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Getting Multicultural Health Care off the Ground: Britain and The Netherlands Compared

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Abstract
This article analyses ‘internal’ (professional) and ‘external’ (social) factors which lead to the implementation of measures to improve health care delivery for migrants and ethnic minorities. Developments in this field in Europe have been slower than in the traditional immigration countries. The Netherlands and the UK, however, are two countries in which measures have been supported by government policy (although in The Netherlands this support was short-lived). The article analyses the similarities and differences between these countries in terms of migrant and minority population, social climate and government policy. It argues that as well as ‘bottom-up’ initiatives undertaken by health care workers and service users, decisive government intervention is an essential condition of structural improvements to health care for migrants and minority groups.

Increasing migration to and within Europe has confronted health care systems with the challenge of developing accessible, appropriate and effective services for migrants and ethnic minorities. Existing service provisions have been developed for majority native populations and often fail to meet the needs of other groups (Watters, 2002). In this article I will try to analyse the factors which may stimulate or impede the development of multicultural health care. The article will draw on data from several countries, but will focus particularly on the two with which I have been most closely concerned – Britain and The Netherlands – to gain more insight into these factors.

Multicultural care as a twin-engined aircraft
In a review article on ‘diversity management’, Glastra (2001) has pointed out that attempts to adapt organisations to cultural and ethnic diversity are motivated by two kinds of factor: external (dominant social notions of fairness, non-discrimination or anti-racism) and internal (the desire of professionals to make services accessible and effective). These factors are often linked.

Taking up this idea, we can use the metaphor of a twin-engined aircraft to describe the process of developing multicultural health care. To get off the ground, both engines have to work; internal as well as external factors have to be supportive of change. Once in the air, it is possible to continue flying on one engine if the other one malfunctions – for example, if public acceptance of diversity turns into hostility, as has happened in The Netherlands in the last five years. However, if this happens there is a risk of going round in circles, and one’s journey may take much longer. In the rest of this article I will analyse ‘internal’ and ‘external’ factors more closely, in order to identify components of each that seem to be necessary conditions for achieving change.

Internal factors
Research basis
In this era of ‘evidence-based’ care, new initiatives have to be backed up by solid empirical evidence that they are necessary and effective. The development of multicultural health care has therefore gone hand in hand with the emergence of new research – for in the past, this area has been sadly neglected.

Mainstream medical and psychological research has been notorious for excluding ethnic minorities (Sheikh, 2006). In a famous article, Graham (1992) showed that 96% of the studies published in the 1970s and 1980s in four leading journals of the American Psychological Association excluded African American subjects. Such
practices have led to a state of profound ignorance about the state of health of minority groups and the effectiveness of treatments for them.

This neglect has several causes. Members of such groups may be excluded from clinical trials for statistical reasons, to keep the sample as homogeneous as possible. Alternatively, they may be present but invisible, because clinical records fail to record the ethnicity or origin of patients.

In any case, clinical records are an inadequate source of data if we are interested in a group’s state of health. They relate only to those who seek treatment, and tell us nothing about those who do not find their way into the care system. Yet methodological obstacles lie in wait for the researcher who sets out to use epidemiological methods of population research. How to locate minority subjects and ensure an adequate response rate? How to be sure that the measuring instruments used are cross-culturally valid?

Despite these difficulties, it remains crucial that efforts to improve multicultural care should be backed up by good research. It is no coincidence that in The Netherlands, the Dutch Health Ministry’s announcement in 2000 of measures to improve migrant health care was preceded by a period of intensive research activity. Yet methodological obstacles lie in wait for the researcher who sets out to use epidemiological methods of population research. How to locate minority subjects and ensure an adequate response rate? How to be sure that the measuring instruments used are cross-culturally valid?

Dominant paradigms
Health care cannot respond to the challenge of diversity if it is dominated by models or paradigms which make no allowance for social and cultural factors. Most insensitive of all are, of course, reductionist biomedical or psychological approaches. Medical care based on a purely technological, symptom-oriented approach, for example psychopharmacology, has little place for diversity.

An example of a discipline which has encouraged attention to cultural differences is transcultural psychiatry (together with its European equivalent, ‘ethnopsychiatry’). This discipline has its roots in colonial (‘tropical’) medicine, though recent work uses more sophisticated anthropological methods and insights.

