can just relax and say I'm going to do that many people per day and I'm going to work a little with prevention and other things. That system is not so bad no, and as far as that's concerned, I'm quite bad at prevention.' (Male, 53 years old, fee-for-service)

R11: 'Yeah I like that a lot about working in capitation, when I hear my colleagues. Well we could and should be doing even more prevention I think but they do make time for that, to think about that. And that's just in your work package, to think about that, while otherwise you're not being paid for that time or something ... So I see a lot of advantages in it, especially towards prevention.' (Female, 32 years old, capitation)

It is important to note here that fee-for-service is still the dominant payment arrangement in primary health care in Flanders, with 80% of all physicians working in this arrangement (Annemans et al., 2008; de Maeseneer et al., 2016). In terms of patient numbers, the fee-for-service covers about 97% of all patients in Flanders (de Maeseneer et al., 2016). Given these numbers, it can be no surprise that prevention for ethno-cultural minorities remains difficult. Studies have indicated that the quality of the health care across payment arrangements is generally equal, however capitation delivers higher quality in terms of prevention activities than fee-for-service (Annemans et al., 2008; de Maeseneer et al., 2016). One of the main concerns that has prevented a shift towards more capitation has been a fear of cost-inefficiency. However, studies have shown that the health expenditures for both systems are equal. The expenditures for patients are lower

in the capitation system, since they do not pay a fee in primary health care, pay a lower fee in secondary health care and consume more generic medication. The absence of a fee makes this system more accessible than fee-for-service, especially for individuals with a lower socio-economic status (Derluyn et al., 2011). In sum, preventive healthcare could benefit a lot from more capitation arrangements.

(2) Ethno-cultural specific problems and their solutions

(2.1) Cultural differences

A first ethno-cultural specific issue that a lot of our respondents have brought to the fore is the cultural dimension. As such, preventive health care encompasses two efforts: the prevention of illness (vaccines, cancer screenings, etc.) and the promotion of the health status (healthy lifestyle, eating habits, anti-smoking, etc.). The great cultural diversity in Antwerp impacts on the two dimensions differently. In terms of preventing illness, physicians do not find much difference between ethno-cultural minorities and natives. The only issue at stake is that the vaccination history of ethno-cultural patients is sometimes unknown, especially when they grew up in a country that did not keep track of/give out vaccinations. It is mainly in the efforts to improve the health status that a clear divergence appears. The physicians with whom we spoke feel that their ethno-cultural patients exhibiting unhealthy lifestyles are not very eager to adapt their lifestyles. The cause of this is often cultural, since many of their unhealthy habits (e.g. smoking, excessive use of sugar in beverages and or/food) are embedded in their specific culture, and are a result of specific norms, values and habits. This has also been addressed in international literature (Betancourt, Green, Carrillo, & Ananeh-Firempong 2nd, 2003; Goth, Berg, & Akman, 2010; Meeuwesen, Tromp, Schouten, & Harmsen, 2007).

R7: ‘They attach less value to a healthy lifestyle, especially towards food and beverages, not alcohol but sweet beverages. ... I don’t know in general, but I get the impression that there’s a tremendous amount of them with diabetes, if they would get checked. And if they have it, don’t follow the diet or don’t take the right pills, even if they have to. That has to do with a little bit of both I think. Knowledge, but also that culture of sugar everywhere, Moroccan tea, I think that for most of them, in a small glass there’s about three lumps of sugar. So yeah, it’s a bit of a mix between knowledge, a lack of knowledge and the culture of sweetness,

also the cookies and stuff. The women are sitting at home as well, so what do they occupy themselves with? With letting other women come over, letting family come over with little children, that's always tea and cookies. That's not 'going to work and having a break at noon to eat alone and then go back to work', that's sitting at home the entire day, having people come over, so I think it's got something to do with that as well.' (Male, 31 years old, fee-for-service)

Ethno-cultural minorities exhibit more detrimental health behaviour than the native population (see Table 3). The consequences of this unhealthy lifestyle are clearly visible to physicians in Antwerp. Many of their ethno-cultural patients have diabetes (Vandenheede & Deboosere, 2009) and struggle with obesity. Another example of how culture has an impact on prevention can be found by means of the GMD+. One of the themes in this questionnaire concerns mental health issues. For many ethno-cultural minorities, the taboo concerning psychological problems is still considerable. Whilst natives also recognise there is still a taboo, the physicians with whom we have spoken argue that the taboo is much more pronounced in the case of ethno-cultural minorities. As this makes mental health much harder to discuss, it is an example of how some forms of prevention may be more difficult for ethno-cultural minorities.

