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Understanding transnational healthcare use in immigrant communities from a cultural systems perspective: A qualitative study of Dutch residents with a Turkish background

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TITLE

Understanding transnational healthcare use in immigrant communities from a cultural systems perspective: A qualitative study of Dutch residents with a Turkish background

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ABSTRACT*Objectives*

Transnational utilisation of healthcare by people with an immigrant background carries risks, including medicalisation and adverse iatrogenic outcomes. We investigated the drivers behind such transnational healthcare use from a cultural perspective on health systems.

Design

Qualitative interview study (2018).

Setting

Two primary care practices in Amsterdam, the Netherlands.

Participants

Thirteen Dutch patients of Turkish background, who had obtained healthcare in Turkey, and who in general visited the primary care practice more than once a month.

Results

We found that: (A) cross-border healthcare use was fostered by cultural mismatches between expected and provided services and by differing explanatory models of illness upheld by patients and Dutch providers; (B) both transnationalism in patients and entitlements to insurance reimbursement facilitated the use of Turkish health services to bypass perceived barriers in the Dutch system; (C) cultural mismatches were reinforced during GP consultations after the patients' return to the Netherlands, thereby inducing further service use abroad.

Conclusions

Although cultural system influences are difficult to bridge, measures to reduce the unwelcome consequences of transnational healthcare use may include (A) strengthening the provision of culturally sensitive care in the country of residence and (B) restricting the

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3 reimbursement of care in the country of origin while maintaining the option to obtain care
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5 abroad.
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10 **KEY TERMS**

11
12 migrants, cultural system, transnationalism, cross-border care, transnational healthcare
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17 **ARTICLE SUMMARY**

18 *Strengths and limitations of the study*

- 19
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22
- 23 • A first strength is our innovative approach to explore the drivers behind transnational
24 healthcare use from a cultural systems perspective
25
26
 - 27 • This cultural systems perspective helped us to understand how transnational
28 healthcare use may be fostered by an interaction of factors in both clinical practice,
29 healthcare system and national culture
30
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32
33
 - 34 • A second strength is the ethnic-concordant interviewer, familiar with the
35 respondents' language and cultural expressions, and the biographic-narrative
36 interpretive interview method, together leading to in-depth and meaningful
37 information
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44
 - 45 • An important limitation is the rather small number of participants in the study,
46 sampled from two primary care practices in one transnational healthcare context,
47 which limits the generalizability of our finding to other populations and contexts
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BACKGROUND

Across the globe, the transnational ties of former migrants and their families are enabling them to retain and pursue private, cultural and economic interests in their countries of origin, including the domain of healthcare. This phenomenon is known as transnationalism (1, 2). People with an immigrant background tend to utilise similar healthcare services in both their country of origin and their country of residence (1, 3). High transnational healthcare use may increase the risk of medicalisation, as different approaches in the assessment of illnesses may cause more ailments to be labelled as diseases. It also increases the risk of iatrogenic complications resulting from additional diagnoses and treatments (4). Upon the patients' return to their country of residence, they may be subject to repetitions of diagnostics, drug interactions in treatments and inadequate treatment aftercare, due to a lack of cross-border medical information transfers (5). Little evidence is available on the drivers that underlie frequent transnational healthcare use. Such information could be helpful in curtailing its adverse effects.

People of Turkish ethnic origin who are resident in the Netherlands are a relevant group for further study of this phenomenon. In this largest ethnic minority group in the Netherlands, transnational health service use is highly prevalent. Dutch residents with Turkish backgrounds are more likely to utilise health services in the country of origin than other migration groups – 46%, as compared to 18% of residents with Moroccan backgrounds (6). This happens even though apparently equivalent facilities are available in the Netherlands (7). Moreover, those who frequently use health services in Turkey also tend to be frequent healthcare users in the Netherlands (often in the top 10% of frequent users). Their overall rates of utilisation are also high in comparison with their co-ethnics who do not obtain healthcare in Turkey (6, 8). As 80% of the Dutch residents of Turkish background

1
2
3 maintain ties with the Turkish culture, they can readily compare, utilise and evaluate various
4
5 features of health services in both countries (2, 5). There is evidence that succeeding
6
7 generations may continue to use healthcare in Turkey in the future, facilitated by European
8
9 Union legislation and reimbursement from Dutch insurers (9, 10). Studying Dutch residents
10
11 of Turkish background also has international relevance in view of the large ethnic Turkish
12
13 populations in other northern European countries, including Germany, France, Austria,
14
15 Belgium and Denmark (11, 12).

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20 Previous research has primarily examined the immediate motives reported by people
21
22 for using cross-border healthcare (1). From an individual perspective, former migrants
23
24 appeared to utilise services in the country of origin on opportunistic occasions, persuaded
25
26 and guided by their social networks or spurred by a high burden of health problems or
27
28 unmet needs attributable to language or cultural barriers (3, 7, 13). However, some are also
29
30 driven by factors relating to both national healthcare systems. They report, for instance, long
31
32 waiting times, unnecessary delays, limited access to specialist care in their country of
33
34 residence (3, 7, 13), and rapidity and effectiveness of services in the country of origin (7, 14).
35
36 Together, experiences like these act as push and pull factors for cross-border healthcare use
37
38 (14). Studies among people using services in different healthcare systems addressed either
39
40 the use by migrants of traditional or alternative medicine to complement conventional
41
42 services within a Western country, or the use of traditional medicine to complement
43
44 conventional medical services within a non-Western country (15, 16). We are not aware of
45
46 studies that have used the cultural systems perspective to explore in depth the experiences
47
48 that people with an immigrant background have with utilising conventional healthcare
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50 services in both the country of residence and the country of origin.
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3 To better understand the motivations and mechanisms that underlie frequent service
4 use in the Dutch and Turkish healthcare systems by Dutch residents of Turkish origin, we
5 designed a qualitative study guided by the cultural systems perspective as proposed by
6 Arthur Kleinman (17). Kleinman regards each healthcare system as a cultural system with its
7 own set of rules and values for dealing with health, illness and healing, even though
8 different systems may share the same foundation of conventional medicine. Such a cultural
9 systems perspective could help us understand the compatibility between a healthcare
10 system and the cultural values of its users by comparing the different systems during the
11 actual transnational use of healthcare by patients.
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28 **METHODS**

29 *Theoretical framework*

30 Viewing a healthcare system as a cultural system enabled us to compare its cultural rules
31 with the cultural values of its users (17, 18). Differences therein express themselves during
32 healthcare consultations as mismatches between the patient's and the provider's
33 explanatory models of illness. Such models include beliefs about aetiology, symptoms,
34 pathophysiology, and course of sickness and/or treatment. In the case of transnational
35 healthcare use, cultural mismatches between explanatory models are more likely to occur,
36 as a medical consultation is influenced by the rules and values of two national healthcare
37 systems.
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51 Cultural mismatches may occur in all three phases of a consultation (17, 19). In the
52 first phase, a patient presents his or her sensations of illness and tries to persuade the
53 healthcare provider to transform these sensations into symptoms. Core to the second phase
54 is the transition of an illness into a disease, as the healthcare provider, through further
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3 diagnostics, links the patient's symptoms to a particular disease, syndrome or condition. In
4
5 the final phase of the consultation, the provider presents a treatment regimen. Each
6
7 consultation phase thus leads to a specific endpoint: defined symptoms, diagnosis and
8
9 treatment. These endpoints may be – or may not be – acceptable within the patient's
10
11 explanatory model of illness.
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15 If we compare the Turkish and Dutch healthcare systems, they appear to generally
16
17 provide similar quality of care in objective terms, but they differ in the organisation and
18
19 delivery of services (20). In Turkey, alongside municipal health centres for low-complexity
20
21 non-acute care, patients have direct access to specialist care (21). In addition, the Turkish
22
23 healthcare system is interventionist in nature, including a generous use of both the available
24
25 diagnostics (aimed at 'ruling in' disease) and the available treatment options (22). In the
26
27 Dutch system, general practitioners provide low-complexity care, while also acting as
28
29 gatekeepers in deciding if and when referral to specialist care is needed (21). Dutch primary
30
31 care is non-interventionist in nature, reflected by both its stepwise diagnostics (aimed at
32
33 'ruling out' disease) and its stepwise treatment. This wait-and-see approach results in a
34
35 parsimonious use of screening, diagnostics and drug prescription (21).
36
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42 In terms of national cultures (23), Turkey has a more hierarchical society than the
43
44 Netherlands. In such a society, power, authority and control are often centralised (physicians
45
46 make the decisions, for example). In addition, collectivity is more important in the Turkish
47
48 than in the Dutch culture. That may imply, for instance, that the family is more involved in
49
50 the healthcare utilisation trajectory and that the provision of care is more family-based. A
51
52 final difference in national cultures is the higher level of uncertainty avoidance in Turkey.
53
54 This means that members of the society feel a greater degree of discomfort with uncertainty
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3 and ambiguity. This may translate into a stronger desire to *rule out* health risks and potential
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5 diseases and to *rule in* some pathophysiological cause to explain sensations or symptoms.
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7

8 These differences between the Turkish and Dutch healthcare systems and national
9
10 cultures create a high potential for cultural mismatches in the medical consultations of
11
12 transnational patients, as they influence which endpoints are reached and are considered
13
14 acceptable in medical consultations. If left unaddressed, cultural mismatches may heighten
15
16 the risks of medicalisation and of iatrogenic reactions (18, 19).
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23 *Participant recruitment, selection and setting*

24
25 Two primary care practices in Amsterdam joined the study. Both practices included an
26
27 ethnic-concordant general practitioner, thereby excluding poor mastery of Dutch as a
28
29 potential reason for healthcare use in Turkey (1). Patients were identified by their GP as
30
31 candidate respondents if they came in for consultation after obtaining healthcare in Turkey,
32
33 and if they generally visited the Dutch practice more than once a month. The GPs were
34
35 asked to invite a variety of candidates to ensure diversity in terms of gender, education and
36
37 migration generation. After being notified by the GP, AŞ phoned sixteen Dutch primary care
38
39 patients with Turkish backgrounds for an interview appointment. Three patients declined
40
41 participation due to work obligations at possible interview times.
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50 *Data collection*

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52 The interviews took place from August to November 2018 in a private room at the primary
53
54 care practice or at the patient's home, depending on their preference. Some respondents
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56 wanted their spouses and/or children to be present in order to help to recollect, supplement
57
58 and/or clarify their own stories. AŞ made sure that the presence of others was voluntary.
59
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1
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3 The interviews ranged from 45 to 120 minutes. They were held primarily in Turkish, although
4
5 some eventually became mixtures of Turkish and Dutch. All interviews were audiotaped and,
6
7 during transcription, translated into English by AŞ.