However, this approach has obvious limitations. Of course it is useful to know how people in immigrants’ countries of origin become ill and how they solve their problems. But we must recognise, first, the heterogeneity and dynamic nature of such cultures. Second, a migrant is by definition negotiating between two or more cultures; we have no way of knowing, simply on the basis of a person’s country of origin, what mix of cultural notions underlies the way they experience their problems and seek help for them.

A further limitation of ethnopsychiatry and transcultural psychiatry is that these disciplines traditionally focus on patients and their illnesses, rather than analysing the (Western) service provider and the social position of the migrant in the host country. Bains (2005) describes how the British Transcultural Psychiatry Society redefined its primary aim in 1985 as ‘correcting the effects of racism’. In short, although the contributions of the transcultural approach are invaluable, it cannot claim to answer all the relevant questions about multicultural health care.

Priorities of service providers
In Britain and The Netherlands, it is only in the past few years that multicultural service provision has been made an official priority within the whole health care system. (In The Netherlands, as we shall see, this advance was short-lived.) Nevertheless, since the 1970s regional authorities and individual service providers in both countries have adopted such a priority from time to time, usually in response to the demographic characteristics of their catchment area. Examples are the setting-up of the Transcultural Psychiatry Unit in Bradford in 1979, the Maudsley Outreach Support and Treatment Team in 1989 and the North Birmingham Home Treatment Service in 1990 (Fernando, 2005). In The Netherlands, interpreter services were set up in 1975 and a National Bureau of Health Promotion for Foreigners in 1978. In the early 1980s the Riaag Rijnmond Noord-West in Rotterdam set up a special team which in 1996 became the Department of Transcultural Care.

Later in this article I will examine the attitude of governments to multicultural health policy. Most initiatives have not enjoyed the backing of specific policy directives from above; they have had to legitimate...
themselves by reference to other priorities. The Dutch medical anthropologist Rob van Dijk has used the expression ‘surfing the waves’ to describe the way in which change has been achieved by exploiting changing priorities within the health care system. The point of this metaphor is that surfers have no independent means of propulsion; they use the energy of the waves to drive themselves forward. I will now describe a few of the ‘waves’ that have been used in this way, as well as one – the drive towards standardisation – which has provided a powerful impediment.

**Health care priorities that have helped or hindered adaptation to diversity**

**Combating inequalities in health**

In The Netherlands, this was the banner under which the first efforts to promote multicultural health care were made. Towards the end of the 1970s – a turbulent decade in which all aspects of Dutch life became politicised – health care workers working with migrants in the major cities conducted advocacy for these groups, who were often burdened with physical and mental problems but had very poor access to appropriate care. The focus of these early efforts was mainly on improving access. The means favoured were information campaigns in migrants’ own languages, improved interpreting facilities and a more ‘culturally sensitive’ approach.

In this way, a broad and loosely organised movement arose, which from about 1990 onwards adopted the term ‘interculturalisation’ to describe its aims. From time to time its supporters succeeded in obtaining short-term project funding from local authorities or central government, but they received no backing from official government policy, which during this period was increasingly dominated by market models imported from the USA. These models focused on the autonomy of the individual ‘consumer’ of health care, rather than the rights of particular social groups such as women or migrants.

The influence of market models was also evident in British health care policy during the Thatcher years (1979–1997), and it has continued since New Labour came to power. Nevertheless, in its early years the Blair administration struck a new note by announcing an ambitious scheme to tackle health inequalities. This policy was operationalised in terms of regional differences, the chosen instrument being the HAZ or health action zone (Barnes et al., 2005). However, few actions within this programme targeted migrants and minority groups.

**Community care**

During the 1980s, discussions about health care in The Netherlands became less politicised and more preoccupied with internal issues of management and (re)organisation. Nevertheless, in both The Netherlands and Britain a policy change was implemented which had important social consequences: the setting-up of a system of ambulant mental health care, based on American-style, multidisciplinary community mental health care centres. Fifty-nine such centres (known as ‘Riaggs’) were set up in The Netherlands (van der Grinten, 1987) and more than twenty in Britain (Sayce et al., 1991).

The ‘community care’ movement provided another useful legitimisation for efforts to improve mental health care for ethnic minorities. The new services emphasised:

- **accessibility, multidisciplinary skills, and sensitivity to the needs of users and local communities** (Sayce et al., 1991).

