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THE PERCEPTIONS OF ELDERLY TURKISH IMMIGRANTS OF THE HEALTH CARE SYSTEMS IN THEIR HOME AND HOST COUNTRIES: A FIELD STUDY FOCUSED ON DENMARK, BRITAIN AND GERMANY

Yaşlı Türk Göçmenlerin Yaşadıkları Ülkenin ve Türkiye'nin Sağlık Sistemine Yönelik Algıları: Danimarka, İngiltere ve Almanya'da Bir Alan Araştırması

Nilüfer KORKMAZ YAYLAGÜL*

Suzan YAZICI**

*Doç. Dr., Akdeniz Üniversitesi Sağlık Bilimleri Fakültesi, Gerontoloji Bölümü

**Aile Hekimi

ABSTRACT

Turkish individuals migrating to European countries are aging, they retire and spent more time in Turkey. Once in Turkey, they use health care services in case of emergencies, routine checks and investigations difficult to obtain in their host countries. This practice has turned into routine with increasing number of retired immigrants. We therefore aimed to evaluate older Turkish immigrant's perceptions of health care services in Turkey and their host countries. This descriptive qualitative study was conducted with individuals over the age of 50, who have migrated from Turkey into Britain, Denmark and Germany. A semi-structured questionnaire was conducted on 67 participants.

Overall there was a high level of satisfaction with the provision of health care services in the host countries in terms of quality and patient centered care but concerns were raised about access to specialist care and language barriers.The structure of health systems, financial and politic conditions shaping those structures and the advantages and disadvantages of the health systems in both countries were affecting perceptions of health care services and pragmatically determine preferences. Respondents

agreed there had been a decrease in quality of health services in their host countries and an opposite trend for Turkey.

***Keywords**: Older immigrants, health service, companionship system*

ÖZET

Türkiye'den Avrupa'ya göç etmiş olan bireyler, yaşlanmakta, emekli olmakta ve yılın daha fazla dönemini Türkiye'de geçirmektedirler. Bunun yanında misafir ülkenin sağlık hizmetlerinden yararlanamadıkları olanaklardan Türkiye'de yararlanmaktadırlar. Bu durum, yaşlı ve emekli göçmenlerin artması nedeniyle kalıcı hale gelmektedir. Buradan hareketle bu araştırmada Avrupa'da yaşayan göçmenlerin yaşadıkları ülkedeki ve Türkiye'deki sağlık sistemine yönelik algılarını ele almak ve sağlık hizmetleri kullanımlarına etkisini ortaya koymak hedeflenmiştir. Bu betimsel nitel araştırmada 50 yaş ve üzeri Danimarka, İngiltere ve Almanya'da yaşayan 67 birey ile yarı yapılandırılmış soru formu ile görüşmeler yapılmıştır.

Göçmenler yaşadıkları ülkenin sağlık hizmetlerinden kalitesi ve hasta merkezli hizmet yaklaşımları nedeniyle memnun olsalar da uzman doktora erişim ve dil bariyeri konusunda endişe duymaktadırlar. Araştırmada sağlık sisteminin yapısı, finansal, politik koşullar ve sağlık sisteminin avantaj ve dezavantajlarının göçmenlerin sağlık hizmetlerine yönelik algılarını etkilediği ortaya çıkmıştır ve bu koşullar göçmenlerin Türkiye'de ve yaşadıkları ülkelerde sağ hizmetleri kullanımını pragmatik olarak etkilemektedir. Katılımcılar genel olarak yaşadıkları ülkelerde sağlık hizmetlerin kalitesinin düşme, Türkiye'de ise yükselme eğiliminde olduğunu ifade etmişlerdir.

***Anahtar Sözcükler**: Yaşlı göçmenler, sağlık hizmeti, refakatçi sistemi*

INTRODUCTION

The rising need for labour force in Europe after the Second World War resulted in a wave of migration from less developed countries such south European countries and Turkey to West European countries. For the sending country, this has been seen as a way of decreasing the high unemployment rate. The migration was considered temporary by both the sending and the receiving countries at the beginning but has become permanent as immigrants became established in their host countries and were joined through family reunification.