8
9
10 After the interview, a semi-structured questionnaire was administered to assess the
11
12 healthcare consumption in Turkey and sociodemographic aspects, including self-reported
13
14 difficulty with the Dutch language.
15
16

17 18 19 20 *Interview approach*

21
22 The biographic-narrative interpretive interview method was used, as it is well suited for
23
24 retrieving enriched data in the domain of healthcare (24). AŞ started the interview with the
25
26 following request: 'Please tell me the story of your life, in the sense of all the events and
27
28 experiences that have been important to you personally regarding health, sickness and
29
30 seeking care.' After the first three interviews, the interviewer began showing respondents a
31
32 diagram of a human life cycle along with this query, so as to visually guide them in retrieving
33
34 their stories without interfering in their thought-forming processes. In the second part of the
35
36 interview, while sticking to the respondent's order of topics raised and their choice of words
37
38 used, the interviewer asked the respondent to elaborate on or clarify certain narratives.
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47 48 *Data analysis*

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50 In the first phase of the data analysis, AŞ and JH familiarised themselves with the content of
51
52 the data by reading through the interview transcripts. Next, they composed an initial coding
53
54 scheme, inspired, first, by the interview method and grounded theory principles and,
55
56 second, by the above theoretical framework and the literature on cross-border care. In the
57
58 subsequent phase, AŞ coded the first four interviews. JH read the coded interviews and
59
60

1
2
3 suggested changes to the coding scheme and/or coded segments. These suggestions were
4
5 discussed and changes were made by consensus, resulting in a final coding scheme (see
6
7 Supplementary Material I). Using qualitative data analysis software (MaxQDA, Version 2018,
8
9 VERBI, Berlin), the first author coded all interviews, which were then checked by the second
10
11 author. Emerging themes and patterns were visualised and discussed together. Both authors
12
13 deemed data saturation to have been reached after analysing nine interviews.
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20 *Research Ethics Approval*

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22 The Dutch legislation (the Medical Research Involving Human Subjects Act) does not require
23
24 ethics approval for this type of interview study. Respondents were asked to sign a written
25
26 consent form for the use of their recordings (for this study only), to confirm their ownership
27
28 of their recordings at all times, and to guarantee confidentiality. Data and analysis logs were
29
30 stored in a protected digital environment, in accordance with the Amsterdam UMC
31
32 guidelines and Dutch and EU privacy legislation.
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40 *Patient and Public Involvement*

41
42 No patient involved.
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47 *Reflexivity*

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49 AŞ had extensive training in qualitative research and previous experience with the same
50
51 community and topic (5). During the interview introduction, he explained his role as both a
52
53 researcher and a physician. It appeared that respondents tended to consider him a member
54
55 of the same community who had been successful in developing his potentials in Dutch
56
57 society. Respondents also seemed proud that he was benefiting the community due to his
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1
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3 choice of a medical career. AŞ was aware that such ascribed authority could lead to socially
4
5 desirable reporting. He attempted to avoid that by creating an open atmosphere and by
6
7 staying alert to hesitations in respondents' narratives and any disagreements with his
8
9 summarisations of their stories. Although all respondents appeared willing to participate in
10
11 an open and honest fashion, a few initially showed signs of distrust due to the ethnic
12
13 concordance and the medical profession of the interviewer. They seemed wary of their
14
15 stories being shared with community members or other health professionals. After
16
17 reassurance about the anonymity of respondents and their option of halting the interview at
18
19 all times, all respondents were eventually willing to openly share their intimate narratives.
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27 **RESULTS**

28
29 After describing the respondents' characteristics (Table 1), we highlight the prominent
30
31 themes that emerged in their narratives on (A) their medical consultations in the
32
33 Netherlands, (B) their healthcare utilisation in Turkey and (C) their subsequent visits to their
34
35 Dutch general practitioner. The supporting quotations (Q1-Q20) are presented in Table 2-4.
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42 *Respondent characteristics*

43
44 Our 13 participants were between 39 and 78 years of age; 5 were in paid employment, 6
45
46 were born in the Netherlands, and 5 reported difficulty with the Dutch language (Table 1).
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50

51 [Insert Table 1]
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55

56 **A. Healthcare utilisation in Netherlands**

57 *Illness presentation and persuasion* 58 59 60

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3 In the first phase of consultation, respondents felt that their general practitioner chose a
4 wait-and-see approach, and they often did not understand why. Respondents felt that their
5
6 sensations were either not acknowledged as symptoms, or were interpreted as symptoms
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8 giving insufficient reason for further diagnostic investigation to rule out underlying causes.
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10
11 This approach was out of line with the perceived urgency of the respondents' embodied
12
13 sensations and their suspicions that something was wrong. They felt that both basic physical
14
15 examination and lab testing were definitely needed to find out the cause (Q01). Many
16
17 respondents said they tried numerous times to convince their GPs to deviate from the wait-
18
19 and-see approach, often without success (Q02).
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21
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25 Respondents frequently indicated that the wait-and-see approach did not provide
26
27 them with an acceptable endpoint. It made them feel they were not taken seriously or not
28
29 getting recognition as a patient. Many wondered whether they were treated differently to
30
31 ethnic Dutch patients, and some explicitly insisted that they were. Some attributed the wait-
32
33 and-see approach to language barriers, but others interpreted it as being treated as a
34
35 second-class citizen (Q03).
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42 *Illness-to-disease transition*

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44 In the second phase of the consultation, even if sensations of illness got transformed into
45
46 symptoms, respondents insisted they still needed proof that the symptoms had a
47
48 pathophysiological origin. They often did not understand why their Dutch GP failed to use all
49
50 the available diagnostics to further 'rule in' a cause (Q04).
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52
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54 Stepwise diagnostics did not address respondents' need for risk avoidance and their
55
56 feeling that something bad could be happening. Especially cancer was believed by patients
57
58 to be unpredictable in its presentation, pace and mortality, and should therefore be ruled in
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3 with all the tests available. Hearsay experiences in their social network, where people
4
5 believed unnecessary harm or death could have been prevented, reinforced the pressing
6
7 need patients felt to follow-up on their symptoms (Q05).
8
9

10 In such cases, most respondents did not regard the diagnosis offered to be an
11
12 acceptable endpoint but believed referral to a specialist was needed. However, given the
13
14 gatekeeper role of Dutch general practitioners, respondents reported they did not get
15
16 referred easily. While some respondents believed that certain authorities were prohibiting
17
18 specialist referral, the GP's reluctance made most respondents question the medical
19
20 knowledge of their doctor (Q06). As a result, respondents said they felt part of an
21
22 experiment, having to undergo a variety of tests first before receiving proper diagnoses
23
24 (Q07).
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32 *Acceptable treatment regimen*

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34 Respondents' stories reflected a conviction that when something is wrong it needs a quick
35
36 fix. Hence, they did not understand why they needed to try different treatments first before
37
38 they got the most optimal treatment available that would eradicate their symptoms (Q08).
39
40 In the respondents' perceptions, being given mere symptom relief instead of treatment for
41
42 the underlying cause (which they assumed to be present) was no acceptable treatment
43
44 procedure and just caused unnecessary delay (Q09). Again, respondents said they felt like
45
46 part of an experiment in which other treatment options were tested out before effective
47
48 treatment was provided (Q10).
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56 [Insert Table 2]
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B. Healthcare utilisation in Turkey

Provoked by their experiences in the Dutch healthcare system (including perceived lack of recognition, mismatches in explanatory models of illness and the provision of unaccepted diagnoses), many respondents felt a strong need to consult the Turkish system, which they typically effectuated during an already scheduled holiday.

In Turkey, respondents felt that the care provided was more in line with the expectations they had of healthcare services, as they perceived fewer differences between their own explanatory model of illness and that of their Turkish physicians. That made them feel taken seriously, recognised as patients and treated as fully fledged individuals (Q11).

Most of the respondents' narratives reflected a better match between their own explanatory models of illness and those of the Turkish healthcare system (Q12). Direct access to swift specialist diagnostics was seen as a way of shortcutting the stepwise diagnostics of Dutch general practitioners, in accordance with their felt urgency of risk reduction (Q13).

Most respondents reported that more effective curative treatments were provided in Turkey, and they implied that they perceived provision of strong medication or an operation to be the only two decisive curative options for health improvement, thereby shortcutting the stepwise treatment approach of the Dutch healthcare system (Q14).

Most respondents thus saw treatment in Turkey as a valid option. This was limited perhaps by a lack of sufficient holidays and/or lack of a local social network for aftercare, but definitely not by financial restraints, even if specific services were not reimbursable (Q15).

[Insert Table 3]

C. Healthcare utilisation on return to the Netherlands

Upon their return to the Netherlands, most respondents went back to their Dutch GP to present Turkish test results, diagnoses and/or suggested treatments in order to discuss subsequent steps in the treatment process. This was not always without difficulty (Q16).

In case the consultation endpoint provided in Turkey was accepted by the Dutch healthcare provider, that justified the respondent's considerations for using Turkish health services and helped to compensate for perceived shortcomings in the Dutch system. At the same time, in case Turkish test results were not accepted, similar feelings of justification were expressed, as the fact that something had actually been found was perceived by respondents as comforting (Q17).

Respondents additionally argued that using healthcare in Turkey would be unnecessary and preventable if their GPs would just attend correctly to their health symptoms (Q18). Nonetheless, respondents said they also appreciated the opportunity to discuss the test results and treatment options provided in Turkey upon their return in the Netherlands. As this was seen as a specific quality of Dutch general practitioners – being a case manager for their patients' health and illnesses – the Turkish respondents continued to use primary as well as specialist healthcare in the Netherlands (Q19).

However, sometimes when the Turkish and Dutch systems provided conflicting diagnoses or treatment options, respondents were left in despair, unsure which version to believe. Such respondents nevertheless continued to see transnational healthcare use as one option to find solutions to their health problems (Q20).

[Insert Table 4]

DISCUSSION

Summary of the findings

This qualitative study among Dutch residents with a Turkish ethnic background showed that: (A) cross-border healthcare use was fostered by cultural mismatches between expected and provided services and by differing explanatory models of illness upheld by patients and Dutch providers; (B) both transnationalism in patients and entitlements to insurance reimbursement facilitated the use of Turkish health services to bypass perceived barriers in the Dutch system; (C) cultural mismatches were reinforced during GP consultations after the patients' return to the Netherlands, thereby inducing further service use abroad.