In The Netherlands typical ‘interculturalisation’ activities, such as preventive and outreaching work with migrants, disseminating information in migrants’ own languages or making TV programmes for them explaining how the health care system works, fitted in perfectly with this agenda.

More recently in Britain, ‘community engagement’ has become the focus of the Government’s Race Equality Action Plan and other initiatives. This, however, is a different approach from that of the ‘community care’ movement, which I will discuss later.

**Needs-driven care**

This concept has been a vital source of legitimisation for multicultural health care. Often, the metaphor of ‘tailoring’ is used; the Dutch speak of ‘tailor-made care’ (zorg op maat), the British condemn the ‘one size fits all’ mentality. The roots of this notion are complex. For managers, it is a question of cost-efficiency; scarce resources should be directed to the activities for which the need is greatest. For
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care-givers, it is a question of effective help. All health care, and mental health care in particular, requires the active participation of clients, and if they are not convinced that the help given is relevant to their needs, they will tend to lose motivation and drop out of treatment. For this reason, much attention is paid in intercultural care to the ‘matching’ between the thinking of the professional and that of the client. Arthur Kleinman’s notion of ‘explanatory models’ (Kleinman, 1980) has inspired much research on this topic.

User involvement
This principle is closely related to ‘needs-driven’ care. User involvement can be regarded as important for a number of reasons. In the USA, a growing climate of mistrust between doctors and the general public, resulting in a ‘claims culture’ that exposes practitioners to enormous legal risks, has forced the medical profession to pay more attention to the wishes of clients. More generally, if one wishes to achieve ‘needs-driven care’, the simplest way of doing so is to involve the users themselves in the design and quality control process.

Such a ‘bottom-up’ approach can be operationalised in different ways. Sometime the ‘users’ will be patients or ex-patients, who may be organised as a lobby or interest group. The contribution of such groups is important, but of course they cannot speak for those who have not been reached by the care system. In general, the existing mechanisms for involving users in service delivery are biased towards vocal individuals who have the time and the skills required to use these platforms effectively. They are not an efficient way to consult minority communities about the needs of the group as a whole. The British ‘community engagement’ approach aims to overcome this problem by using a new type of NHS professional called ‘community development workers’ (CDWs) to bridge the gap between services and local communities.

Quality control, evidence-based good practices
These notions, introduced as part of the rationalisation of care services since the 1980s known as ‘managed care’, can be important weapons in the struggle for better multicultural services. However, they have one important limitation; as we saw earlier, research on migrant and minority users is beset by practical difficulties and tends to be systematically neglected. As a result, most of the ‘evidence’ on which ‘good practices’ are based is of doubtful relevance to these users.

Standardisation
Within ‘managed care’ there also exists a strong tendency that actually impedes the development of ‘needs-driven’ care. This is the ever-present drive towards standardisation and the use of uniform protocols for diagnosis and treatment. Unfortunately, standardised diagnostic instruments and treatments – by definition – only work well with ‘standard’ patients; they are unable to cope with diversity. The introduction of such measures has met with much resistance from professionals brought up on the notion that every client is unique. Nevertheless, the present Dutch Government, having scrapped the multicultural policies of its predecessor, had no hesitation in introducing standardised ‘diagnosis-treatment protocols’ as the basis on which the new health care system (introduced in 2006) is financed.

External factors
So far, this article has examined factors within the health care system which may promote or impede the development of multicultural health care. We now turn to the external factors that can influence this process.

Migrant and minority population
Perhaps the most important factor is the presence of substantial groups that have different needs in respect of health care. If the ethnic minority population is very small, or if its needs do not differ significantly from those of the majority, then there will be little incentive to pay special attention to its care.

Social climate
The political attitudes of the dominant majority also have to be sympathetic to the notion of paying special attention to the needs of migrants and minorities. For example, the US Census Bureau recorded that in 1850 the negro population of USA was 16%, whereas in 2000 this group (now called ‘Afro-American’) comprised only 12%. Because of the racist ideology which dominated in 1850, however, virtually no attention was paid to their health needs at that time.

Government policy
Linked to the social climate are official policy measures relating to immigration, the place of minorities in the
community and special health care provisions. Health care policy provides a link between ‘internal’ and ‘external’ factors, since it influences directly the priorities of service providers.

I will now examine these factors one by one, looking at a number of countries but paying particular attention to The Netherlands and Britain.