The first migrations from Turkey were to Germany and Germany still remains the country with the highest Turkish immigrant population (Kızılocak, 2007). Bilateral workforce agreements started with Germany in1961 and were followed by agreements with France, Holland, Belgium and other West European Countries (Danış and Üstel, 2008; Abadan-Unat, 2006). There is no bilateral workforce agreement between Turkey and Denmark and Britain but both countries have received significant numbers of Turkish immigrants since the 1970's. Britain has received the bulk of its immigrants from Turkey since the 1980's mainly for political reasons (Hazidimitriadou and Çakır, 2009).

"Migration and Health" has received much attention in current research. The research results suggest that being a immigrant has negative effects on health and access to health services due to factors such citizenship, integration and language barriers (Grollman, 2014; Jatrana and Toyota, 2005; Campbell and Mclean, 2002; Poortinga, 2006; Nazroo, Jackson, Karlsen, Torres, 2008; Fokkema and Naderi, 2013). Old age increases the disadvantages of being a immigrant. Ferraro and Farmer have called this the "double disadvantage", meaning that old age related disadvantages added to the past disadvantages coming from migration create new disadvantages. All those disadvantages negatively affect access and use of health services (Ferraro and Farmer, 1996).

Problems arising in terms of cultural adaptation, a low language competency and a dependency on children for translation issues are among the disadvantages associated with being a immigrant (Martin, 2009; Topal, Eser, Sanberk, Bayliss, Saatci, 2012; Papadopoulos, Lay, Gebrehiwot, 2007). Additional to those issues, old age is a period where there is a higher need for the use of health services (Warnes, Friendich, Kellaher, Torres, 2004).

Globalisation, via communication networks and commonly used transportation possibilities, in recent decades resulted in increased global individual movements and similarly the movements of immigrants (Phillipson and Ahmed, 2006). Other reasons for the increase in transnational mobility for older immigrants include more spare time and wealth due to retirement and less responsibility for grown up children. Older immigrants tend to spend more time in Turkey, with visits becoming more regular and longer. All those factors result in a greater need for health care services abroad.

Global institutions such as the World Health Organisation (WHO) and the European Union (EU) pay attention to the concept of "Transnational Health Services" (IOM 2013; Phillipson and Ahmed, 2006). Transnational health care use is affecting national health system planning, implementation and budgets directly resulting in increased interest from national health institutions. In order to understand the experiences and perceptions of service users, questions such as "how" and "why" need to be revealed in addition to quantitative data. In attempting to address these questions, this paper focuses on the perceptions and conditions shaping perceptions about the health services of the older Turkish immigrants in their home and host countries using qualitative methodology. This is an attempt to contribute to the baseline data to inform the policy makers to consider immigrants friendly health services.

All the host countries included in this research have similarities in their health systems as they are comprehensive and mainly based on public services. All three countries give primary health care through general physicians in local clinics and specialized health services are accessed through referrals by general physicians (Ozdemir, Ocaktan, Akdur, 2003). The British health care system (NHS: National Health Service) was founded in1948 and is seen as a model for the world for its several aspects. The NHS was established in order to convert health services into a social right, to serve the public good and to cover all sections of society (Ettelt, Nolte, Thomson, Mays, 2010). The Danish health care system similarly, is a universal welfare system financed by taxes and is free except for some services such dentistry and physiotherapy. Health services are provided mainly by public institutions (Olejaz, Nielsen, Rudkjøbing, Birk, Krasnik, Hernandez-Quevedo, 2012). Known as Bismark's System, the German Health care system covers all its citizens and health care providers are predominantly public. Health services are financed under the social security system. Individuals pay health insurance contributions related to their income (Ozdemir, Ocaktan, Akdur, 2003). The health system in Turkey however is multi-structured. The public health services were transformed after 1990's and the share of health services given by private sector has been increased since. Private and public health service providers have been funded by the social security institutions (Sosyal Güvenlik Kurumu, SGK) since 2003. The number of private health services has increased and the public ones became semi-autonomous. Even though a general practice system was introduced in 2006, there is still no referral obligation as in the case of Denmark,

Britain and Germany (Erol, 2014) which enables people to see a specialist directly on demand.