Interpretation

Our findings indicate that the regular transnational healthcare use of Dutch residents with a Turkish ethnic background (6) may be the result of cultural differences in both healthcare systems and national cultures, as these created mismatches between the patients' and physicians' explanatory models of illness. Although such mismatches made some of our respondents feel a second-class citizen, most of them continued to see their GP as their case manager and a reliable source in seeking care. This means that the GP in the Netherlands, and perhaps also in other countries with a similar gatekeeper system, could play key role in reducing transnational healthcare use. Although cultural gaps may be difficult to bridge (21), cross-border healthcare utilization also rests on individual beliefs, motivation and decisions (15, 16). Therefore, one approach is to strengthen culturally sensitive and competent care during the consultation, as to achieve mutual understanding between the patient and the GP (17, 25). First, this includes being aware of cultural differences, such as in uncertainty avoidance (23), and the related need to find pathophysiological causes of sensations and

1
2
3 symptoms. Second, it requires cross-cultural communication (25), such as discussing
4
5 mismatches and negotiating the need for transnational healthcare use (17), including
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7 possible iatrogenic outcomes and timely seeking professional help if these might occur (4).
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11
12 However, providing culturally sensitive care alone may not be sufficient to change the
13
14 transnational healthcare use of Dutch residents of Turkish origin. Our results confirm that
15
16 the insurers' reimbursement of healthcare and/or the low cost of care in the country of
17
18 origin may play an equally important part in transnational healthcare uptake (1, 26). These
19
20 instruments made opting for health services in Turkey feel natural to our respondents. For
21
22 Dutch insurance companies, one option to limit the higher than average healthcare use
23
24 could be contracting only a selection of care providers for the delivery of care to people with
25
26 Dutch insurance (9). Currently, insurance companies reimburse services from all possible
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28 providers abroad, while in the Netherlands they only reimburse care from "preferred
29
30 providers" meeting certain quality standards (21). Introducing similar quality procedures in
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32 countries abroad could also contribute to a further harmonisation between health services
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34 in different countries as well as to cost-effective care, while the patient's option to obtain
35
36 care abroad is being maintained. To additionally minimise the risks of medicalisation and
37
38 adverse iatrogenic effects, and to coordinate transnational diagnostics and treatment, an
39
40 online portal for international medical information transfer could be considered.
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51 *Strength and limitations*

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53 Our main strength is the use of a cultural systems perspective (17, 27). This helped us to see
54
55 how transnational healthcare use may be fostered by an interaction of factors in both
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57 clinical practice, healthcare system and national culture. Another strength lies in the ethnic-
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2
3 concordant interviewer (AŞ), who was familiar with respondents' language and cultural
4
5 expressions. As the biographic-narrative interpretive method (24, 28, 29) led to in-depth and
6
7 meaningful information, we feel confident to have successfully addressed the potential
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9 downsides of such an interviewer, by both reassuring anonymity and letting respondents
10
11 have ownership of the interviews.
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14
15 An important limitation is the rather small number of participants in the study,
16
17 sampled from two primary care practices, in one transnational healthcare context. This
18
19 limits the possibility to generalize our findings to other Dutch primary care patients of
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21 Turkish background as well as to other patient populations, both within and beyond our
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23 country. Although the pattern in transnational healthcare use we found was pronounced,
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25 additional research in other populations and transnational healthcare contexts seems
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27 warranted.
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32 A second limitation is that we only included patients with a Turkish background and
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34 no patients of Dutch ethnic origin. Therefore, we cannot say that it are especially Dutch
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36 patients of Turkish origin that bypass the general practitioner as to access specialist care. As
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38 patient satisfaction can increase when such a bypass option is available (30), it would be
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40 interesting to compare our findings with data from patients of Dutch ethnic origin.
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47 *Conclusions*

48
49 Our study uncovered how the transnational healthcare use of Dutch patients with a Turkish
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51 background was fostered by cultural mismatches with their Dutch general practitioner.
52
53 Those mismatches reflected differences in both healthcare systems and national cultures. In
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55 order to reduce the unwelcome consequences of transnational healthcare use, measures
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57 may include strengthening the provision of culturally sensitive care in the country of
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3 residence, and restricting the reimbursement of care in the country origin while maintaining
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5 the option to obtain care abroad.
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Competing interest statement

None declared.

Availability of data and materials

The interview transcripts, the models of each phase of medical consultation, and the MaxQDA project file for the current study are not publicly available, as the respondents' conditions of consent restricted the use of the interviews and the derived data to this research study only. The documents and qualitative data analyses are stored locally in accordance with the guidelines set by the anonymized and by Dutch and European Union privacy legislation.

Authors contributions

anonymized analysed the transcripts and drafted the article. JH read the coded interviews and reflected on the analysis and interpretation of the data. anonymized and anonymized contributed to the conception and design of the study, and anonymized provided the daily

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3 supervision of the fieldwork. All authors were involved in revising initial drafts of the article.
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6 All authors read and approved the final manuscript.
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Table 1. Characteristics of interviewed respondents

	Summarised characteristics		
Participants (number)	13		
Age (range)	39–78		
Gender (% female)	62%		
Migration generation ¹ (% 1st, 1.5, 2nd)	31	23	46
Employment status (% paid, % unemployed, % retired)	38	54	8
Educational attainment level ² (% low, middle, high)	70	30	0
Number of years in Netherlands (% born in NL, range)	31	24–54	
Number of yearly visits to Turkey (range)	0.5–4		
Preference to stay in which country ³ (% NL, % TR, % circular)	23	23	54
Number of diseases (range)	0–6		
Difficulty with Dutch language (% yes)	31		

¹ 1.5 migration generation: migration to Netherlands before age 12

² Low: primary or less education; middle: lower general or vocational secondary; high: upper general or vocational secondary or tertiary

³ Circular: preference to stay longer periods of time in both countries

Table 2. Quotes supporting Results part A. Healthcare utilisation in the Netherlands

Quote no.	Quotation
Q01	<p>My first experience.... I was at work, I'd been tired lately, I only wanted to sleep. I went to my GP. He was my first GP after my own GP retired. He was new, fresh. He didn't even do a physical examination. His answer was, 'Yeah, just keep going. You're young, you don't want to be on social welfare.' I said, 'You don't know me. You didn't even do a medical examination and you don't know what I have.' He told me, 'You should just live with it, there's some things we can't explain.' I said to him, 'What did you do? Nothing.' I went away angry. [I-03]</p>
Q02	<p>This time with my right leg.... Four months ago I had a sudden pain in my right leg. I went to my GP; the pain was of a degree that I couldn't walk. I was stumbling. I went to my GP and said my leg really hurt, it wasn't a normal pain. I couldn't stand, I had to lean on my knee to vacuum the floor. I said to him that the pain in my leg was not a normal pain. He said no, you probably overstrained it. I went to my GP twice, and the third time I went to the emergency department. I went to the ... hospital; on the phone they'd said not to worry about it, just take [painkiller] and it'll go away. I went to the GP for the third time with my daughter [<i>anger in the voice</i>]. I said to him there's a torn tissue in my foot, I'm not a doctor but a patient. He didn't believe I had the pain. My ... GP said that if it was torn there would be a bruise. I said this is not a normal pain. He gave me [painkiller] again. [I-01]</p>

Q03	<p>If it really is a doctor who is discriminating, then you see the attitude immediately. He calls your name and walks back. <i>[By contrast:]</i> ‘Mister Janssen’ <i>[typical Dutch surname]</i>.... He waits. ‘Hello Mister Janssen, I’m Dr Smit, please come with me.’ Stays politely behind that man. The doctor stays behind that man. But when it’s a foreigner, whoosh.... You don’t see where the doctor’s gone to. [I-05]</p>
Q04	<p>What kind of testing did you guys do? ... If I have a problem, the answer is take a paracetamol, see how it’s going a week later and then we’ll check further. A week later, if it didn’t work, they do some lab tests, but it’s only one or two options they look at. No findings, then again, and again and again. It’s tiresome.... Nowadays we have everything, the best machines, but if they’re not used properly then what good are they to me? [I-03]</p>
Q05	<p>Why does it take a month in the Netherlands [to get an appointment]? You get cancer. A friend tells you he didn’t hear about his for 2 months. Why can’t [the testing] be the next day? But it takes a whole month. It might’ve metastasised by then. These events happened recently, what more can I tell you? There’s lots of stories like that. Because I often go as a translator I know what those people experience. [I-09]</p>
Q06	<p>I don’t blame the GPs, because they only have certain knowledge. But then I say okay, I can accept that you only possess certain knowledge, I can appreciate that, but if it’s beyond your knowledge then send me to a specialist.... If you don’t have the knowledge, then you need to refer me. [I-05]</p>

Q07	<p>She [the GP] told me it's probably gastroenteritis, even though I'd told her I hadn't been eating or drinking for a couple of days and felt like knives were being stabbed in my gut. She didn't do anything. She told me I had to submit a stool sample the following day to the lab, so they can maybe see it's a bacteria. The following day I didn't end up at the lab but in the emergency department, because I fainted. They brought me to the emergency department and they found I was completely dehydrated. The GP hadn't done any checks. I was in hospital for 2 weeks. [I-03]</p>
Q08	<p>For example, I tell them I have stomach aches or that something else hurts. Maybe there's a bacteria. However, they want to do some research [with different treatments] first. First they'll give you a painkiller to try, and if that doesn't work than we can try another one. If you've already had a light medication, why don't they just try prescribing the other medicine that will have an effect? [I-08]</p>
Q09	<p>The only thing they can tell you and do for you is give painkillers and paracetamol, nothing else. In the Netherlands, how can I say it, they only take care of your disease when it has progressed for quite a while. [I-12]</p>
Q10	<p>I got a splint that would slip off after two steps. I went back and got another one. Exactly the same, after two steps it slipped off. I went back again. Listen, what are we up to here? What do you guys want? Am I the first person this happened to, that had to walk around with a splint? After great difficulty ... I got referred.... Listen, why didn't you guys give me that in the first place? Why? It was a mere €10 more.... They don't come through with the full</p>

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	<p>treatment but do everything step by step. I don't mind that. I can understand that they don't give my body an uppercut. I can understand that, but some things like those splints – why do you need to treat me like an experiment?</p> <p>[I-05]</p>
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Table 3. Quotes supporting Results part B. Healthcare utilization in Turkey

Quote no.	Quotation
Q11	I notice when I'm in Turkey that they listen to me.... Okay, these are special clinics you visit, I understand that as well, but there they not only think about their own specialisation, but also outside of that.... It felt more like they took me seriously than they do here. [I-03]
Q12	My [Dutch] GP, I told him something was wrong but I didn't know what. I told him it can't be good for your heart to beat at such a speed. He told me that's what it's made for. No, a heart is made to beat at a certain rhythm and to accelerate when you exercise or get frightened. It was made to function like that. I asked him what will happen if my heart goes on beating this fast? Yeah, then maybe you'll live 50 years instead of 80. You can't give a patient an answer like that. To me that was the limit. So I took a plane to Istanbul and went to a cardiologist because I thought something was wrong with my heart. The doctor thought I'd already had some bloodwork done, but he didn't ask what the results were. I told him they couldn't find anything, but that I have a high heart rhythm and I'm tired. He did all the diagnostics a cardiologist would do: an ultrasound, an exercise stress test, a bicycle test, a lab workup. In the ultrasound they looked at the blood supply in my heart, looked for hardening of the arteries. Everything he told me put me at ease. He told me he could find nothing. He looked at my lab workup – he did a full workup – and he told me the problem was clear. He said they probably didn't test that. I had a vitamin D deficiency. [I-03]

Q13	<p>In the Netherlands they suspected my husband's pancreas, he was admitted to hospital, he had lost a lot of weight and they'd given him an appointment for a month later. He went to Turkey, got his results, went back and gave them the report. The answer he got was that they [the Dutch hospital] were also planning to look at that. But it takes a whole month, maybe it could have metastasised by then? [I-09]</p>
Q14	<p>In Turkey they tell me I need an operation for my most recent symptoms. Even if they tell me no in the Netherlands, I'll go to Turkey for the necessary [operation]. Nothing more I can do. [I-02]</p>
Q15	<p>This year I was admitted to hospital [in Turkey] and they [Dutch insurance company] told me they might not pay for it. That doesn't interest me. Just let me know what's wrong and what we can do about it. I want to be free of the pain.... An MRI is just 400 lira, €50. I won't die from that expense, but getting an MRI in the Netherlands? ... I also bring back a lot of medicines from Turkey nowadays. [I-03]</p>