R14: 'About psychiatric illnesses for example we see a lot of that for a lot of people... That's still a big taboo in many cultures. People who get cast out because of it, euh... People who are afraid to be labelled crazy, euh... To be locked up, things like that. It's all very biased because of things they have experienced or witnessed in their country of origin, yes.' (Female, 40 years old, capitation)

Although these cultural belongings may have a negative impact on the efficacy of prevention, physicians also recognise that 'culture' is certainly not the only factor that determines the extent to which ethno-cultural minorities make use of prevention. The lower socioeconomic status of many individuals in these minority groups is also perceived to have an impact.

R11: 'I think that food is anyhow difficult for all the patients we see, and especially because we have a low socioeconomic population group. ... So yes I think that's difficult because it's a real task to buy healthy food

for them. And I don't know if that's got to do with culture... We try, for example soon we'll be doing a breakfast for diabetes patients, and we ask that people bring something from their own culture, so that they can keep eating within their culture but that you still try to tell them to maybe pay attention to this or that, instead of just saying you have to eat this and this...' (Female, 32 years old, capitation)

A healthier lifestyle is often perceived to be more expensive than an unhealthy one, and ethno-cultural minorities do not always possess the financial means to improve, for example, their eating habits. This illustrates the extent to which it is important to take into account all aspects of a patient's daily life and culture.

R12: 'Yeah, it is important to be aware of the social environment of the people. Ramadan, the dates, the sweetmeat, you got to do it all...' (Male, 64 years old, capitation)

Physicians in the capitation arrangement seem more sensitive to this and more willing to take the whole picture of a patient's life into account. In line with literature, the approach of physicians in the capitation arrangement can be characterised as befitting the theoretical model known as the social determinants of health (Whitehead & Dahlgren, 2006). In this model, health issues are framed within the broader socioeconomic context of a patient. They are also more likely to take personal initiatives related to prevention (such as specialised food courses, group exercises, etc.) in order to promote a healthier lifestyle, without additional cost to the patient. Those who work in the fee-for-service arrangement acknowledge that they make less effort to understand the context of the patient, and are equally less likely to take personal initiative.

(2.2) Linguistic diversity

The final obstacle in prevention for ethno-cultural minorities has to do with language. Super-diversity not only results in a culturally diverse region, it also complicates the linguistic context. According to our respondents, the linguistic diversity is the biggest barrier for prevention. The physicians with whom we have spoken indicate that a consultation with a patient who does not speak the native tongue in Antwerp (Dutch) takes much more time than average. This exacerbates the time barrier as well, since physicians, as we have observed, already struggle for time without communication issues.

R6: 'Also because your translation, it will make your consultation last at least half as long, not twice as long, but half longer. Instead of one minute, a minute and a half, so to speak.' (Male, 54 years old, capitation)

The cultural barrier also becomes more apparent when there is no common language, since it becomes harder to convince patients of the value of prevention. In some cases, patients in Antwerp are found to be illiterate, which obviously makes communication between client and physician much more difficult. It is also noted that most of the written communication in terms of prevention (e.g. government campaigns, leaflets and brochures) are almost exclusively distributed in Dutch, making them less accessible to ethno-cultural minorities. Developing these tools in languages other than Dutch, depending on the composition of the population, could be an important step in creating awareness concerning preventive measures amongst ethno-cultural minorities (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003; Betancourt et al., 2003). Patients sometimes try to overcome this linguistic barrier themselves by bringing along a family member who speaks Dutch. This is also seen as problematic since the content of consultations can be very private in nature.