Health systems are one of the results of modernisation and are standardised through medicalisation. Health is defined similarly in all around the world and health services are similar everywhere. Social and cultural conditions however can cause individuals to interpret health services differently. Systems offering health services are shaped by national economic and political conditions. Dealing with individual perceptions in research about health systems requires the consideration of both individuals and the economic and political conditions influencing national health systems (Merrill, 1986). In order to discuss the interaction between the individual and health systems both subjective conditions creating individual experiences and objective conditions need to be taken into consideration. According to Fabian (1985), health attitudes shouldn't be viewed as arising just from culturally determined beliefs. Those attitudes and tendencies are shaped through practice as well as culture besides innovations, regulations and disharmonies (Pool and Geissler, 2005). Health attitudes need to be evaluated using a holistic approach (Winkelman, 2009). Therefore a holistic approach has been adopted in this study whereby the health system conditions and the immigrant's experiences are discussed together in order to identify immigrants perceptions' of health services.

METHOD

Qualitative methodology has been used to explore the meaning of individual experiences. Interview techniques are relevant in order to uncover the reality (Benton and Craib, 2001). This method was selected for this study to reveal the health system perceptions of immigrants. Semi-structured in-depth interviews have been conducted. The following research question is addressed in this paper: "How do older Turkish immigrants use and perceive health care systems in their home and host countries?". The Akdeniz University Department of Gerontology took part in all three field research studies, in collaboration with Copenhagen University, Centre for Healthy Aging (2011), Oxford University Institute of Aging (2013) and Hildesheim University, Department of Social Pedagogy (2015).

Participants

The aim was to recruit 20 participants from each country (60 in total) at the planning stage of the study, however the presence of spouses resulted with 67 interviews (25 male, 42 female). Even though officially not termed "old" at the age of 50, the respondents 50 years and older were recruited as they self-identified as "old" or are ill and are mostly retired. A maximum variety sample was chosen purposively to represent different groups (different motives for immigration, different religious views, different educational levels etc.). Therefore, participants were recruited by co-researchers in the partner Universities, professional contacts, and friends of the researchers and also through centres where people with Turkish origin frequently gather (Arbeiterwohlfahrt (AWO) centre, Alevi Associations, Muhabbet etc.) and using a snowball technique. However most of the participants were labour immigrants, sunni muslims and had low education level, which also represents the profile of the Turkish immigrants in general. The interviewees were informed about the research and written consents were obtained for audio recording and photos.

Data collection and analysis

The questionnaire was based on demographic findings, migration history, daily lives, health status, use of health services and expectations. A literature review and 5 pilot interviews with older Turkish immigrants visiting Antalya were gathered to set the final questionnaire. The pilot interviews were not added to the total number of the participants. Semi structured in-depth interviews were used in order to examine the ideas thoroughly and to enable a flexible environment for interviews (Cohen, Morrison, Manion, 2007). Interviews were mainly conducted at the respondents' homes. The preferred language for interviews was Turkish except 2 in Kurdish (translated by an assistant student participating the interview), and one in English. All interviews were tape recorded and lasted between 60 and 115 minutes. The interviews were named with an abbreviation of country name, sex and age respectively (e.g. DK.M.67). All opinions about health care systems were noted and recorded using standard manual qualitative techniques of open coding. The main categories were determined using descriptive analysis methods and analysed by separating them into sub-themes (Bradley et al.,2007). In the second stage, sub-themes were identified. Both researchers analyzed the data independently and the final decision about sub-themes was made unanimously.