Table 4. Quotes supporting Results part C. Healthcare utilisation on return to the Netherlands

Quote no.	Quotation
Q16	<p>I had great difficulty convincing my GP that this was it. Couldn't be possible! I showed him the blood levels. I don't understand them, but according to my GP my vitamin B was above the Dutch recommended level. But the professor in Turkey had told me ... people from Turkey should have above 100.... I told my GP, listen, this and that is the case. She wouldn't believe it. But all right, it didn't matter, with great difficulty they gave me those 3 injections, once a week, and thank God, the symptoms were gone. [I-05]</p>
Q17	<p>It's not nice to not be heard, that's what I notice in the Netherlands, be it a GP or a medical specialist. They're too simplistic about your issues, they send you away too easily and there's no alternative but to think up another solution.... Last time, my reassurance in Turkey was only because they do extensive testing. And even if it eventually turns out to be something small, they can explain my health issue with it. And if you treat that, it's over after that. That's my experience, that's why I prefer using healthcare in my country of origin. Nowadays I just buy a ticket without hesitating. My second opinion is now in Turkey. [I-03]</p>
Q18	<p>I had to go 3000 kilometres to learn that I have a vitamin D deficiency. No answer. 'We didn't think of that.' I told them my body was giving a signal. They told me it was all in my mind. I got vitamin D drops. I noticed my heart rhythm was decreasing. So that was the cause of my problem. You're</p>

	inclined to start searching elsewhere. In the past 10 to 15 years I've been doing that more and more. [I-03]
Q19	Also about my legs and sleeplessness. It had taken me years, and in Turkey the whole diagnosis took 2 hours and they told me I have restless legs. True, the whole night. He told me to take these pills, and thank God I still have those pills in case I need them. I went to the GP in the Netherlands and it all started up again from the beginning. Eventually she accepted it, but it had some side-effects. So again I'm happy with my GP, I can get along well with her, and we're now trying the third medication because of the side-effects.... Now when I get side-effects, we try something else. That's also positive... [I-05]
Q20	If everything is fine, why do I have problems? I'm still suffering.... I'm at the point where I am losing myself. They couldn't find a solution to my headaches. For years, I've been going to doctors here as well as in Turkey. If need be I'll just have to go in Turkey as well. [I-02]

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3 **Supplementary Material 1. Codes used in the Qualitative Analysis**
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Steps of consultation (negotiation at each phase)
Illness presentation and persuading
Illness to disease translation
Acceptable treatment regimen
Sensation to symptom
Vulnerability
Urgency
Disability/death (seriousness)
Core adaptive tasks of healthcare systems
Dealing with illness
Healthcare strategies
Consultation
Healing activities
Health influencing behaviours
Dealing with healthcare outcomes
Explanatory model
Patient
Provider
Differences/troubles
Agreement
Endpoint
Conflicting
Unacceptable
Acceptable
Test result
Diagnosis
It's nothing serious
Turkish Healthcare
Direct access to specialist care
Ruling in versus ruling out
Interventionalist
Value for money
"Broad" & fast diagnostics
Dutch Healthcare
Specialist referral
Ruling out versus ruling in
Non-intentionalist
Stepwise diagnosis
Stepwise treatment
Life World Intern
Turkish examples
Dutch examples
Cultural assumptions
Life World Extern

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Dutch setting experience
Turkish setting experience
Cultural context
Being an experiment
Self-reliance
Finances
Language
Delay
Shopping (behaviour)
Uncertainty avoidance
Transnationalism
Access without barriers
Why? Expressing lack of understanding
Metaphor

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Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

YOU MUST PROVIDE A RESPONSE FOR ALL ITEMS. ENTER N/A IF NOT APPLICABLE

No. Item	Guide questions/description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Interviewer/facilitator	Which author/s conducted the interview or focus group?	9
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	1
3. Occupation	What was their occupation at the time of the study?	10-11
4. Gender	Was the researcher male or female?	10-11
5. Experience and training	What experience or training did the researcher have?	10-11
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	8, 10-11
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	10-11
8. Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	10-11
Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	6-8, 9
Participant selection		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	8
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	8
12. Sample size	How many participants were in the study?	8
13. Non-participation	How many people refused to participate or dropped out? Reasons?	8
Setting		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	8
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	8-9
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	11, 25

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3	Data collection		
4	17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	9
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6	18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	N/A
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9	19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	8
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11	20. Field notes	Were field notes made during and/or after the interview or focus group?	N/A
12			
13	21. Duration	What was the duration of the interviews or focus group?	8
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15	22. Data saturation	Was data saturation discussed?	10
16			
17	23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	N/A
18			
19	Domain 3: analysis and findings		
20			
21	Data analysis		
22			
23	24. Number of data coders	How many data coders coded the data?	9-10
24	25. Description of the coding tree	Did authors provide a description of the coding tree?	9-10; Supplementary Material I
25			
26	26. Derivation of themes	Were themes identified in advance or derived from the data?	9-10
27			
28	27. Software	What software, if applicable, was used to manage the data?	9-10
29			
30	28. Participant checking	Did participants provide feedback on the findings?	N/A
31			
32	Reporting		
33			
34	29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	26-33
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36	30. Data and findings consistent	Was there consistency between the data presented and the findings?	11-15, 26-33
37			
38	31. Clarity of major themes	Were major themes clearly presented in the findings?	11-15
39			
40	32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	11-15
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Understanding transnational healthcare use in immigrant communities from a cultural systems perspective: A qualitative study of Dutch residents with a Turkish background

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3 **TITLE**
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7 Understanding transnational healthcare use in immigrant communities from a cultural
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10 systems perspective: A qualitative study of Dutch residents with a Turkish
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14 background
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ABSTRACT

Objectives

Transnational utilisation of healthcare by people with an immigrant background carries risks, including medicalisation and adverse iatrogenic outcomes. We investigated the drivers behind such transnational healthcare use from a cultural perspective on health systems.

Design

Qualitative interview study (2018).

Setting

Two primary care practices in Amsterdam, the Netherlands.

Participants

Thirteen Dutch patients of Turkish background, who had obtained healthcare in Turkey, and who in general visited the primary care practice more than once a month.

Results

In the respondents' stories, we observed how: (A) cross-border healthcare use was encouraged by cultural mismatches between expected and provided services and by

1
2
3 differing explanatory models of illness upheld by patients and Dutch providers;
4
5

6
7 (B) both transnationalism in patients and entitlements to insurance reimbursement
8
9

10 facilitated the use of Turkish health services to bypass perceived barriers in the
11
12

13
14 Dutch system; (C) cultural mismatches were reinforced during GP consultations after
15
16

17 the patients' return to the Netherlands, thereby inducing further service use abroad.
18
19

20 21 *Conclusions* 22

23
24 Although cultural system influences are difficult to bridge, measures to reduce the
25
26

27
28 unwelcome consequences of transnational healthcare use may include (A)
29
30

31 strengthening the provision of culturally sensitive care in the country of residence and
32
33

34 (B) restricting the reimbursement of care in the country of origin while maintaining the
35
36

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38 option to obtain care abroad.
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45 **KEY TERMS** 46 47

48 migrants, cultural system, transnationalism, cross-border care, transnational
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52 healthcare
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59 **ARTICLE SUMMARY** 60

Strengths and limitations of the study

- A first strength is our innovative approach to explore the drivers behind transnational healthcare use from a cultural systems perspective
- This cultural systems perspective helped us to understand how transnational healthcare use may be encouraged by an interaction of factors in both clinical practice, healthcare system and national culture
- A second strength is the ethnic-concordant interviewer, familiar with the respondents' language and cultural expressions, and the biographic-narrative interpretive interview method, together leading to in-depth and meaningful information
- An important limitation is the rather small number of participants in the study, sampled from two primary care practices in one transnational healthcare context, which limits the generalizability of our finding to other populations and contexts

BACKGROUND

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6
7 Across the globe, the transnational ties of former migrants and their families are
8
9
10 enabling them to retain and pursue private, cultural and economic interests in their
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12
13 countries of origin, including the domain of healthcare. This phenomenon is known as
14
15
16 transnationalism (1, 2). People with an immigrant background tend to utilise similar
17
18
19 healthcare services in both their country of origin and their country of residence (1,
20
21
22 3). High transnational healthcare use may increase the risk of medicalisation, defined
23
24
25 as expansion of the medical domain (4). Different diagnostic approaches may cause
26
27
28 more ailments to be labelled as diseases (4) and thus also increase the risk of
29
30
31 iatrogenic complications resulting from additional treatments (5, 6). Due to a lack of
32
33
34 cross-border medical information transfers, upon the patients' return to their country
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36
37 of residence they may be subject to repetitions of diagnostics, drug interactions in
38
39
40 treatments and inadequate treatment aftercare (7). In addition, transnational
41
42
43 healthcare use is likely to foster antimicrobial drug resistance (6). At the system level,
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45
46 it may increase healthcare spending in the country of residence, pull resources from
47
48
49 the public sector in the country of origin, and thus widen health disparities (6).
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59 Motivators for treatment abroad generally include low costs, short waiting lists, quality
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3 of care and the available medical procedures (8, 9). Yet, the drivers that underlie
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6
7 frequent transnational healthcare use are complex and deserve further
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9
10 investigation(9), as to curtail its adverse effects.
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12

13
14 People of Turkish ethnic origin who are resident in the Netherlands are a
15
16
17 relevant group for further study of this phenomenon. With about 425.000 people, they
18
19
20 form the largest ethnic minority group in the Netherlands (10). Migration from Turkey
21
22
23 was encouraged in the 1960s and early 1970s to fill labour shortages in unskilled
24
25
26 occupation (11). In the years that followed (1970-80), many “guest workers” brought
27
28
29 their spouses and children to the Netherlands (11). As 80% of the Dutch residents of
30
31
32 Turkish background identify as being both Dutch and Turkish and maintain ties with
33
34
35 the Turkish culture, they can readily compare, utilise and evaluate various features of
36
37
38 health services in both countries (2, 7). Being residents of the European Union, they
39
40
41 have access to necessary health care in all countries in Europe (12) and Dutch
42
43
44 insurance companies reimburse public as well as private healthcare in both the
45
46
47 Netherlands and Turkey (13). There is also evidence that succeeding generations
48
49
50 may continue to use healthcare in Turkey in the future (12, 13). Studying Dutch
51
52
53 residents of Turkish background also has international relevance in view of the large
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1
2
3 ethnic Turkish populations in other northern European countries, including Germany,
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6
7 France, Austria, Belgium and Denmark (10, 14).
8
9

10 Transnational health service use is highly prevalent in Dutch residents with a
11
12
13 Turkish background. They are more likely to utilise health services in the country of
14
15
16 origin than other migration groups – 46%, as compared to 18% of residents with a
17
18 Moroccan background (15). This happens even though apparently equivalent
19
20
21 facilities are available in the Netherlands (16). Moreover, those who frequently use
22
23
24 health services in Turkey also tend to be frequent healthcare users in the
25
26
27 Netherlands (i.e. often in the top 10% of frequent users). Their overall rates of
28
29
30 utilisation are also high in comparison with their co-ethnics who do not obtain
31
32
33 healthcare in Turkey (Dutch primary care use: 40.4% versus 22.5%; specialist
34
35
36 medical care use: 57.8% versus 33.9%) (15, 17). The few factors identified to be
37
38
39 associated with healthcare use in the country of origin are poorer self-reported health
40
41
42 and a wider perceived cultural distance to the healthcare system in the country of
43
44
45 residence (16).
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54
55 Previous research has primarily examined the immediate motives reported by
56
57
58 people for using cross-border healthcare (1). From an individual perspective, former
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1
2
3 migrants appeared to utilise services in the country of origin on opportunistic
4
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6
7 occasions, persuaded and guided by their social networks or spurred by a high
8
9
10 burden of health problems or unmet needs attributable to language or cultural
11
12
13 barriers (3, 16, 18). However, some are also driven by factors relating to both
14
15
16 national healthcare systems. They report, for instance, long waiting times,
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18
19 unnecessary delays, limited access to specialist care in their country of residence (3,
20
21
22 16, 18), and rapidity and effectiveness of services in the country of origin (16, 19).
23
24
25 Together, experiences like these act as push and pull factors for cross-border
26
27
28 healthcare use (19). Studies among people using services in different healthcare
29
30
31 systems addressed either the use by migrants of traditional or alternative medicine to
32
33
34 complement conventional services within a Western country, or the use of traditional
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37 medicine to complement conventional medical services within a non-Western country
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residence and the country of origin.