**Migrant and minority population**

One in four of the current population of Australia is foreign-born; the corresponding figures for Canada and the USA are 19% and 12% respectively. In these countries, multicultural health care has become securely established. In Australia it has been supported by the central government since 1995, while in Canada and the USA numerous state and federal initiatives guarantee attention to diversity.

Turning to Europe, Northern countries have experienced substantial immigration only in the last 50 years; the foreign-born percentage of the population is typically about 7–9%. In Southern, Eastern and Central Europe, migration is even more recent and small-scale. Accordingly, migrants and minorities in Europe have much less political ‘clout’ than in the traditional countries of immigration.

The proportion of immigrants in the UK population is slightly less than in Holland, but the patterns of immigration in both countries since 1950 are comparable. An important difference, however, is that in Britain – with its strong colonial past – the volume of immigration from the former colonies was sufficiently large in the 1950s and 1960s to make it unnecessary to recruit very large numbers of ‘guest workers’ from Southern Europe, Turkey and North Africa – as was done in Germany and The Netherlands. As the name implies, ‘guest workers’ were not expected to settle permanently, and they had few ties of language, education or religion with the host country. In Britain, the immigrant communities which were first established in this period are currently referred to as black and minority ethnic (BME) groups. These groups tend not to regard themselves as ‘migrants’, because the term suggests they are outsiders to mainstream British society. Asylum seekers and refugees are not categorised as BME groups.

Another important difference between minority groups in Britain and The Netherlands concerns their level of organisation. The multicultural policies adopted in The Netherlands at the beginning of the 1980s gave minorities little incentive to organise themselves as a political force. Indeed, some cynical observers talk of these groups being ‘smothered with subsidies’. In contrast, Britain in the same period was being subjected to Mrs Thatcher’s Reaganite economic policies, which imposed savage cuts in all areas of public spending. The large number of BME community and self-help organisations in the UK, including many concerned with health and social care, can be ascribed partly to the hardships of the Thatcher years.

Migrants and minorities in The Netherlands (who are referred to collectively as *allochtonen*) include a substantial core of former guest workers and their families, who experience more problems of integration than migrants from the former Dutch colonies. Because they are Muslims, hostility towards them has increased in the wake of ‘9/11’. Their political influence is weak – although in the local government elections in February 2006, they had for the first time a noticeable impact on the result.

**Social climate**

Traditional immigration countries, though they may harbour racist attitudes, cannot ignore the fact that practically the whole population is of migrant origin. European countries, however, have shown a stubborn reluctance even to acknowledge the existence of immigration, let alone accept it. Some five centuries of colonial history have reinforced European notions of superiority and anxieties about being ‘swamped’ or having their culture ‘diluted’ by foreign hordes.

When one examines Britain and The Netherlands in this respect, one is once again struck by the similarities. Both countries have a colonial tradition and a tendency to see themselves as representatives of a superior civilisation. At the same time, both have a tradition of tolerance and openness to diversity, reflected in a long history of immigration and experience as trading nations.

Britain can perhaps be described as a society in a state of permanent tension regarding immigration and cultural
diversity. On the one hand, attitudes to diversity - whether this takes the form of personal eccentricity or strange cultural practices - are traditionally quite tolerant; individualism is valued more than slavish conformism. Thanks to this, Britain has managed to absorb, over many centuries, an amazing variety of cultural and linguistic influences. On the other hand, xenophobic and racist attitudes are never far beneath the surface, as the contents of certain right-wing mass circulation newspapers confirm every day. Political parties with thinly disguised racist programmes are an ever-present threat to the established political system. Because of these potentially explosive contradictions, there is a strong legal framework of anti-racism legislation, backed up by frequent statements by public figures (from the Queen downwards) confirming Britain's commitment to diversity.

It is hard to summarise the situation in The Netherlands, because the country has undergone such a radical transformation in the last few years. From the 1970s, the country enjoyed a world-wide reputation for tolerance and progressive social attitudes, particularly in relation to sexuality, penal policy, drug use, social equality and global responsibility. For many observers it was the paradigm of an 'inclusive' social system. This concern for individual and group rights can be linked to the tradition of tolerance which has been a feature of Dutch society since the Middle Ages (Schuyt, 1997). From the end of the nineteenth century, the policy of 'pillarisation' (verzuiling) also guaranteed harmony in a pluralistic society and prevented the types of conflict which have plagued Northern Ireland. Concern for human rights was intensified by the ordeal of occupation by the Nazis, which gave the Dutch first-hand experience of life under a racist, authoritarian regime.

