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THE PERCEPTIONS OF OLDER TURKİSH IMMIGRANTS OF THE HEALTHCARE PROFESSIONALS IN THEIR HOME AND HOST COUNTRIES

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Abstract

The Turkish immigrants use of the health services in Turkey has increased because during their retirement they spend more time in Turkey and also since they are at an older age they have more chronic illnesses. This research is focused on the perceptions of Turkish immigrants living in Europe towards healthcare professionals in Turkey and their host countries. The qualitative method has been used, whereby Turkish immigrants living in Denmark, Britain (UK) and Germany (a total of 67 individuals over the age of 50) have been interviewed between 2011-2015, using a semi-structured questionnaire.

The immigrants' perception about healthcare professionals is found to be two-dimensional. The Turkish physicians are preferred for prompt diagnosing and treatment, however, the health professionals of the host countries were found to be more humane and reliable. The respondents are frequently treated by their family physicians in their host countries and are generally satisfied. The main dissatisfaction from family physicians are the barriers to advanced investigations and specialist referrals. The respondents use the Turkish health system in order to be examined by specialists and get advanced investigations done. Their perceptions of healthcare professionals are shaped pragmatically at the practical level.

Key words: health professionals' attitudes, older immigrants, staff-patient relationship, heath services

1. INTRODUCTION

Cross-border health care use attracts more attention in the last few decades. Immigrant workers develop closer relations with their home countries due to increased transportation and communication opportunities as a result of globalization. The increased demand for natives and immigrants to foreign countries in order to seek cheaper, accessible and satisfactory health care created a need for new national health care policies (Österle at al., 2013). Besides, the common use of cross-border health care services resulted in increased research in this area (Lokdam at al., 2016; Şekercan at al., 2015; Horton, and Cole, 2011; Lee at al., 2010). Research findings show that in general, immigrants are shown to have more illness and a worse health status compared to native citizens, and they use healthcare services more frequently. They are considered to be disadvantaged in terms of health (Steinbach, 2017; Leduc and Proulx, 2004; Warnes et al., 2004; Papadopoulos et al., 2007; McDonald and Kennedy, 2004; Lai and Chau, 2007; Fokkema and Naderi, 2013; Martin, 2009; Topal et al., 2012). The language barrier, socioeconomic disadvantages, working conditions and culture are all factors creating those disadvantages. The use of healthcare services abroad appears to be an important problem in terms of health system use, quality and cost.

Turkish immigrants compose the majority of the immigrant population in Europe and show a different pattern of cross-border health care use compared to immigrants of other ethnic origin. Turkish immigrants living in Europe generally maintain their relationships in Turkey through regular visits and owned properties back home. Longer visits to the home countries, basically due to retirement, results in the higher use of national and transnational healthcare services (Razum et al., 2005; Şekercan et al., 2014). In this case the immigrants come into contact with healthcare professionals of both countries and, as a result, their perceptions about healthcare systems and healthcare professionals in both countries are constantly reshaped, affecting their decisions of the country of preference for the use of healthcare services (Lee et al., 2010).

Cross-border health care service use of migrants and their motives concerning their use of health systems have been researched widely (Glinos et al., 2010). The effect of healthcare providers within the range of variables has not received sufficient attention. In this context, the present study discusses perceptions of the immigrants of the healthcare professionals in their host (Denmark, Britain, Germany) and home countries (Turkey). The term “health care professionals” refers only to physicians and nurses in the study as they undertake the main role in terms of diagnosis and treatment.

Health systems in Britain, Denmark and Germany are based on public services. In all those three countries specialized health services are accessed only through referrals by general physicians. Health services are financed under the social security system and individuals pay health insurance contributions (Ozdemir, Ocaktan, Akdur, 2003). Private health services are not widely used. In Turkey, however, there is still no referral obligation as in the case of Denmark, Britain and Germany (Erol, and Özdemir, 2014) which enables people to see the specialist directly on demand. Since the 1990’s public health services were transformed (Saygın Avşar at al., 2017) and the share of health services given by the private sector has been gradually increased.

The study mainly focused on the following question: "What is the perception of older Turkish immigrants on healthcare professionals in their host country and in Turkey and how do those perceptions influence their health care use practices?”

2. MATERIALS AND METHOD

The present study uses qualitative methodology to study immigrants' perceptions of physicians and the ways in which their perceptions influence their use of healthcare.