RESULTS

Among 67 respondents, 25 were male, 42 female. Their age ranged from 50 to 83. Seven were divorced or had lost their spouses. The rest were married and were living with their spouses. They migrated from several parts of Turkey, however most migrated from rural areas. Only 5 respondents were still working, the rest were unemployed, on sick leave, early retirement or were retired. Many had multiple illness, mainly hypertension, diabetes, cardiovascular diseases or cancer. Table 1 shows the demographic features of respondents.

Table 1. Demographic Characteristics

		Denmark (N=27)	**U.K. (N=20)**	**Germany (N=20)**	**Total (N=67)**
Age	Mean	61,5	62,3	64,1	62,6
	Minimum	50	50	51	50
	Maximum	83	82	78	83
Gender	Female	15	10	17	42
	Male	12	10	3	25
Education	İlliterate	6	5	5	16
	Primaryschool	14	12	5	31
	Secondaryschool	1	2	5	8
	University	6	1	5	12
Retirement	Retired	16	5	14	35
	Not retired *	11	15	6	32
ChronicIllness	Yes	26	16	17	59
	No	1	4	3	8

*on sick leave, social security support, early retirement

Three different themes emerged after data analysis concerning the perception of health systems in Turkey or in the country of residence. Themes and subthemes of immigrants can be seen in Table 2.

Table2. Health Systems Themes and subthemes:

Themes	Subthemes
Accessibility	Referral System
	Bureaucracy
	Language and Communication
Features of Health Services	Service Provider
	Physical Conditions
	Companionship System (*Refakatçi Sistemi)*
Finance	

Accessibility

Referral systems, bureaucracy, communication and language were determined to be subthemes of accessibility to health services.

Referral System

Research on immigrants living in countries with a referral system shows that the immigrants view the referral system as a barrier and find the direct access to specialist and further investigations in their home country easier (Lee, Kearns, Friesen, 2010; Searight, 2003). A referral system in general practice is mandatory in all the host countries where this research has been conducted. The respondents believe to have easy access to their general practitioners but not to specialists in their host countries. They have mentioned that their general practitioners (GP) were hesitating to refer them to specialists due to the pressure of budget restrictions and complained of late appointments to specialist and investigations. Perceived mis-diagnoses or late diagnoses were seen as results of referral restrictions. In Turkey however, there is no such referral system and patients can directly apply to specialists and hospitals. Private hospitals enable all kind of investigations promptly. This has resulted in high levels of satisfaction in the Turkish health system.

> " ...here the appointments are so late, they don't want to refer you to the hospital. It is all about your GP. He decides. In our case, we were informed about my husband's prostate cancer in Turkey. We would be late here..." GB, F, 61

Bureaucracy

The bilateral agreement between Turkey and Germany enables German citizens to receive health care in Turkey for free. An official letter (TA11) needs to be obtained from German authorities in advance. Patients obtaining this paper need to apply to the Social Security officials in Turkey for the procedures in hospitals to be activated. In the case of an emergency, official papers need to be completed by relatives which can be very problematic.

> "I fell and broke my foot in Turkey. They asked me for money as I didn't have time to complete the papers (TA 11). I had to walk with my broken foot to Social Security Office and tried to fill in the papers. I gave up and returned with my broken foot to receive treatment in Germany" G, F, 71

This situation is valid only for residents in Germany. Turkish older immigrants living in Denmark or Britain pay for all medical treatment in Turkey as there is no such agreement (Sosyal Güvenlik Kurumu, 2012).

Immigrants mentioned that they could easily access health services in Turkey but complained about official procedures needed for admission, investigations and treatment in public hospitals. They see the Turkish public health services as being "difficult" as the patients in Turkey are responsible for all bureaucratic procedures.