This climate of tolerance started to change when, in 2000, a bitter debate broke out in the Dutch media concerning the multicultural policies of the previous two decades. The year 2001 brought '9/11' and a wave of xenophobia and intolerance, particularly directed against Muslims. In 2002, shortly before the general election, the right-wing populist politician Pim Fortuyn - who, among other things, had called for a total halt to immigration - was assassinated. In November 2004, the murder of the controversial anti-Islamic writer and film-maker Theo van Gogh by a young Moroccan increased inter-ethnic tensions to an unprecedented degree.

**Government policy**

During the 1960s and 1970s, 'multicultural' policies were developed in immigration countries such as the USA, Canada and Australia. They represented a departure from the traditional monocultural, assimilationist policies that had asserted the right of the dominant cultural group to define the standards to which all citizens had to adhere. European countries, however, were slow to embrace this new philosophy. France and Germany both maintained, in different ways, assimilationist policies, though these have been modified over the years. Sweden adopted a multicultural policy as early as 1975 and The Netherlands in 1980. The retreat from multiculturalism which we have noted above in the case of The Netherlands is not an isolated case; it is an extreme example of a tendency that is visible in most European countries during the last decade.

Looking more closely at Britain and The Netherlands, we can observe that both countries have adopted restrictive policies on labour immigration since the 1970s, while accepting secondary migration (family reunion) and taking in relatively large numbers of asylum seekers (though Dutch asylum policy was made more restrictive in 2001, even before the new right-wing government came to power). Until recently, however, the attitude to ethnic minorities once they were inside the country was one of tolerance.

In The Netherlands, the increasing numbers of *allochtonen* and their socially disadvantaged position obliged the Government towards the end of the 1970s to adopt an explicit policy on diversity. There was particular concern about the marginalisation of Turkish and Moroccan labour migrants and their families, as well as migrants from Surinam and the Antilles. These groups were designated as 'ethnic minorities' and as such were entitled to extra resources to improve their education and housing. Stronger measures were also taken against discrimination.

The most radical innovation, however, concerned the principle of *pluralism* and the replacement of an assimilation policy by one based on integration. Cultural
diversity was accepted and even fostered, based on the notion that a strong sense of their own separate identity would actually help migrants to integrate, rather than handicapping them. This ‘multicultural’ policy was taken over largely from the traditional immigration countries. It was seen as a logical extension of the notion of ‘equal rights’, as well as being a natural policy for a tolerant and open society to adopt. The way it was implemented in The Netherlands bore strong resemblances to the policy of ‘pillarisation’ adopted earlier to contain religious differences.

However, the dramatic political changes just described swept this policy away. The right-wing coalition which took over in 2002 sacrificed many sacred cows of previous administrations, including the commitment to multiculturalism and the taboo on victimising and stigmatising minority groups. As Penninx (2006 p11) puts it:

_The tone of policy management is authoritarian and policies are more and more mandatory, laying the burden of integration unequally on the shoulders of immigrants… Such a policy polarises, sustains and increases the divide between natives and immigrants._

At the same time, the Dutch economy slid into a steadily deeper recession. Health and welfare budgets were cut back and the position of _allochtonen_ became disproportionately worse. Whereas enthusiasm for cultural diversity was once ‘politically correct’, for a politician to voice such sentiments at the present time is to commit political suicide.

British policy in relation to diversity has usually been formulated in terms of ‘combating racism’. At this point it is necessary to reflect on the special meaning that the terms ‘race’ and ‘racism’ have in the UK. There, as in the USA, ‘race’ is an everyday term for referring to ethnic groups. Moreover, all forms of discrimination against such groups are referred to as ‘racism’. This may have to do with the fact that the major ethnic groups are of ex-colonial origin (Kirmayer & Minas, 2000). In The Netherlands, by contrast, the countries which supplied the largest numbers of immigrants (Turkey and Morocco) had never been Dutch colonies. The very concept of ‘race’, with its overtones of Nazism, is anathema to Dutch people; racism is distinguished from religious and ethnic discrimination. Against this background, it is perhaps easier to understand why ‘race’ plays a much more important role in Britain than in The Netherlands. It is simply not the same concept.