This study is drawn from a project called "First Generation Turkish Migrants in Europe" which was lead by Akdeniz University, Department of Gerontology. Three different field studies were carried out by both of the authors. The first one is carried out at 2011-2012 in Kopenhagen, Denmark, with the collaboration of *Copenhagen University Centre for Healthy Aging* whereby 27 interviews have been carried out. The second fieldwork has been done in London, Britain at 2012-2013 with the collaboration of *Oxford University Institute of Aging,* and the third fieldwork has been carried out

in Hildesheim, Germany at 2015 with the collaboration of *Hildesheim University, Department of Social Pedagogy*. 20 interviews have been carried out in fieldworks both in London and Hildesheim. A total of 67 interviews were completed. Throughout the process of this study, the authors conducted all interviews in person, supported by collaborative Institutions and centers (Arbeiterwohlfahrt – AWO center, Alevi Associations, Muhabbet etc.).

The chronological age of 65 years is defined as old age in most of the developed countries however this limit is under discussion for several developing countries (Ferreira and Kowal, 2006). Certain life conditions such as disasters, poverty, climate change and migration affect health and healthy life expectancy. In the example of Turkish older immigrants, difficult working conditions, poverty and difficulties of integration have created physical and mental health problems resulting in disability and early retirement (Schenk, 2008; Wengler, 2011). Therefore we have decided to lower the age limit of the participants to 50 years and older for this research. Older individuals use health care services in their home and host countries more often than younger individuals and have more contact with health professionals.

Data collection

A semi-structured questionnaire has been used to gather information. A semi-structured questionnaire allows for detailed analysis and creates a flexible interview environment (Glesne, 2012). The content of the interviews was based on the migration stories, daily life, current health conditions, the use of health services in home and host country and their perceptions of health professionals. Data were collected from November 2011 through March 2015. Face to face interviews was 60-120 minute voice recorded. Being over the age of 50 and using health care services both in the home and host country were determined as inclusion criteria.

The sample was chosen purposely to represent different groups as different motives for immigration, different religious views and different educational levels using a snowball technique. The interviews were generally conducted in participants' houses (n=40), at work (n=2), and at community centres (n=25) depending on the preference of the participants. The interviews were generally conducted in Turkish (one interview was conducted in English; two in Kurdish). A significant number of the participants interviewed immigrants in Britain are refugees and immigrants of Kurdish origin. In Denmark and Germany however, the majority of respondents are Turkish worker immigrants. This distinction did not impact the results in the three field sites and for the sake of consistency, the participants are referred to as "Turkish immigrants". The term "Turkish" should be understood as representing citizenship rather than ethnic origin.

Data analysis

All the recorded interviews were audio transcribed. Data analysis began with repeated readings of interview transcripts. Interviews were grouped in three according to their host countries. The purpose was to reveal similarities and differences in perceptions of older immigrants related to the countries they live. All opinions about physicians 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. In the second stage, sub-themes were identified. Both researchers analysed the data independently and the final decision about sub-themes was made unanimously. The interviews were named with an abbreviation of the country, sex and age respectively (e.g. Germany, female, 70 : G.f.70).

Strengths and limitations

An environment of trust was created because potential participants were contacted through associations and personal contact and by the virtue of the fact that both researchers are Turkish. The fact that the majority of the respondents were female might have caused a gender bias as the perceptions about health care professionals can differ by gender.

3. RESULTS

Participants

The characteristics of the participants are shown in Table 1. Among the 67 participants, 25 were male and 42 were female. The gender balance was tried to be considered whereas participants from Germany showed an apparent female predominance. The reason for this is that the

fieldwork, Hildesheim received primarily female labor immigrants in contrast to other cities. The mean age was 62.6, participants from Germany being the oldest (64.1). The number of participants still working was 5, the rest were unemployed, on sick leave. 35 participants were either on early retirement or retired. The majority of the respondents (70%) were either illiterate or primary school graduates.

Table 1. Demographic characteristics of the respondents

		Denmark (N=27)	UK (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	Illiterate	6	5	5	16
	Primary school	14	12	5	31
	Secondary school	1	2	5	8
	University	6	1	5	12
Retirement	Retired	16	5	14	35
	Nonretired*	11	15	6	32
Chronic Illness	Yes	26	16	17	59
	No	1	4	3	8

Themes about Perceptions

Analysis of the responses revealed frequently used themes. Personal attitudes, diagnosis and treatment and communication were determined as three main themes.