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4 To better understand the motivations and mechanisms that underlie frequent
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7 service use in the Dutch and Turkish healthcare systems by Dutch residents of
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9
10 Turkish origin, we designed a qualitative study guided by the cultural systems
11
12
13 perspective as proposed by Arthur Kleinman (22). Kleinman regards each healthcare
14
15
16 system as a cultural system with its own set of rules and values for dealing with
17
18
19 health, illness and healing, even though different systems may share the same
20
21
22 foundation of conventional medicine. Such a cultural systems perspective could help
23
24
25 us understand the compatibility between a healthcare system and the cultural values
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28 of its users by comparing the different systems during the actual transnational use of
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31 healthcare by patients.
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42 **METHODS**

43 *Analytical framework*

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48 Viewing a healthcare system as a cultural system enabled us to compare its cultural
49
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51 rules with the cultural values of its users (22, 23). Differences therein express
52
53
54 themselves during healthcare consultations as mismatches between the patient's
55
56
57 and the provider's explanatory models of illness. Such models include beliefs about
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1
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3 aetiology, symptoms, pathophysiology, and course of sickness and/or treatment. In
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6
7 the case of transnational healthcare use, cultural mismatches between explanatory
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10 models are more likely to occur, as a medical consultation is influenced by the rules
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12
13 and values of two national healthcare systems and two national cultures. Therefore,
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16
17 the analytical framework comprised the concept of cultural mismatches, the
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19
20 differences between national health care systems, and a comparison of national
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23
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25 cultures.

26
27
28 Cultural mismatches may occur in all three phases of a consultation (22, 24).

29
30
31 In the first phase, a patient presents his or her sensations, as the basis of the
32
33
34 recognition that something is wrong, and tries to persuade the healthcare provider to
35
36
37
38 transform these sensations into symptoms, as a recognized objective clinical reality
39
40
41 (24). Core to the second phase is the transition of an illness into a disease, once the
42
43
44 healthcare provider, through further diagnostics, links the patient's symptoms to a
45
46
47
48 particular disease, syndrome or condition. In the final phase of the consultation, the
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51 provider presents a treatment regimen. Each consultation phase thus leads to a
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55 specific endpoint: defined symptoms, diagnosis and treatment. These endpoints may
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57
58
59 be – or may not be – acceptable within the patient's explanatory model of illness.
60

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4 If we compare the Turkish and Dutch healthcare systems, they appear to
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6
7 generally provide similar quality of care in objective terms, but they differ in the
8
9
10 organisation and delivery of services (25). In Turkey, alongside municipal health
11
12
13 centres for low-complexity non-acute care, patients have direct access to specialist
14
15
16 care (26). In addition, the Turkish healthcare system is interventionist in nature,
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19 including a generous use of both the available diagnostics (aimed at 'ruling in'
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21
22 disease) and the available treatment options (27). In the Dutch system, general
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24
25 practitioners provide low-complexity care, while also acting as gatekeepers in
26
27
28 deciding if and when referral to specialist care is needed (26). Dutch primary care is
29
30
31 non-interventionist in nature, reflected by both its stepwise diagnostics (aimed at
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33
34 'ruling out' disease) and its stepwise treatment. This wait-and-see approach results in
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36
37 a parsimonious use of screening, diagnostics and drug prescription (26).
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45 In terms of national cultures, Turkey has a more hierarchical society than the
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47
48 Netherlands (28). In such a society, power, authority and control are often centralised
49
50
51 (physicians make the decisions, for example). In addition, collectivity is more
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53
54 important in the Turkish than in the Dutch culture(28). That may imply, for instance,
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56
57 that the family is more involved in the healthcare utilisation trajectory and that the
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3 provision of care is more family-based. A final difference in national cultures is the
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6
7 higher level of uncertainty avoidance in Turkey (28). This means that members of the
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9
10 society feel a greater degree of discomfort with uncertainty and ambiguity. This may
11
12
13 translate into a stronger desire to *rule out* health risks and potential diseases and to
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16
17 *rule in* some pathophysiological cause to explain sensations or symptoms. Despite
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19
20 these differences between the two nations, it should be noted that culture is a
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23
24 dynamic concept, that may express itself in different ways.
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27

28 These differences between the Turkish and Dutch healthcare systems and
29
30 national cultures create a high potential for cultural mismatches in the medical
31
32
33 consultations of transnational patients, as they influence which endpoints are
34
35
36 reached and which are considered acceptable in medical consultations. If left
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38
39 unaddressed, cultural mismatches may heighten the risks of medicalisation and of
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42 iatrogenic reactions (23, 24).
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52 *Participant recruitment, selection and setting*

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55 Two primary care practices in Amsterdam joined the study. Both practices included
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57
58 an ethnic-concordant general practitioner, thereby excluding poor mastery of Dutch
59
60

1
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3 as a potential reason for healthcare use in Turkey (1). Patients were identified by
4
5
6
7 their GP as candidate respondents if they came in for consultation after obtaining
8
9
10 healthcare in Turkey, and if they generally visited the Dutch practice more than once
11
12
13 a month. The GPs were asked to invite a variety of candidates to ensure diversity in
14
15
16 terms of gender, education and migration generation. After being notified by the GP,
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18
19 AŞ phoned sixteen Dutch primary care patients with Turkish a background for an
20
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22 interview appointment. Three patients declined participation due to work obligations
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27 at possible interview times.
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35 *Data collection*

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38 The interviews took place from August to November 2018 in a private room at the
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41 primary care practice or at the patient's home, depending on their preference. Some
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43
44 respondents wanted their spouses and/or children to be present in order to help to
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48
49 recollect, supplement and/or clarify their own stories. AŞ made sure that the
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51
52 presence of others was voluntary. The interviews ranged from 45 to 120 minutes.
53
54
55 They were held primarily in Turkish, although some eventually became mixtures of
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1
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3 Turkish and Dutch. All interviews were audiotaped and, during transcription,
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6 translated into English by AŞ.
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9

10 After the interview, a semi-structured questionnaire was administered to
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12
13 assess the healthcare consumption in Turkey and sociodemographic aspects,
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15
16 including self-reported difficulty with the Dutch language.
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24 *Interview approach*

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26
27 The biographic-narrative interpretive interview method was used, as it is well suited
28
29
30 for retrieving enriched data in the domain of healthcare (29). AŞ started the interview
31
32
33 with the following request: 'Please tell me the story of your life, in the sense of all the
34
35
36 events and experiences that have been important to you personally regarding health,
37
38
39 sickness and seeking care.' In the first three interviews the respondents tended to
40
41
42 focus on one episode of healthcare use or to discuss different episodes while mixing
43
44
45 these up. Therefore, in the following interviews the interviewer began showing
46
47
48 respondents a diagram of a human life cycle, so as to visually guide them in
49
50
51 retrieving their stories in a chronological order without interfering in their thought-
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53
54 forming processes. In the second part of the interview, while sticking to the
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1
2
3 respondent's order of topics raised and their choice of words used, the interviewer
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5
6
7 asked the respondent to elaborate on or clarify certain narratives, specifically in
8
9
10 relation to the different phases of the consultation. For the interview guide, please
11
12
13
14 see Supplementary Material I.
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16
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20

21 *Data analysis*

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23
24 In the first phase of the data analysis, AŞ and JH familiarised themselves with the
25
26
27 content of the data by reading through the interview transcripts. Next, they composed
28
29
30 an initial coding scheme, inspired first by the interview method and grounded theory
31
32
33 principles, and second by the above analytical framework and the literature on cross-
34
35
36 border care. In the subsequent phase, AŞ coded the first four interviews. JH read the
37
38
39 coded interviews and suggested changes to the coding scheme and/or coded
40
41
42 segments. These suggestions were discussed and changes were made by
43
44
45
46
47
48 consensus, resulting in a final coding scheme (see Supplementary Material II). Using
49
50
51 qualitative data analysis software (MaxQDA, Version 2018, VERBI, Berlin), the first
52
53
54 author coded all interviews, which were then checked by the second author.
55
56
57
58
59 Emerging themes and patterns were visualised and discussed together. The pattern
60

1
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3 of drivers behind transnational health care use was almost homogeneous across the
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6
7 sample. Both authors deemed data saturation to have been reached after analysing
8
9
10 nine interviews.
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17 *Informed consent*

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20 Respondents were asked to sign a written consent form for the use of their
21
22
23 recordings (for this study only), to confirm their ownership of their recordings at all
24
25
26 times, and to guarantee confidentiality.
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34 *Patient and Public Involvement*

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38 No patients or public involved.
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45 *Reflexivity*

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47
48 AŞ had extensive training in qualitative research and previous experience with the
49
50
51 same community and topic (7). During the interview introduction, he explained his
52
53
54 role as both a researcher and a physician. It appeared that respondents tended to
55
56
57 consider him a member of the same community who had been successful in
58
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60

1
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3 developing his potentials in Dutch society. Respondents also seemed proud that he
4
5
6
7 was benefiting the community due to his choice of a medical career. AŞ was aware
8
9
10 that such ascribed authority could lead to socially desirable reporting. He attempted
11
12
13 to avoid that by creating an open atmosphere and by staying alert to hesitations in
14
15
16 respondents' narratives and any disagreements with his summarisations of their
17
18
19 stories. Although all respondents appeared willing to participate in an open and
20
21
22 honest fashion, a few initially showed signs of distrust due to the ethnic concordance
23
24
25 and the medical profession of the interviewer. They seemed wary of their stories
26
27
28 being shared with community members or other health professionals. After
29
30
31 reassurance about the anonymity of respondents and their option of halting the
32
33
34 interview at all times, all respondents were eventually willing to openly share their
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36
37 intimate narratives.
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49 RESULTS

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51
52 After describing the respondents' characteristics (Table 1), we highlight the
53
54
55 prominent themes that emerged in their narratives on (A) their medical consultations
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1
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3 in the Netherlands, (B) their healthcare utilisation in Turkey and (C) their subsequent
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6
7 visits to their Dutch general practitioner.
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9