The adoption of anti-racist policies in Britain reflects not only central government’s anxiety about violent conflict, but also the growing political power of the BME groups. Even the ultra-nationalist Mrs Thatcher courted these groups, in particular the Asian business community with its tradition of hard work and individual enterprise. The positive stance which the government of Tony Blair has adopted on multiculturalism since coming to power in 1997 also owes much to the political power of the BME groups. The Government’s stance on asylum seekers is curiously contradictory; it continues to admit them in large numbers, yet treats them in a way that regularly outrages human rights groups. For example, at the last count (NCADC, 2004) there were facilities for detaining no fewer than 2,644 asylum seekers, some of them families with young children. A possible explanation has to do with the virulent campaign against asylum-seekers conducted by a powerful section of the British press. If a few asylum-seekers are thrown to the wolves, the Government may reason, the other passengers in New Labour’s multicultural sledge can perhaps be kept safe.

What did the diversity policies adopted in Britain and The Netherlands have to say about health? The answer is: practically nothing. In fact, all countries which have adopted such policies have implemented them in the fields of education, the labour market, housing and equal rights legislation – but only much later in the field of health. This blind spot is also reflected in the academic discipline of migration studies, where health issues are curiously neglected. (This is hardly a coincidence, because it is often experts from this discipline who get commissioned to draft multicultural policies for governments.) In both Britain and The Netherlands, therefore, separate developments were necessary in order to get policy measures adopted on the health of migrants and minorities.
Health policy for migrants and minorities in the UK and The Netherlands

This section will zoom in on the factors responsible for the emergence of an official policy on migrant and minority health at the beginning of the 21st century in Britain and The Netherlands. It will consider only the ‘external’ factors, since the ‘internal’ ones are remarkably similar on both sides of the North Sea (Ingleby, 1998). As we shall see, the two countries are currently heading in dramatically different directions.

The Dutch story

As mentioned earlier, the first attempts to get migrant health on the agenda date from the late 1970s. During the preceding 20 years, many ‘guest workers’ had been recruited to work in the rapidly expanding Dutch economy. As in Germany, the expectation was that they would return to their home countries, but for a variety of reasons many of them – in particular Turks and Moroccans – did not. Government policy in this period was characterised by what Penninx (1996) calls ‘the illusion of temporariness’. According to official thinking, Holland was not an immigration country. Immigrants from the former colonies (rijksgenoten) were regarded as already half-Dutch, while the Moroccans and Turks were treated like party guests who had missed the bus home. Sooner or later, another bus would come to take them away.

In fact, the predicament of the guest workers was quite serious. No attention had ever been paid to their ability to survive in Dutch society; the policy applied to them was what Castles (1995) would term ‘differential exclusion’. Even today, many of the first generation do not speak Dutch. Most guest workers had minimal educational qualifications and the same applied to the family members whom they later brought to The Netherlands. After the oil crisis of 1972, unemployment began to rise, and this group was the hardest hit. Many had been disabled by the hard and stressful work which they had been recruited to do, and the attitude of many Dutch people was hostile or, at best, indifferent. In reality, this group had been the victim of a monumental policy failure on the part of the Dutch Government, but a process of ‘blaming the victim’ set in which ascribed the problems to the migrants. Instead of their disadvantaged social position, it was their culture and – in particular – their religion which stood in the way of their integration.

The efforts by professionals to mobilise special help for this group were the starting-point for what later became known as the ‘interculturalisation’ movement. Regular conferences and meetings were held, and interest in interculturalisation grew steadily. The movement embraced a wide range of views. For some, multicultural health care was simply a matter of delivering the existing product in a ‘culturally sensitive’ way; for others it presented a radical challenge to accepted notions about care systems, health and illness. Generally speaking, an ‘integrated’ approach was favoured above a ‘categorical’ one.

However, one group for which a categorical approach was initially adopted were the refugees and asylum-seekers. The peak of asylum applications in The Netherlands was reached in 1998 with 45,000 new applicants. Since the 1980s, the view had gained ground that the main problems afflicting refugees were the post-traumatic symptoms caused by their experiences in their country of origin. The refugee health centre Pharos was set up by the Government in 1993 to consolidate and expand the provisions already implemented for this group. In the 1990s, increasing attention was paid to other problems that refugees might have besides their traumatic symptoms, and in 2000 categorical services were almost entirely integrated within general health services (Ingleby, 2005). A useful spin-off from the integration of care for asylum-seekers and refugees has been that even health workers in remote parts of The Netherlands have become aware of the challenge of multicultural care.