In discussing these experiences with health care professionals, the participants concentrated more on personal relations, culture- language differences, system related problems and the different approach to health in home and host countries. Nurses were mentioned under the category of personal attitudes only. All other categories are focused on physicians.

Personal Attitudes

Experiences with physicians were concentrated on primary care, while in contrast, experiences with nurses mainly focused on hospital care. Respondents mentioned different perceptions about physicians and nurses. In all host countries, the participants frequently came into contact with family practitioners. As a result of this close relationship, their perception about physicians is shaped largely by their experience with their family practitioners. Time spent with the physician, getting the right information about the disease or illness also play important roles in their perceptions. Respondents reveal that the *interest* of the physicians is mostly felt by their "touching" and behaving in a humane way:

> "My blood pressure was about 240, my physician walked with me to the taxi. He (physician) calls my home at 8 o'clock in the morning, and asks "how are you today, are you better than yesterday?" I really cannot receive such care and interest and humane behaviour in Turkey" UK.m.65

*onsickleave, social security aids, early retirement

"In my country, Turkey, does the physician stand up and shake hands with a villager when s/he goes to the hospital? Does the physician walk him/her out? No, they do not, they do not even stand up from their desks. I want and look for such care and interest " G.f.63

During the treatment process in hospitals, patients have the closest contact with the nurses and aides. The participants believe that in all three host countries healthcare professionals in hospitals are *caring*. It was stated that, at their first hospital experiences in the countries they came to as immigrants, the participants were surprised at the close and caring behavior of nurses and mentioned that they were pleased with that. Many participants expressed that healthcare professionals in host counties are "extremely" compassionate and caring:

"The nurses here are like a man's mum. They love talk, an approach like a man's mum. But those there (Turkey) are coming into the room rude, screaming and shouting. ..... " DK.f.60

In contrast to nurses in the host countries, the nurses in Turkey provide mainly medical treatment and the provision of personal care is expected from the patients' relatives. It has been a matter of complaint that nurses in Turkey do not take care of many things related to patient care, that patient relatives are made to do those things and that nurses are not there whenever they are needed. For example:

"Here it is impossible for a nurse to treat patients rudely, and give orders. In a case where a cancer patient's temperature has to be taken in Turkey, the nurse calls the patient's name, shouts out loud and asks the relative to take the patient's temperature and report it to the nurse. What is the role of the nurse there… "UK.m.58

The participants from all research countries commonly voiced the observation that, due to financial reductions in health expenditure, a drop in the number of health care staff has been observed resulting in a diminished level of care over time since they first came to the host country. A Danish participant explained:

" People were more valuable around the 1980s but nowadays it is difficult to see a nurse in hospitals. Older people are left alone; they send them home before even treating them..." DK.f.57

Diagnosis and Treatment

Accurate diagnosis is another important category in the participants' perception about physicians. The immigrants in all three countries think that the physicians in Turkey are better when it comes to accurate diagnosis. A distinction between the general practitioner (GP) or specialists hasn't been mentioned. The participants commonly tell stories of "late diagnosis" or "incorrect diagnosis" in their host countries.

"Here he went to the hospital for over a year, and they could not diagnose the illness. It is not like that in Turkey. That is the good side, physicians diagnose the illness very fast in Turkey... " G.f.70

Such issues in terms of the effectiveness of physicians are related to the fact that the referral systems work slowly in the host countries and the differences in the medical training systems. Participants relate the fact that Turkish physicians are better in terms of diagnosis to the fact that medical training in Turkey provides more practice and that the Turkish physicians encounter a greater number of illnesses since the number of patients per physician in Turkey is higher than in the host countries.

All research countries have a strong referral system in health provided by social welfare state. In such systems, general practitioners serve as a barrier for advanced examination and referral to specialized physicians (Lee et al., 2010). Individuals await their turn for months for *appointments and referral* for advanced examination by a specialized physician.

"…I had cataracts, received a letter from the hospital, I checked and guess when? Look, I applied in the fifth month (2011), and the appointment is on the 29th of the tenth month of 2012. I will not be able to see for one and a half years, and then the physician will make me see again!" DK.m.70

Problems related to referral systems are attributed to physicians and that creates negative perceptions about them. Although there is the general practice system in primary care in Turkey, patients can still apply directly to hospitals. The participants frequently use paid private hospitals in Turkey. There, it is possible to have early contact with the desired physician and to have detailed examinations. This might increase the chance of an early diagnosis of the illness.