10 11 12 13 *Respondent characteristics*

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16
17 Our 13 participants were between 39 and 78 years of age; 5 were in paid
18
19
20
21 employment, 6 were born in the Netherlands, and 5 reported difficulty with the Dutch
22
23
24 language (Table 1). Their primary reason to go to Turkey was visiting relatives, while
25
26
27 decisions about using healthcare were in general made after arriving in Turkey.
28
29

30
31 Respondents usually made use of private healthcare services, as these were
32
33
34 regarded more accessible and providing quicker services than public services.
35
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41

42 [Insert Table 1]
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47

48 **A. Healthcare utilisation in Netherlands**

49 50 51 *Illness presentation and persuasion*

52
53
54
55 In the first phase of consultation, respondents typically felt that their general
56
57
58
59 practitioner chose a wait-and-see approach, and they often did not understand why.
60

1
2
3 They felt that their sensations were either not acknowledged as symptoms, or were
4
5
6 interpreted as symptoms giving insufficient reason for further diagnostic investigation
7
8
9
10 to rule out underlying causes. This approach was out of line with the perceived
11
12
13 urgency of the respondents' embodied sensations and their suspicions that
14
15
16 something was wrong. All but one of the respondents explained that both basic
17
18
19 physical examination and lab testing were definitely needed to find out the cause
20
21
22 (Q01). The vast majority said they tried numerous times to convince their GPs to
23
24
25 deviate from the wait-and-see approach, often without success (Q02).
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35 Q01: My first experience.... I was at work, I'd been tired lately, I only wanted to
36
37
38 sleep. I went to my GP. He was my first GP after my own GP retired. He was
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40
41 new, fresh. He didn't even do a physical examination. His answer was, 'Yeah,
42
43
44 just keep going. You're young, you don't want to be on social welfare.' I said,
45
46
47
48 'You don't know me. You didn't even do a medical examination and you don't
49
50
51 know what I have.' He told me, 'You should just live with it, there's some things
52
53
54 we can't explain.' I said to him, 'What did you do? Nothing.' I went away angry.
55
56
57
58
59 [I-03, 1st generation migrant, paid work, no difficulty with Dutch language]
60

1
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4
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6
7 Q02: This time with my right leg.... Four months ago I had a sudden pain in my
8
9
10 right leg. I went to my GP; the pain was of a degree that I couldn't walk. I was
11
12
13 stumbling. I went to my GP and said my leg really hurt, it wasn't a normal pain. I
14
15
16 couldn't stand, I had to lean on my knee to vacuum the floor. I said to him that
17
18
19 the pain in my leg was not a normal pain. He said no, you probably overstrained
20
21
22 it. I went to my GP twice, and the third time I went to the emergency
23
24
25 department. I went to the ... hospital; on the phone they'd said not to worry
26
27
28 about it, just take [painkiller] and it'll go away. I went to the GP for the third time
29
30
31 with my daughter [*anger in the voice*]. I said to him there's a torn tissue in my
32
33
34 foot, I'm not a doctor but a patient. He didn't believe I had the pain. My ... GP
35
36
37 said that if it was torn there would be a bruise. I said this is not a normal pain.
38
39
40
41
42
43
44
45 He gave me [painkiller] again.
46
47

48 [I-01, 1st generation migrant, paid work, no difficulty with Dutch language]
49
50
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52
53
54

55 Respondents frequently indicated that the wait-and-see approach did not provide
56
57
58 them with an acceptable endpoint. It made them feel they were not taken seriously or
59
60

1
2
3 not getting recognition as a patient. Most wondered whether they were treated
4
5
6
7 differently to ethnic Dutch patients, and some explicitly insisted that they were. Some
8
9
10 attributed the wait-and-see approach to language barriers, but others interpreted it as
11
12
13
14 being treated as a second-class citizen (Q03).
15
16
17
18
19
20

21 Q03: If it really is a doctor who is discriminating, then you see the attitude
22
23 immediately. He calls your name and walks back. *[By contrast:]* 'Mister Janssen'
24
25 *[typical Dutch surname]*.... He waits. 'Hello Mister Janssen, I'm Dr Smit, please
26
27
28 come with me.' Stays politely behind that man. The doctor stays behind that
29
30
31 man. But when it's a foreigner, whoosh.... You don't see where the doctor's
32
33
34 gone to.
35
36
37
38
39
40

41 [I-05, 2nd generation migrant, paid work, no difficulty with Dutch language]
42
43
44
45
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47
48

49 *Illness-to-disease transition*

50
51
52 In the second phase of the consultation, even if sensations of illness got transformed
53
54
55 into symptoms, respondents typically insisted they still needed proof that the
56
57
58
59
60

1
2
3 symptoms had a pathophysiological origin. They often did not understand why their
4

5
6
7 Dutch GP failed to use all the available diagnostics to further 'rule in' a cause (Q04).
8
9
10

11
12
13
14 Q04: What kind of testing did you guys do? ... If I have a problem, the answer is
15

16
17 take a paracetamol, see how it's going a week later and then we'll check further.
18

19
20 A week later, if it didn't work, they do some lab tests, but it's only one or two
21

22
23 options they look at. No findings, then again, and again and again. It's
24

25
26 tiresome.... Nowadays we have everything, the best machines, but if they're not
27

28
29 used properly then what good are they to me?
30
31

32
33
34 [I-03, 1st generation migrant, paid work, no difficulty with Dutch language]
35
36
37
38
39
40
41

42 Generally, stepwise diagnostics did not address the respondents' need for risk
43

44
45 avoidance and their feeling that something bad could be happening. Especially
46

47
48 cancer was believed by almost all patients to be unpredictable in its presentation,
49

50
51 pace and mortality, and should therefore be ruled in with all the tests available.
52
53

54
55 Hearsay experiences in their social network, where people believed unnecessary
56
57
58
59
60

1
2
3 harm or death could have been prevented, reinforced the pressing need most
4
5
6
7 patients felt to follow-up on their symptoms (Q05).
8
9
10
11
12

13
14 Q05: Why does it take a month in the Netherlands [to get an appointment]? You
15
16
17 get cancer. A friend tells you he didn't hear about his for 2 months. Why can't
18
19
20 [the testing] be the next day? But it takes a whole month. It might've
21
22
23
24 metastasised by then. These events happened recently, what more can I tell
25
26
27 you? There's lots of stories like that. Because I often go as a translator I know
28
29
30
31 what those people experience.
32
33

34
35 [I-09, 2nd generation migrant, unemployed, no difficulty with Dutch language]
36
37
38
39
40
41

42 In such cases, most respondents did not regard the diagnosis offered to be an
43
44
45 acceptable endpoint but believed referral to a specialist was needed. However, given
46
47
48 the gatekeeper role of Dutch general practitioners, respondents reported they did not
49
50
51
52 get referred easily. While a few respondents believed that certain authorities were
53
54
55 prohibiting specialist referral, the GP's reluctance made most respondents question
56
57
58
59 the medical knowledge of their doctor (Q06). As a result, some respondents said they
60

1
2
3 felt part of an experiment, having to undergo a variety of tests first before receiving
4
5
6
7 proper diagnoses (Q07).
8
9
10
11
12

13
14 Q06: I don't blame the GPs, because they only have certain knowledge. But
15
16
17 then I say okay, I can accept that you only possess certain knowledge, I can
18
19
20 appreciate that, but if it's beyond your knowledge then send me to a
21
22
23 specialist.... If you don't have the knowledge, then you need to refer me.
24
25

26
27
28 [I-05, 2nd generation migrant, paid work, no difficulty with Dutch language]
29
30
31
32
33

34
35 Q07: She [the GP] told me it's probably gastroenteritis, even though I'd told her
36
37
38 I hadn't been eating or drinking for a couple of days and felt like knives were
39
40
41 being stabbed in my gut. She didn't do anything. She told me I had to submit a
42
43
44 stool sample the following day to the lab, so they can maybe see it's a bacteria.
45
46
47
48 The following day I didn't end up at the lab but in the emergency department,
49
50
51 because I fainted. They brought me to the emergency department and they
52
53
54 found I was completely dehydrated. The GP hadn't done any checks. I was in
55
56
57
58 hospital for 2 weeks.
59
60

[I-03, 1st generation migrant, paid work, no difficulty with Dutch language]

Acceptable treatment regimen

All respondents' stories reflected a conviction that when something is wrong it needs a quick fix. Hence, they did not understand why they needed to try different treatments first before they got the most optimal treatment available that would eradicate their symptoms (Q08). In the respondents' perceptions, being given mere symptom relief instead of treatment for the underlying cause (which they assumed to be present) was no acceptable treatment procedure and just caused unnecessary delay (Q09). Again, some respondents said they felt like part of an experiment in which other treatment options were tested out before effective treatment was provided (Q10).

Q08: For example, I tell them I have stomach aches or that something else hurts. Maybe there's a bacteria. However, they want to do some research [with different treatments] first. First they'll give you a painkiller to try, and if that doesn't work than we can try another one. If you've already had a light

1
2
3 medication, why don't they just try prescribing the other medicine that will have
4
5
6
7 an effect?
8
9

10 [I-08, 2nd generation migrant, unemployed, difficulty with Dutch language]
11
12
13
14
15
16

17 Q09: They only thing they can tell you and do for you is give painkillers and
18
19
20 paracetamol, nothing else. In the Netherlands, how can I say it, they only take
21
22
23 care of your disease when it has progressed for quite a while.
24
25
26

27 [I-12, 1.5 generation migrant, unemployed, no difficulty with Dutch language]
28
29
30
31
32
33

34 Q10: I got a splint that would slip off after two steps. I went back and got
35
36
37 another one. Exactly the same, after two steps it slipped off. I went back again.
38
39
40 Listen, what are we up to here? What do you guys want? Am I the first person
41
42
43 this happened to, that had to walk around with a splint? After great difficulty ... I
44
45
46 got referred.... Listen, why didn't you guys give me that in the first place? Why?
47
48
49 It was a mere €10 more.... They don't come through with the full treatment but
50
51
52
53
54
55
56 do everything step by step. I don't mind that. I can understand that they don't
57
58
59
60

1
2
3 give my body an uppercut. I can understand that, but some things like those

4
5
6
7 splints – why do you need to treat me like an experiment?

8
9
10 [I-05, 2nd generation migrant, paid work, no difficulty with Dutch language]

11 12 13 14 15 16 17 **B. Healthcare utilisation in Turkey**

18
19
20 Provoked by their experiences in the Dutch healthcare system (including perceived
21
22
23
24 lack of recognition, mismatches in explanatory models of illness and the provision of
25
26
27
28 unaccepted diagnoses), the majority of the respondents felt a strong need to consult
29
30
31 the Turkish system, which they typically effectuated during an already scheduled
32
33
34
35 holiday.