The Dutch interculturalisation movement, whose roots go back to the 1970s, has always been dynamic, broad-based and multidisciplinary. It has had the advantage of operating in a small country where almost everyone is within easy reach of meetings and conferences. However, frustrations grew in the 1990s as its members realised that on a structural level, little was being achieved. There was no systematic programme of research and training; projects were funded on a short-term basis and fizzled out as soon as the money was spent. Too many initiatives depended for their existence on one enthusiastic individual, tolerated but not actively supported by management. The tone of discussions
became increasingly militant, leading to the publication of a manifesto (van Dijk et al., 2000) calling for a radical change in approach. Interculturalisation must become a co-ordinated process of structural change. Moreover, an expertise centre was necessary to act as a clearing-house for knowledge, skills and ideas.

In the same year, two highly critical reports by the Council for Public Health and Health Care (RVZ, 2000a, 2000b) highlighted the health problems of migrants and ethnic minorities, as well as the problems of accessibility and quality in service provision. In response to these pressures, the then Minister of Health (Els Borst, herself a doctor) announced the setting-up of a project group to work out a strategy for interculturalising health care. A four-year action plan for intercultural mental health was launched, to be supervised by the co-ordinating agency for mental health services (GGZ Nederland). At the same time an intercultural centre of mental health expertise (Mikado) was set up, with financing guaranteed until 2007.

With this, it seemed that 25 years of campaigning had achieved their goal. At long last, the Government had been persuaded to make interculturalisation an official priority. However, storm clouds were already on the horizon. The elections of May 2002 brought a right-wing government to power; public attitudes to migrants and ethnic minorities became increasingly hostile. Health and social services were subject to severe cuts.

Against this background, few were surprised when the new Minister of Health (Hans Hoogervorst, a banker by profession) announced that the Government saw no role for itself in the process of interculturalisation (Hoogervorst, 2003). If service providers felt it was a priority, they would have to undertake it on their own initiative. The main responsibility for the health of migrants and ethnic minorities was placed firmly on the shoulders of these groups themselves; they must learn to take better care of themselves and to use the existing services more effectively. The Government’s policy on integration stressed ‘inburgering’, the adaptation of the migrant to dominant Dutch norms. Though nobody dared to use the word, this is of course an ‘assimilation’ policy, because the essence of integration is that it is a two-way process of adaptation.

At the moment, therefore, the Dutch movement can be likened to an aircraft flying on one engine. There has been a noticeable decline in research on the health of allochttonen and the effects of the withdrawal of government support are visible in many areas of service provision. Only the ‘internal’ factors – the convictions of professionals themselves – have kept the process of interculturalisation in the air.

The British story

Developments in Britain have taken a completely different turn. Only recently, Suman Fernando (2005 p433) could write:

*Cultural psychiatry research and theory is now extensive, but as a body it is politically weak and has very little impact on training of professionals who by and large run the mainline mental health services in the UK… The picture in the UK at present is of a few interested and committed individuals struggling at the grass roots (usually in the voluntary sector) to bring into being services that are responsive to and appropriate for a multicultural society.*

At the moment, however, the NHS has embarked on an ambitious and wide-ranging programme to adapt health services to the needs of BME groups. The content of these changes is based on arguments provided by researchers and professionals, but the driving force is provided by recent anti-discrimination legislation, which has come into being – as so often the case in Britain – in response to events which caused public outrage. In fact, it would not be an exaggeration to say that two unlawful killings were necessary in order to bring about a British policy on multicultural health.

The first of these killings was the racist murder of Stephen Lawrence by five youths in 1993. The Metropolitan Police Service failed to track down and effectively prosecute his killers, and attempted to cover up this failure in an internal investigation. Public indignation led to the setting-up of the Macpherson Inquiry in 1999, which produced the following, now famous, definition of ‘institutional racism’ (chapter 6.34).
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… the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.

In response to this report, the Race Relations (Amendment) Act of 2000 was passed, which imposed a ‘general duty’ on all public authorities:

- to eliminate unlawful racial discrimination
- to promote equality of opportunity
- to promote good relations between persons of different racial groups.