> "... but it is different in Turkey. You receive treatment on the same day or the next day in Turkey. But here, you wait for days, months, and people are almost left to die" UK.f.53

The participants generally consider non-referral or late referral to hospitals by family practitioners in Denmark, Britain and Germany as something negative. The easy access to specialized physicians in Turkey and requests by physicians for a detailed examination are considered positive factors in terms of early diagnosis.

Trust between the patient and the physician is highly important particularly at the stage of diagnosis and treatment (Scheppers et al., 2006). The participants who generally use private hospitals in Turkey complained about unnecessary investigations and treatment attempts by private hospitals for profit, and for that reason, some participants stated that they refrain from receiving healthcare services in Turkey.

> "If truth be told, I have no trust in Turkish physicians. It is all about money in Turkey, how can you trust such people? All they think is their profit" DK.m.62

In Turkey, the participants prefer to visit "familiar" physicians or they choose to seek the recommendations of their relatives or friends and select their physicians according to such recommendations. In this context, the participants refer to an "acquaintance" factor in respect to the trust of healthcare professionals in Turkey. According to the participants, having a friend or someone familiar at the hospital is something that facilitates the administration process and accelerates the appointments for investigations. This indicates that the participants preserve primary relationships with respect to medical issues. Participants have no such behavior in their host countries. However, "incidental friends" (e.g. a Turkish healthcare professional in the hospital they visit) seem to be important particularly at hospitals where there is a language barrier. This statement of a participant shows the wish to trust someone who is not even familiar, but who feels familiar because of the similar ethnic origin and the common language at hospitals which are considered to be "unfamiliar environments".

> "My uncle's son came to visit me at the hospital. He said that there is a Turkish nurse at this hospital. That gave me the world..." UK.f.65

Communication

Communication is an important issue in terms of the participants' thoughts and perceptions about healthcare professionals. There are two factors that stand out in respect to the communication between the patient and healthcare professional. The first factor is the language barrier that participants experience in host countries as they are immigrants. Many studies show that the language barrier is a significant factor in the use of healthcare services by immigrants (Lee et al., 2010; Papadopoulos, 2007; Martin, 2009; Nazroo et al., 2008; Campbell, 2002). In addition to the language barrier, social barriers such as being from a different culture, ethnic exclusion or status also have an impact on the perception about healthcare professionals with respect to the communication.

Most of the participants stated that they spoke the *language* of the host country only well enough to cope in their daily lives. While 11participants spoke the language of the host country fluent, there were participants who could not understand or speak the host language at all. Most of the participants suffer a language barrier intensely at hospitals. Hospitals require communication with more people and more detailed examinations are performed, therefore participants reported needing support mainly from their children in regard to language. In case the adult children cannot allocate time to their parents, the participants communicate to the best of their ability. Problems arising through language problems, however, were not found to affect the level of satisfaction with the physician, because they were not seen as the physician's responsibility.

> "I am old. When I apply to a General Practitioner, when he does not

> understand me he says,'mummy sorry'". What can I do when the physician says 'Sorry', we do our best to express ourselves. It is not the fault of the physician ".UK.f.65

Even though the language is not a barrier between Turkish health providers and Turkish immigrants, the immigrants experience communication problems with Turkish health providers. They have mentioned the Turkish health providers hierarchical behaviour as a reason for this. This attitude has been felt especially at health providers in state hospitals. An example ofe this has been mentioned by a respondent from Germany such as:

> " The doctors and nurses in Turkey don't even take you seriously, you can't even get an answer for your questions ." G.f.70

When the participants are asked if they particularly want to see a Turkish physician in the host country, they stated that they have no such special preference, but that they are pleased when, they incidentally, see a Turkish physician.

The participants pointed out that they did not face any negative behavior from healthcare professionals for being Turkish and Muslim. All participants stated their appreciation that they were informed that the meals did not include pork and that the hospital staff members were supportive in respect of religion and culture. However, *inter-cultural differences* between patients and healthcare professionals may affect the approach to diseases and treatments. Many participants think that Turkish people have a traditional health approach compared to western medical approach and are more emotional about illness, and this has a negative effect on treatment perceptions. A participant stated that she changed many psychologists due to cultural differences.