R8: 'For example, yesterday there was an older woman who comes in with chest pains and her son translates. Yeah, and you have to ask delicate questions such as: Is she in her menopause? Where does it hurt on her breasts? She has to take off her clothes, her son's face becomes really red like 'oh no, my mother'. It's pretty embarrassing.' (Female, 31 years old, capitation)

This is the case for the GMD+ as well. As a written tool for prevention, it is distributed to physicians in Dutch. This makes it much more difficult and time-consuming to complete the questionnaire with a patient who does not speak the language. In order to be forthcoming to these patients, physicians undertake several efforts themselves to overcome these communication issues. Some will utilise their imagination to explain what is going on or what patients need to do.

R11: 'Euh certainly for prevention that's very difficult, because you have to explain that is for something which could happen in their lives, so I try to work with images a lot and then try to show them on the computer why we do it. So I try to explain it like that so that they can use it

visually and I notice that that helps if people can see it. And have a lot of patience and explain it a lot of times, and then check if they really understood it or not.' (Female, 32 years old, capitation)

Another group of physicians uses translation services, such as 'Ba-bel', which proved very effective. Ba-bel is a Flemish interpreter service over the telephone that provides translation for organisations under Flemish competence. Though initially free, this service is now charging a fee. 'Ba-bel' was popular amongst the physicians who participated in this research, but was shunned after becoming a paid service.

R7: 'I did a study on telephone translation services within primary health care when I was still a student. Ba-bel was, yeah that worked extremely well because you understand your patient right away, but of course, it's 10 minutes added on.' (Male, 31 years old, fee-for-service)

Using certified translators is also an option, but this is costly and, as a result, less popular. Hence, it seems rather obvious that efforts should be made to improve and maintain competent translation services. Making such services more readily available to physicians could be another way to improve prevention for ethno-cultural minorities (Derluyn et al., 2011).

Discussion and conclusion

With this study we have attempted to chart the perceptions of physicians concerning key issues in prevention efforts for ethno-cultural minorities in the super-diverse region of Antwerp. Since there is a clear inequality between the native Flemish population and ethno-cultural minority groups in terms of health and access to general and preventive health care, it is necessary to know how this inequality manifests itself on the field in order to develop new policy. By interviewing 18 physicians in the Greater Antwerp area, we have created a picture of the physicians' perceptions of prevention for ethno-cultural minorities based on the experiences of the most accessible health-care providers. The information gathered from the interviews shows that physicians perceive five key obstacles in prevention for ethno-cultural minorities in Antwerp: time constraints, financial difficulties, the payment arrangement, cultural differences and linguistic diversity.

Concerning the payment arrangement, we observe that in the capitation system, physicians are more likely to undertake personal effort and take into account the broader social context of the patient when analysing their health issues. As many of the obstacles related to prevention for ethno-cultural minorities are closely tied to the payment arrangement, moving away from the dominance of fee-for-service could have positive effects on prevention (Nuyens, 2010). This becomes more urgent with the increasing super-diversity that continues to establish itself in Flanders in general and in Antwerp in particular.

Improving prevention, both in general and specifically for ethno-cultural minorities, will not only depend on the increase in capitation practices. There are other, more concrete, initiatives to be taken. Hiring a doctor's assistant would prove very helpful for the organisation of a practice, as well as alleviating the time constraints on physicians. They could perform many of the tasks related to prevention which now fall on the shoulders of physicians. Reducing or eliminating the costs for a prevention consultation (for patients with a physician in the fee-for-service arrangement) could also prove to be useful, since this financial barrier excludes the poorest minority groups from prevention. In terms of the cultural and linguistic barrier, it is important to take into account the patient's socioeconomic situation. Culture itself is almost never believed to be the sole cause of a lack of (interest in) prevention; insufficient knowledge and poor socioeconomic status are equally important. Hence, what is needed is a certain 'mind switch'. People should become convinced that a physician is not only for the ill, but also for those who wish to prevent illness in the future. In terms of language, it is necessary to develop and raise awareness of sufficient imagery that can be used by physicians to communicate with patients who do not speak the native tongue. Governmental prevention campaigns, which are currently exclusively carried out in Dutch, also need to be multilingual. Finally, keeping translation services widely available (and free of charge) will also prove useful in simplifying communication with ethno-cultural minorities that do not speak Dutch.