> "The system here (Germany) is much better. My mother was ill. We had to find out where to give the blood sample, and where to get the x-ray. This is difficult for us" G, F, 60

Language and Communication

Current research shows that language is the main barrier for health service use (Sahami, 2009; Marshall, Wong, Haggerty, Levesque, 2010). Most of the respondents mentioned that they were able to communicate with their GP's but needed help in case they needed further treatment and hospital care. An official translator service was available in the past but in all countries this service has been restricted or cancelled. This is seen as a factor affecting access to health care services and the decision to get health care negative. The language support was and is still provided mainly by children, relatives or friends. As the children become adults themselves, they have difficulties to find time for their parents as they work or have their own children to care for. A respondent described his situation as follows:

> "I go to doctor with my son, but have to postpone my appointment when he tells me that he is busy..." DK, M, 78

Features of Health Services

The number of health care providers per person is one of the most important health indicators. At 2012, in Turkey the number of doctors per 1000 person was 1.7 and the number of nurses was 1.8, compared to 4 and 11.3 in Germany, 3.5 and 15 in Denmark and 2.8 and 11.2 respectively in Britain (OECD, 2014).The number of health care provider per patient is higher in all the host countries compared to Turkey. The number of health care staff can affect access to services, service quality and the workload of the health care provider directly. Perceptions of health services are discussed in three subthemes; service provider, physical conditions and the companionship system.

Service Provider

Respondents from all three countries complained of not getting the expected care from health care staff in Turkey. They appreciated the care given in their host countries describing it as "humane" and "kind". Physical care and attention were main issues shaping their perceptions of health care providers.

> “I gave birth here (Denmark) in the 1970's. They kept us in bed for a week. They came and even washed us. They care you here like a baby” DK, F, 66

The first health experiences in host countries were unimaginably humanistic and of high quality. Respondents accepted this easily, and became accustomed to this level of care. In the course of time immigrants started to criticise the services given in Turkey and found them to be of "lower quality".

> “The nurse saw me standing from far away, ran to me and held me by my arm, helped me to my bed. She touched my hand like a baby. If that would happen in Turkey, no one would care. Nurses there don’t want any extra work" G, F, 64

Physical Conditions

Physical conditions of hospitals such as private and clean rooms are seen as important factors for patient satisfaction. The physical conditions in Turkey were found to be insufficient compared to their host countries.

> “Here, the hospitals are very clean. You have your own shower and toilet. In Turkey you become sick in hospitals. They are crowded" DK, M, 75

A distinction between private and public hospitals in Turkey were also made whereby private hospitals are found to have the "same" conditions as in their host countries.

Companionship System (Refakatçı sistemi)

The care in hospitals in the host countries is provided mainly by nurses, but in Turkey a companionship system exists whereby relatives of patients are asked to stay by the patient overnight and carry out the personal care of their patients, take samples to laboratory, get appointments for investigations, arrange medications etc. This is known as the "refakatçi sistemi". The main concerns about hospitals was this system as the respondents got used having these services being provided by nurses and were disappointed to meet this system in Turkey.

> “My husband was hospitalised for 6 months here. There is no such "refakatçi system" here. In Turkey a *refakatçi* needs to stay with the patient and not under good conditions. You have to sleep on a chair, don't you?" G, F, 66

Finance

Despite some small differences, the health systems of Germany, Denmark and Britain are similar, being comprehensive and having social welfare systems (Ozdemir, Ocaktan, Akdur, 2003). A study carried out in Germany showed that the immigrants appreciated the German health and social system more than that of Turkey (Razum, Sahin-Hodoglugil, Polit, 2005). Similarly, all respondents in this study appreciated the free health services given by their host countries.

> “We don’t have there (in Turkey) anything... About health, we visit the doctor here (Britain) even for headache. We don't pay anything for medicine or for the visit.” GB, F, 65

The respondents believe that the health service provision in Turkey is based on money either in private or public hospitals. They believe that unnecessary investigations and treatment are carried out.

> “What do you expect from Turkey? You get it if you have money, not if you don’t have any. Turkey takes all the money you have in your pocket" DK, M, 72

Even though the respondents mentioned their appreciation for health services in their host countries, many mentioned negative changes due to restrictions resulting from neoliberal policies.

"You can't believe how they were treating you. I felt like a princess! But nowadays, I go to hospitals, there is a downwards move comparing the past to present. It's all about money now" DK, F, 57

DISCUSSION

Belonging to two countries due to migration creates unforeseen challenges independent of the time of migration, education level or the level of integration. Health care needs are one of the factors affecting even the immigrants' choice of their country of preference which was also the case in this study (Razum, Sahin-Hodoglugil, Polit, 2005).