> "Psychologists need to know our culture well when they make decisions. For example, they (the Danish) just dismiss. If something is upsetting you, just leave it. It is so easy to say this… They can do this but we can never do it… They can't make a correct diagnosis as they don't understand us."Dk.f.50

Disease perceptions may also vary from one culture to another. Some participants stated that certain illnesses such as a slipped disk and rheumatism, which are regarded by Turkish immigrants as illnesses, were disregarded by the healthcare professionals in the host country. As a result of this distinction, they cannot receive the treatment they want. In such cases, participants try to see a physician or seek alternative treatment methods in Turkey.

4. DISCUSSION

Cross-border health care use turned out to be more common in recent years, which has also resulted in more attention to the current literature (Horton and Cole, 2011; Lee at al., 2010). A relation is created between health care provider and user which shapes the perceptions. This research aims to reveal the perceptions of Turkish immigrant health care user of their health care providers and aims to represent the way how their perceptions affect health care use. A literature search has shown that this research can be accepted as the first qualitative research about the perceptions of Turkish immigrants of their health care provider in their home and host countries.

The respondents use healthcare services both in their home and host countries. They consciously choose the services in Turkey with which they were not satisfied or which they think are more expensive in their host countries as reported in several studies on cross-border health for immigrants from different countries (Main 2014, Lokdam, 2016). In his study carried out in Holland Şekercan el al. (2014) found dissatisfaction with care in the residence country and seeking second opinions as the main motivations for cross-border health care use.

Several studies reveal language to be an important communication barrier for immigrants creating disadvantages in health access and patient satisfaction (Scheppers et al., 2006; Ferraro and Shippee, 2009; Poortinga, 2006; Davies et al., 2009). In our research, however, language has not been found to be a primary factor affecting the immigrants' perception of health care providers and health service preferences. This can be seen as a striking result of our study with respect to language. In terms of communication with healthcare professionals in Turkey, participants reported a different problem, however. According to them, in contrast to their host country, there is a

sharp hierarchy between the healthcare professionals (physician-nurse-caregiver) and the patient in Turkey which negatively affects the communication between healthcare professionals and patients. Most of the participants complain that it is hard to communicate with the physicians in Turkey and that physicians do not share the diagnosis and treatment methods and options in detail with the patients. Participants also think that the nurses and caregivers "look down on" the patients and their relatives and do not establish "humane" communication, which is not the case in their host countries. A humane relationship with health care providers in host countries neutralizes the language advantage of communication with Turkish health care providers.

According to a study carried out by Yıldız and Erdoğmuş (2004) in Turkey about satisfaction from healthcare provider reveals that communication with doctors, respect from health care providers, sharing of information and attitudes of nurses were the main factors affecting satisfaction.

Martin (2009) found that "care and interest" plays a significant role in immigrants' perception of the "good (ideal)" physician which is similar to our research findings. The respondents revealed that they were satisfied with the care and interest shown by the health care providers in their host countries. Familiarity with health systems and culture are found to be important factors in the research of immigrants healthcare use (Şekercan at al., 2014). On the contrary, our respondents indicated that the Turkish health system and health professionals were unfamiliar to them and a striking result of this study states that they were trying to search for an acquaintance in health professionals before receiving health care.

A feeling of trust towards the healthcare system among immigrants may turn into distrust in cases of dissatisfaction with the healthcare services. Incorrect diagnosis and treatment have been found to have a significant effect on trust (Perloff et al., 2006; Migge and Gilmartin, 2011; Van de Ven, 2014). Another striking result is that trust and distrust in this study were expressed in two different ways: physicians in the host countries were distrusted in terms of accurate and prompt diagnosis as referenced above, whereas the physicians in Turkey were found to be distrusted in terms of financial abuse of their patients.

5. CONCLUSION

It may be asserted that generally, immigrants' perception about healthcare professionals are two-dimensional. While Turkish physicians are considered to be more competent in terms of diagnosis and treatment, the healthcare professionals of the host country are found to be more humane and reliable in terms of interest and care-giving. The participants who were generally satisfied with the primary care services given in all of the host countries have complaints about advanced investigations and referral to specialized physicians. In order to bypass this situation, they self-referred to healthcare providers in Turkey when they believed their medical condition required advanced examinations. The migration incentive, literacy level and country of residence have been found not to have a significant role in their perception and practices for cross-border health care. The outcomes of this study indicate that immigrants' perceptions of healthcare professionals are more affected at the practical level, that is, from healthcare professional-patient experience and these perceptions are shaped pragmatically.

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