Additionally, there are already several other good practices that take ethno-cultural differences into account, as shown by international studies (Anderson et al., 2003; Betancourt et al., 2003; Wade & Bernstein, 1991). It could prove interesting to adopt or expand some of these. A *first* possible practice could be to institutionalise cultural competence training for physicians. This training could aim to (1) enhance self-awareness of attitudes towards ethno-cultural minorities; (2) improve care by increasing knowledge about the cultural beliefs or practices,

attitudes towards health care, health care-seeking behaviours, and the burden of various diseases in the different groups served; and (3) improve skills such as communication. The need for such cultural competence training is illustrated in research where (culturally diverse) patients are more satisfied with health-care providers who received cultural competence training (Cooper-Patrick et al., 1999; Derluyn et al., 2011; Wade & Bernstein, 1991). Implementing these elements in the medical training of Flemish practitioners is necessary in order (1) to train future physicians how to treat diverse patients effectively, (2) to battle stereotypes, (3) to understand different cultural representations of health, and (4) to work with translators (Derluyn et al., 2011). A *second* practice includes recruiting and retaining health workers who reflect the cultural diversity of the community. This may reduce barriers related to both culture and language. Furthermore, studies have found that ethno-cultural patients have a more positive attitude towards this group (Anderson et al., 2003). A *third* practice concerns an already existing initiative in Flemish health care. Some hospitals utilise the services of a so-called ‘intercultural broker’. This individual is tasked with dealing with a multitude of issues, ranging from communication to cultural differences, between ethno-cultural patients (and their families) and health care providers and organisations. As of this moment, these individuals can only be found in hospitals, but it could be helpful to expand this initiative to primary health care (Derluyn et al., 2011). As the current Flemish Government highlights the importance of prevention, embedded in a culturally competent health care (Flemish Government, 2014), it should become clear that in a super-diverse society, numerous actions can and should be taken in order to make primary health care more accessible and effective for ethno-cultural minority groups.

Notes

* This chapter is based on research of the Centre for Integration and Civic Integration (see Tibax, Levrau & Piqueray, 2016).

1 Belgium has a multi-layered institutional context. Next to the federal state and the communities are the regions. There are three regions. The names of these three regional institutions are derived from the name of their respective territories. Hence we speak (from North to South) of the Flemish Region, the Brussels Capital Region and the Walloon Region.

2 $135.441 = 641.851 - 506.41$.
 $75.186 = 538.766 - 463.580$.

- 3 The Greater Antwerp area consists of the municipality of Antwerp and nine districts (sub-municipalities): Antwerp district, Berchem, Berendrecht-Zandvliet-Lillo, Borgerhout, Deurne, Ekeren, Hoboken, Merksem and Wilrijk.
- 4 - Neighbouring countries: France, Germany, Luxembourg, Netherlands;
 - Western- and Northern-EU15-countries: Austria, Denmark, Finland, Ireland, Sweden, United Kingdom;
 - Southern-EU15-countries: Greece, Italy, Portugal, Spain;
 - EU12-countries: Bulgaria, Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovenia;
 - Europe non-EU: Albania, Andorra, Belarus, Bosnia, Croatia, Iceland, Kosovo, Liechtenstein, Macedonia, Moldova, Monaco, Montenegro, Norway, Russia, San Marino, Serbia, Switzerland, Ukraine;
 - Turkey
 - Maghreb: Algeria, Libya, Mauretania, Morocco, Tunisia;
 - Other countries: countries other than the aforementioned groups.
- 5 The 'worried well' is a term which refers to individuals who are generally healthy, yet are unnecessarily anxious about their physical or mental health (Rost et al., 2002).
- 6 Domus Medica is an association without lucrative purpose. It takes care of the interests of physicians in Brussels and Flanders at a scientific, societal and syndicate level by way of democratic and evidence-based decision-making. It also improves the development and realisation of a patient-oriented health care and health care policy. <http://www.domusmedica.be/>

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