In addition, an ‘employment duty’ required authorities to monitor by reference to racial group the numbers of staff in post and applicants for employment, training and promotion. Authorities were required to publish, by 30th November 2002, a race equality scheme. This document should summarise their approach to racial equality, set out arrangements made to meet the duties and include a detailed strategy and action plan with clear timescales. Progress must be monitored and reported on annually and the policy must be reviewed and updated every three years.

These far-reaching and radical measures had repercussions for almost every agency in the field of health. One of the earliest responses was the NHS programme Race for Health, which targeted 13 primary care trusts in England, working in partnership with local black and minority ethnic communities to improve health, modernise services, increase choice and create greater diversity within the NHS workforce. Another initiative was the appointment of race equality leads (RELS) within the 28 strategic health authorities (SHAs) that were set up in 2002 to improve health services in their local area.

A second death – that of David Bennett, a 38-year-old African-Caribbean patient, who died on 30 October 1998 in a medium secure psychiatric unit in Norwich after being restrained by staff for around 25 minutes – increased still further the pressure for action against ‘institutional racism’ in the NHS. The report of the independent inquiry into David Bennett’s death, published in December 2003, contained a long list of recommendations for improving service delivery. In the same year, the National Institute for Mental Health in England published a report on this topic (NIMH, 2003) and the Department of Health published a paper outlining a strategy for reform (DoH, 2003). This flurry of activity culminated in the launch in 2004 of the DoH’s ambitious race equality action plan, under which an equality and human rights director was appointed (Mr Surinder Sharma, then European diversity director for Ford Europe) and a wide-ranging programme of measures was initiated. This programme focused on improving services, combating health inequalities and recruiting more minority staff.

As part of this programme, the action plan Delivering Race Equality in Mental Health Care (DoH, 2005) was based on ‘three main building blocks’ (p12):

- development of appropriate, sensitive and responsive services
- engagement of BME communities with service providers
- good-quality, intelligently used information on the ethnic profile of local populations and of service users.

These goals were to be realised by an extensive programme of actions, involving 80 community engagement projects and 500 community development workers (CDWs). At present, this action plan is in full swing, and a conference was held in February 2006 to celebrate its first year and review progress to date.²

Conclusion

When we compare the Dutch Government’s action plan for mental health, set up in 2000, with the British plan set up a few years later, a number of interesting contrasts

1 Defined as ministers and central government departments, local authorities, regional development agencies and enterprise networks, police authorities, health authorities, health boards, NHS trusts and primary care trusts, education authorities, grant-aided and self-governing schools, colleges and universities, communities in Scotland, professional bodies, libraries, museums and galleries.

emerge. First, of course, the Dutch plan was scuppered - some would say, murdered in the cradle - by the government which took over in 2002. Some existing actions were allowed to run their course, but no new actions were undertaken. By contrast, the British plan is alive and well and set to run for many years.

There is also an obvious contrast in scale. The Dutch plan was modest, involving 34 rather small-scale projects, while the British plan has all the trappings of a typical New Labour project, involving massive financing, a deluge of new acronyms and a large, complex organisational structure. If the Dutch plan was a bicycle, the British one is more like an armour-plated Mercedes. The British plan placed a great deal of power in the hands of a small number of key players and was put together in a very short time. The Dutch plan, on the other hand, was based on 25 years of innovation, network-building and debate within a broad, multidisciplinary movement.

There are also interesting differences in content. The British plan places far more emphasis on ‘community engagement’, reflecting the substantially greater degree of self-organisation among minority communities in the country. In The Netherlands, with a few exceptions, it is difficult to know where such communities might be found, let alone who might represent them. Moreover, ‘user involvement’ does not rank highly among the priorities of Dutch service providers, whose ideal often seems to be one of ever-increasing professionalisation. Another difference concerns the place in the British policy of asylum-seekers, refugees and newcomers such as Roma from Eastern Europe; these are not regarded as BME groups and are only included by invitation, as it were, in the current plans.

Though it is too soon to evaluate the success of the British programme, one thing is clear; decisive government intervention is the sine qua non of getting consistent improvements in health care for migrants and minority groups off the ground. However important a ‘bottom-up’ approach may be (involving health care workers on the ‘shop floor’ as well as the users of services), ‘top-down’ interventions are essential as well. This is perhaps the most important lesson to be learnt from recent events in The Netherlands and Britain.

References