36
37
38 In Turkey, respondents as a rule felt that the care provided was more in line
39
40
41
42 with the expectations they had of healthcare services, as they perceived fewer
43
44
45
46 differences between their own explanatory model of illness and that of their Turkish
47
48
49 physicians. That made them feel taken seriously, recognised as patients and treated
50
51
52 as fully fledged individuals (Q11).
53
54
55
56
57
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1
2
3 Q11: I notice when I'm in Turkey that they listen to me.... Okay, these are
4
5
6 special clinics you visit, I understand that as well, but there they not only think
7
8
9 about their own specialisation, but also outside of that.... It felt more like they
10
11
12 took me seriously than they do here.
13
14
15

16
17 [I-03, 1st generation migrant, paid work, no difficulty with Dutch language]
18
19
20
21
22
23

24 The respondents' narratives typically reflected a better match between their own
25
26
27 explanatory models of illness and those of the Turkish healthcare system (Q12).
28
29
30

31 Direct access to swift specialist diagnostics was seen as a way of shortcutting the
32
33
34 stepwise diagnostics of Dutch general practitioners, in accordance with their felt
35
36
37 urgency of risk reduction (Q13).
38
39
40
41
42
43
44

45 Q12: My [Dutch] GP, I told him something was wrong but I didn't know what. I
46
47
48 told him it can't be good for your heart to beat at such a speed. He told me
49
50
51 that's what it's made for. No, a heart is made to beat at a certain rhythm and to
52
53
54 accelerate when you exercise or get frightened. It was made to function like
55
56
57 that. I asked him what will happen if my heart goes on beating this fast? Yeah,
58
59
60

1
2
3 then maybe you'll live 50 years instead of 80. You can't give a patient an
4
5
6
7 answer like that. To me that was the limit. So I took a plane to Istanbul and went
8
9
10 to a cardiologist because I thought something was wrong with my heart. The
11
12
13 doctor thought I'd already had some bloodwork done, but he didn't ask what the
14
15
16 results were. I told him they couldn't find anything, but that I have a high heart
17
18
19 rhythm and I'm tired. He did all the diagnostics a cardiologist would do: an
20
21
22 ultrasound, an exercise stress test, a bicycle test, a lab workup. In the
23
24
25 ultrasound they looked at the blood supply in my heart, looked for hardening of
26
27
28 the arteries. Everything he told me put me at ease. He told me he could find
29
30
31 nothing. He looked at my lab workup – he did a full workup – and he told me the
32
33
34 problem was clear. He said they probably didn't test that. I had a vitamin D
35
36
37 deficiency.
38
39
40
41
42
43
44

45 [I-03, 1st generation migrant, paid work, no difficulty with Dutch language]
46
47
48
49
50
51

52 Q13: In the Netherlands they suspected my husband's pancreas, he was
53
54
55 admitted to hospital, he had lost a lot of weight and they'd given him an
56
57
58 appointment for a month later. He went to Turkey, got his results, went back
59
60

1
2
3 and gave them the report. The answer he got was that they [the Dutch hospital]
4
5
6
7 were also planning to look at that. But it takes a whole month, maybe it could
8
9
10 have metastasised by then?
11
12

13
14 [I-09, 2nd generation migrant, unemployed, no difficulty with Dutch language]
15
16

17
18
19
20
21 Almost all respondents reported that more effective curative treatments were
22
23 provided in Turkey. They implied that they perceived provision of strong medication
24
25 or an operation to be the only two decisive curative options for health improvement,
26
27
28 thereby shortcutting the stepwise treatment approach of the Dutch healthcare system
29
30
31
32
33
34
35 (Q14).
36
37
38
39
40
41

42 Q14: In Turkey they tell me I need an operation for my most recent symptoms.
43
44

45 Even if they tell me no in the Netherlands, I'll go to Turkey for the necessary
46
47
48 [operation]. Nothing more I can do.
49
50

51
52 [I-02, 1.5 generation migrant, unemployed, difficulty with the Dutch language]
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1
2
3 All but one respondent thus saw treatment in Turkey as a valid option. This was
4
5
6 limited perhaps by a lack of sufficient holidays and/or lack of a local social network
7
8
9
10 for aftercare, but definitely not by financial restraints, even if specific services were
11
12
13 not reimbursable (Q15).
14
15
16
17
18
19
20

21 Q15: This year I was admitted to hospital [in Turkey] and they [Dutch insurance
22
23 company] told me they might not pay for it. That doesn't interest me. Just let me
24
25 know what's wrong and what we can do about it. I want to be free of the pain....
26
27
28
29

30 An MRI is just 400 lira, €50. I won't die from that expense, but getting an MRI in
31
32 the Netherlands? ... I also bring back a lot of medicines from Turkey nowadays.
33
34
35

36 [I-03, 1st generation migrant, paid work, no difficulty with Dutch language]
37
38
39
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41
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43
44

45 **C. Healthcare utilisation on return to the Netherlands**

46
47

48 Upon their return to the Netherlands, almost all respondents went back to their Dutch
49
50
51 GP to present Turkish test results, diagnoses and/or suggested treatments in order to
52
53
54 discuss subsequent steps in the treatment process. This was not always without
55
56
57
58 difficulty (Q16).
59
60

1
2
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4
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6
7 Q16: I had great difficulty convincing my GP that this was it. Couldn't be
8
9
10 possible! I showed him the blood levels. I don't understand them, but according
11
12
13 to my GP my vitamin B was above the Dutch recommended level. But the
14
15
16 professor in Turkey had told me ... people from Turkey should have above
17
18 100.... I told my GP, listen, this and that is the case. She wouldn't believe it. But
19
20
21 all right, it didn't matter, with great difficulty they gave me those 3 injections,
22
23
24 once a week, and thank God, the symptoms were gone.
25
26
27
28
29

30
31 [I-05, 2nd generation migrant, paid work, no difficulty with Dutch language]
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In case the consultation endpoint provided in Turkey was accepted by the Dutch healthcare provider, that justified the respondent's considerations for using Turkish health services and helped to compensate for perceived shortcomings in the Dutch system. At the same time, in case Turkish test results were not accepted, similar feelings of justification were expressed, as the fact that something had actually been found was perceived by respondents as comforting (Q17).

1
2
3 Q17: It's not nice to not be heard, that's what I notice in the Netherlands, be it a
4
5
6
7 GP or a medical specialist. They're too simplistic about your issues, they send
8
9
10 you away too easily and there's no alternative but to think up another solution....

11
12
13 Last time, my reassurance in Turkey was only because they do extensive
14
15
16 testing. And even if it eventually turns out to be something small, they can
17
18 explain my health issue with it. And if you treat that, it's over after that. That's
19
20
21 my experience, that's why I prefer using healthcare in my country of origin.
22
23
24

25
26
27 Nowadays I just buy a ticket without hesitating. My second opinion is now in
28
29
30 Turkey.
31
32

33
34 [I-03, 1st generation migrant, paid work, no difficulty with Dutch language]
35
36
37
38
39
40
41

42 Generally, respondents additionally argued that using healthcare in Turkey would be
43
44 unnecessary and preventable if their GPs would just attend correctly to their health
45
46 symptoms (Q18). Nonetheless, almost all respondents said they also appreciated the
47
48 opportunity to discuss the test results and treatment options provided in Turkey upon
49
50
51 their return in the Netherlands. As this was seen as a specific quality of Dutch
52
53
54
55
56 general practitioners – being a case manager for their patients' health and illnesses –
57
58
59
60

1
2
3 the Turkish respondents continued to use primary as well as specialist healthcare in
4
5
6
7 the Netherlands (Q19).
8
9
10
11
12
13

14 Q18: I had to go 3000 kilometres to learn that I have a vitamin D deficiency. No
15
16
17 answer. 'We didn't think of that.' I told them my body was giving a signal. They
18
19
20 told me it was all in my mind. I got vitamin D drops. I noticed my heart rhythm
21
22
23 was decreasing. So that was the cause of my problem. You're inclined to start
24
25
26 searching elsewhere. In the past 10 to 15 years I've been doing that more and
27
28
29 more.
30
31
32
33
34

35 [I-03, 1st generation migrant, paid work, no difficulty with Dutch language]
36
37
38
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40
41

42 Q19: Also about my legs and sleeplessness. It had taken me years, and in
43
44
45 Turkey the whole diagnosis took 2 hours and they told me I have restless legs.
46
47
48 True, the whole night. He told me to take these pills, and thank God I still have
49
50
51 those pills in case I need them. I went to the GP in the Netherlands and it all
52
53
54 started up again from the beginning. Eventually she accepted it, but it had some
55
56
57 side-effects. So again I'm happy with my GP, I can get along well with her, and
58
59
60

1
2
3 we're now trying the third medication because of the side-effects.... Now when I
4
5
6
7 get side-effects, we try something else. That's also positive...
8
9

10 [I-05, 2nd generation migrant, paid work, no difficulty with Dutch language]
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12
13
14
15
16

17 However, sometimes when the Turkish and Dutch systems provided conflicting
18
19
20 diagnoses or treatment options, respondents were left in despair, unsure which
21
22
23 version to believe. These few respondents nevertheless continued to see
24
25
26 transnational healthcare use as one option to find solutions to their health problems
27
28
29
30
31 (Q20).
32
33
34
35
36
37

38 Q20: If everything is fine, why do I have problems? I'm still suffering.... I'm at the
39
40
41 point where I am losing myself. They couldn't find a solution to my headaches.
42
43
44
45 For years, I've been going to doctors here as well as in Turkey. If need be I'll
46
47
48 just have to go in Turkey as well.
49
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51

52 [I-02, 1.5 generation migrant, not employed, difficulty with Dutch language]
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DISCUSSION

Summary of the findings

In the stories of Dutch residents with a Turkish ethnic background, this study observed how: (A) cross-border healthcare use was encouraged by cultural mismatches between expected and provided services and by differing explanatory models of illness upheld by patients and Dutch providers; (B) both transnationalism in patients and entitlements to insurance reimbursement facilitated the use of Turkish health services to bypass perceived barriers in the Dutch system; (C) cultural mismatches were reinforced during GP consultations after the patients' return to the Netherlands, thereby inducing further service use abroad.