The structure of health systems affect perceptions of health care services. Respondents rated their host countries above their home country Turkey for their health care needs, except for direct access to specialist and early diagnosis. Free health care and comprehensiveness are the main factors for the preference of health care use in their host countries. As an important factor, finance have affected the perceptions, increased the expectations and raised doubts about unnecessary treatments of the older Turkish immigrants. The social security and health insurance agreement between Turkey and Germany allows Turkish and German citizens to get free health care provided they apply before their trip to Germany or Turkey. No such agreement exist between Turkey and Denmark or Britain (Sosyal Güvenlik Kurumu, 2012). Respondents from Germany showed a more flexible and frequent use resulting from a greater knowledge of health care services. This familiarity has been shown to increase the trust in health services. Health care systems can change over time as a result of economic, political and social conditions. All respondents have experienced changes and agreed that there was a deterioration in quality of health services in their host countries due to the increasing cost of health care resulting from demographic trends of an aging population and cuts in funding provision, resulting in restrictions in health expenditure. In comparison, respondents mentioned that the constantly increasing share of private health sector in the last decade has increased the quality of services in Turkey and this was perceived positively and increased trust in the system. On the other hand, some negative outcomes of this change, such as increased health expenses and unnecessary investigation were mentioned.

The results of this study reveal two main factors affecting the perceptions of health services: *Quality* and *trust*. Physical conditions and structures of health services, comprehensiveness, accessibility, bureaucracy, and personal attitudes have been found to constitute the perceived quality of a health system. Immigrants put greater trust in health systems which are perceived to be of higher quality. Trust in the health system affects the decision to use a health service and the decision of the country of residence. This research has shown trust in health services to be an important factor connecting them to their host countries. The Turkish health system is less trusted in that way.

These research results are not specific for Turkish older immigrants. Cross border health care use practices and the complaints were found similar for European immigrants with different backgrounds and immigrants living in other developed countries (Lee, Kearns, Friesen, 2009; Bergmark, Barr, Garcia, 2010; Gideon, 2011). The negative changes in health care systems possibly affect all citizens but the impact may be greater on immigrants because of additional challenges such communication problems, economic disadvantages and cultural differences.

Having a immigrant background on the other hand enables pragmatic cross border health care use in both countries. Attention should be focused on this opportunity to change those individual choices into regular health care policies. Further research is needed to reveal the positive and negative structural conditions of the health care systems both in the home and host countries in order to create a more efficient service use.

CONCLUSION

Health and health care use make up an important part in the daily lives of older Turkish immigrants. Respondents rated the quality of health care they receive in host countries very high except the language barriers and access to specialist care. They appreciated the free, equal, comprehensive and patient-centred care where they feel respected during interaction with health care providers. However, some experienced barriers to access to the services due to language issues (e.g. lack of translators) and delayed diagnosis due to poor secondary care access which some attempted to overcome by going back to Turkey to seek secondary care. For some, free health care was the main reason to continue to live in their host countries, which was expressed by an older immigrant from Germany as:

> "Turkey can't be better in health than here. First generation immigrants nowadays spent 6 months there and 6 months here but no one wants to move there. Why? For doctors, for their health. They come here got their investigations and return after. We love our country but go there just for our holidays" G, F, 66.

Turkish immigrants are using the Turkish health systems often. Even though, the health systems of host countries are perceived as main and the Turkish health systems are perceived as secondary resources only. Therefore in this study a comparison of health systems was not aimed. Turkish immigrants use the health services of host countries primarily but health services in Turkey in case of emergencies, to get a second opinion or investigations difficult to obtain in host countries. This practice has turned into routine with increasing number of retired immigrants and we can foresee that we can expect a rising tendency in the near future with the increase of aging population. In order to adapt to demographic and global changes and to increasing cross border movements, the health care experiences of immigrants should be taken into consideration.

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