Interpretation

Our findings indicate that the regular transnational healthcare use of Dutch residents with a Turkish ethnic background (15) may be the result of mismatches between the patients' and physicians' explanatory models of illness in relation to cultural differences in both healthcare systems and national cultures. First, the feeling of our respondents that their illness sensations were not easily acknowledged as symptoms

1
2
3 reflects that the interpretation of such sensations may heavily depend on culture (22).
4
5

6
7 Our findings and previous studies suggest that mismatches in explanatory models
8

9
10 may result from a perceived cultural distance to the Dutch healthcare system (16)
11

12
13 rather than from a perceived cultural distance to the Dutch society (30). Second,
14

15
16 such mismatches made some of our respondents feel a second-class citizen. In this
17

18
19 respect, another Dutch qualitative study found that Dutch patients from Turkish origin
20

21
22 regularly reported that they were being treated indifferently, inattentively or
23

24
25 discriminatorily by physicians in primary care, while native Dutch patients did not
26

27
28 mention such experiences (31).
29
30
31
32
33

34
35 Despite the mismatches in explanatory models of illness, most of the
36
37 respondents in our study continued to see their GP as their case manager and a
38
39 reliable source in seeking care. This means that the GP in the Netherlands, and
40

41
42 perhaps also in other countries with a similar gatekeeper system, could play key role
43

44
45 in reducing transnational healthcare use. Although cultural gaps may be difficult to
46

47
48 bridge (26), cross-border healthcare utilization also rests on individual beliefs,
49

50
51 motivation and decisions (20, 21). Therefore, one approach could be to strengthen
52

53
54 patient centred primary care (32), by providing culturally sensitive and competent
55

56
57
58
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60

1
2
3 care during the consultation, as to achieve mutual understanding between the patient
4
5
6
7 and the GP (22, 33). First, this includes being aware of cultural differences, such as
8
9
10 in uncertainty avoidance (28), and the related need to find pathophysiological causes
11
12
13 of sensations and symptoms. Second, it requires cross-cultural communication (33),
14
15
16 such as discussing mismatches and negotiating the need for transnational healthcare
17
18
19 use (22), including possible iatrogenic outcomes and timely seeking professional help
20
21
22 if these might occur (5).
23
24
25
26
27

28 However, providing culturally sensitive care alone may not be sufficient to
29
30
31 change the transnational healthcare use of Dutch residents of Turkish origin. Our
32
33
34 results confirm that the insurers' reimbursement of healthcare and/or the low cost of
35
36
37 care in the country of origin may play an equally important part in transnational
38
39
40 healthcare uptake (1, 34). These instruments made opting for health services in
41
42
43 Turkey feel natural to our respondents. For Dutch insurance companies, one option
44
45
46 to limit the higher than average healthcare use could be contracting only a selection
47
48
49 of care providers for the delivery of care to people with Dutch insurance (13).
50
51
52
53
54
55 Currently, insurance companies reimburse services from all possible providers
56
57
58
59 abroad, which can be justified by comparable scores on quality outcome indicators
60

1
2
3 (25), while in the Netherlands they only reimburse care from “preferred providers”
4
5
6
7 meeting additional quality process standards (26). Introducing similar quality
8
9
10 procedures for the delivery of healthcare in countries abroad could also contribute to
11
12
13 a further harmonisation between services in different countries as well as to cost-
14
15
16
17 effective care, while the patient’s option to obtain care abroad is being maintained.
18
19
20 To additionally minimise the risks of medicalisation and adverse iatrogenic effects,
21
22
23 and to coordinate transnational diagnostics and treatment, an online portal for
24
25
26
27 international medical information transfer could be considered, although achieving
28
29
30
31 personal data safety in conformity with privacy legislations may be challenging.
32
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37

38 *Strength and limitations*

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40
41 Our main strength is the use of a cultural systems perspective (22, 35). This helped
42
43
44 us to see how transnational healthcare use may be encouraged by an interaction of
45
46
47
48 factors in both clinical practice, healthcare system and national culture. Another
49
50
51
52 strength lies in the ethnic-concordant interviewer (AŞ), who was familiar with
53
54
55
56 respondents’ language and cultural expressions. As the biographic-narrative
57
58
59 interpretive method (29, 36, 37) led to in-depth and meaningful information, we feel
60

1
2
3 confident to have successfully addressed the potential downsides of such an
4
5
6 interviewer, by both reassuring anonymity and letting respondents have ownership of
7
8
9
10 the interviews.
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12

13
14 An important limitation is the rather small number of participants in the study,
15
16
17 sampled from two primary care practices, in one transnational healthcare context.
18

19
20 This limits the possibility to generalize our findings to other Dutch primary care
21
22
23 patients of Turkish background as well as to other patient populations, both within
24
25
26 and beyond our country. Although the pattern in transnational healthcare use we
27
28
29 found was pronounced, additional research in other populations and transnational
30
31
32 healthcare contexts seems warranted.
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38 A second limitation is that we only included patients with a Turkish background
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41 and no patients of Dutch ethnic origin. Therefore, we cannot say that it is especially
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44 Dutch patients of Turkish origin that bypass the general practitioner to directly access
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47 specialist care. Similarly, we cannot tell whether the Dutch patients of Turkish origin,
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50 while visiting Turkish health care services, were treated differently from the Turkish
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53 residents without a migration history. As patient satisfaction can increase when such
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3 a bypass option is available (38), it would be interesting to compare our findings with
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7 data from patients of Dutch ethnic origin.
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13 *Conclusions*

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17 Our study uncovered how transnational healthcare use of Dutch patients with a
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21 Turkish background was encouraged by mismatches with their Dutch general
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24 practitioner. Their dissimilar explanatory models of illness reflected differences in
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27 national healthcare systems and national cultures. In order to reduce the unwelcome
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30 consequences of transnational healthcare use, measures may include strengthening
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34 the provision of culturally sensitive care in the country of residence, and restricting
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37 the reimbursement of care in the country origin while maintaining the option to obtain
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40 care abroad. Future research could include other migrant populations, qualitatively
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44 compare the healthcare experiences of migrant and native communities, and
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48 quantitatively assess the importance of the patterns we identified.
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Acknowledgements

We are most grateful for the investments of time and energy made by the respondents in sharing their stories and welcoming the first author into their homes.

Without them, this study would not have been possible.

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Grant number: N/A.

Competing interest statement

None declared.

Availability of data and materials

The interview transcripts and the data analysis in the MaxQDA project file are not publicly available. In order to build the required trust, the respondents' informed

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3 consent remained restricted to the use of the interview data for the present study
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13 *Authors contributions*

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17 AŞ collected the data, analysed the interviews and drafted the manuscript. JH read
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20 the coded interviews and reflected on the analysis and interpretation of the data. KS
21
22
23 and RJGP contributed to the conception and design of the study. KS also provided
24
25
26 the daily supervision of the fieldwork. All authors were involved in revising initial
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29 drafts of the manuscript, and read and approved the final manuscript.
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38 *Ethics statement*

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41 According to the Dutch Medical Research Involving Human Subjects Act, this
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44 interview study did not require approval by a medical research ethics committee.
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48 Data and analysis logs were stored in a protected digital environment, in accordance
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52 with Amsterdam University Medical Centers guidelines and Dutch and EU privacy
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55 legislation.
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Table 1. Characteristics of interviewed respondents

	Summarised characteristics		
Participants (number)	13		
Age (range)	39–78		
Gender (% female)	62%		
Migration generation ¹ (% 1st, 1.5, 2nd)	31	23	46
Employment status (% paid, % unemployed, % retired)	38	54	8
Educational attainment level ² (% low, middle, high)	70	30	0
Number of years in Netherlands (% born in NL, range)	31	24–54	
Number of yearly visits to Turkey (range)	0.5–4		
Preference to stay in which country ³ (% NL, % TR, % circular)	23	23	54
Number of diseases (range)	0–6		
Difficulty with Dutch language (% yes)	31		

¹ 1.5 migration generation: migration to Netherlands before age 12

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3 ² Low: primary or less education; middle: lower general or vocational secondary;
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7 high: upper general or vocational secondary or tertiary
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10 ³ Circular: preference to stay longer periods of time in both countries
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Supplementary Material I. Interview approach

We used the biographic-narrative interview method (1). The first part of the interview was an open interview, the second part was structured around the episodes of health care use that the respondent had mentioned in the first part.

Part 1. Open query

“Lütfen bana hayatınızın hikayesini, sizin için sağlık, hastalık ve bakım ilgili önemli olan tüm olayları ve yaşadıklarınızı bana anlatın. Başlamak istediğiniz yerde başlayın, ve istediniz kadar anlatın, vaktim çok, ben siz anlatınız an, sissiz kalıyorum, sadece sonra için birkaç not alacağım”

“Please tell me the story of your life, in the sense of all the events and experiences that have been important to you personally regarding health, sickness and seeking care. Start wherever you want to, and tell me as much as you want, I have a lot of time, and if I get confused, I'll make some notes for later”

Part 2. In-depth questions

Questions to further explore the respondent's experiences during the subsequent episodes of healthcare use. These questions were not pre-determined, but guided by (a) the topics raised by the respondent; and (b) the exact wording used by the respondent. In order to understand the respondent's experiences and explanatory model of illness, this part of the interview was structured around the three phases of the consultation (2, 3): (I) the presentation of illness sensations; (II) the transition of an illness into a disease; (III) presenting a treatment regime.

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3 **Supplementary Material II. Codes used in the Qualitative Analysis**
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Steps of consultation (negotiation at each phase)
Illness presentation and persuading
Illness to disease translation
Acceptable treatment regimen
Sensation to symptom
Vulnerability
Urgency
Disability/death (seriousness)
Core adaptive tasks of healthcare systems
Dealing with illness
Healthcare strategies
Consultation
Healing activities
Health influencing behaviours
Dealing with healthcare outcomes
Explanatory model
Patient
Provider
Differences/troubles
Agreement
Endpoint
Conflicting
Unacceptable
Acceptable
Test result
Diagnosis
It's nothing serious
Turkish Healthcare
Direct access to specialist care
Ruling in versus ruling out
Interventionalist
Value for money
"Broad" & fast diagnostics
Dutch Healthcare
Specialist referral
Ruling out versus ruling in
Non-intentionalist
Stepwise diagnosis
Stepwise treatment
Life World Intern
Turkish examples
Dutch examples
Cultural assumptions
Life World Extern

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Dutch setting experience
Turkish setting experience
Cultural context
Being an experiment
Self-reliance
Finances
Language
Delay
Shopping (behaviour)
Uncertainty avoidance
Transnationalism
Access without barriers
Why? Expressing lack of understanding
Metaphor

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Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

YOU MUST PROVIDE A RESPONSE FOR ALL ITEMS. ENTER N/A IF NOT APPLICABLE

No. Item	Guide questions/description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Interviewer/facilitator	Which author/s conducted the interview or focus group?	9
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	1
3. Occupation	What was their occupation at the time of the study?	10-11
4. Gender	Was the researcher male or female?	10-11
5. Experience and training	What experience or training did the researcher have?	10-11
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	8, 10-11
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	10-11
8. Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	10-11
Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	6-8, 9
Participant selection		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	8
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	8
12. Sample size	How many participants were in the study?	8
13. Non-participation	How many people refused to participate or dropped out? Reasons?	8
Setting		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	8
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	8-9
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	11, 25

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3	Data collection		
4	17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	9
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6	18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	N/A
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9	19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	8
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11	20. Field notes	Were field notes made during and/or after the interview or focus group?	N/A
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13	21. Duration	What was the duration of the interviews or focus group?	8
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15	22. Data saturation	Was data saturation discussed?	10
16			
17	23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	N/A
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19	Domain 3: analysis and findings		
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21	Data analysis		
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23	24. Number of data coders	How many data coders coded the data?	9-10
24	25. Description of the coding tree	Did authors provide a description of the coding tree?	9-10; Supplementary Material I
25			
26	26. Derivation of themes	Were themes identified in advance or derived from the data?	9-10
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28	27. Software	What software, if applicable, was used to manage the data?	9-10
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30	28. Participant checking	Did participants provide feedback on the findings?	N/A
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32	Reporting		
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34	29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	26-33
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36	30. Data and findings consistent	Was there consistency between the data presented and the findings?	11-15, 26-33
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38	31. Clarity of major themes	Were major themes clearly presented in the findings?	11-15
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40	32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	11-15
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Once you have completed this checklist, please save a copy and upload it as part of your submission. When requested to do so as part of the upload process, please select the file type: *Checklist*. You will NOT be able to proceed with submission unless the checklist has been uploaded. Please DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.

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