'I think that Polish doctors are better': Experiences with and views of health services in Scotland among newly arrived migrant children and their parents

1. Introduction

The impact of migration on public services is a key issue which frames current debates on immigration (Spencer, 2011). Despite public speculation that migrants add pressure on services (Delanti *et al.*, 2011), there is very little systematic evidence in the UK on migrants' use of services in terms of services accessed, patterns of use and migrants' views of services available (Collis *et al.*, 2010). Data on migrants' health is scarce, mainly to do with the fact that migrants are not a homogenous group and immigration status is not recorded consistently when health services are provided.

The last two decades have also brought significant changes in migratory patterns to the UK, in terms of migrants' country of origin, reasons for migration and settlement patterns (Castles and Miller, 2009). The large scale migration from the 1950s to 1980s from the Carribean, Asia and Africa of labour migrants from the former British colonies has been replaced by people seeking political asylum due to political persecution and conflict in parts of Asia, Africa and Eastern Europe in the 1980s and 1990s. In the last decade, with the expansion of the European Union, migrants from Central and Eastern Europe, particularly Poland, have come to the UK in search of better employment opportunities. Recent population figures indicate that over 7.5 million people, or 12 per cent of the UK population, were born abroad (ONS, 2013), with the most common countries of birth being Poland, India and Pakistan. While some argue that this had led to pressure on the organisation of public services in local areas (Institute of Community Cohesion, 2007), others have raised concerns that the health of recently arrived migrants needs more attention, due to their low uptake of health care (Rolfe and Metcalf, 2009; Collis *et al.*, 2010) and the so-called 'health acculturation' (Ronellenfitsch and Razum, 2004), where migrants' health status deteriorates over time. Evidence suggests that Eastern European migrants, for example, generally engage with health services less regularly than the majority population (Spencer *et al.*, 2007; Collins *et al.*, 2010) and present an increased risk of somatic complaints and illnesses such as depression, anxiety and heart conditions (Robila, 2010).

Studies have also investigated the range of factors which impact on migrants' health and their service uptake after migration. A recent review (Heaman *et al.,* 2013) reported on the more prevalent rates of inadequate prenatal care among migrant women, and predictors of

this included being very young, single, with poor language skills and low education. Other studies have reported on the structural barriers to good health among migrants, including low income which lead to poor nutrition and living conditions (Spencer *et al*., 2007), isolation and lack of transport to access services (De Lima *et al*., 2007), inadequate information on services, often due to the language barrier (Collins *et al*., 2010; Migge and Gilmartin, 2011) or practitioners' lack of cultural sensitivity (Dias *et al*., 2012).

In order to provide a truly patient-centred service, it is critical for health care providers and policy makers in the receiving countries to understand how being recent migrant impacts on individuals' ability to engage in health-promoting activities. Migrants' cultural beliefs about the role of services will have a direct impact on individuals' readiness to engage in desirable health practices. However, very little research is based upon the perspectives of migrants themselves and few studies have involved families with children. This leaves migrant families voiceless in terms of experiences of health care, which limits their participation rights in improving public services and practitioners' ability to provide patient-centred care (IAPO, 2012). In the UK, policies such as the Children and Families Bill 2013 in England (Department of Education, 2013), and the Children and Young People (Scotland) Bill 2013 (Scottish Parliament, 2013), in line with the provisions of the Convention on the Rights of the Child (United Nations, 1989), emphasise the importance of giving children and families an active role in improving services and place responsibility on services to create opportunities for consultation. As ethnic minority groups are less represented in research (Nazroo, 2006), this study aimed to examine the lived experiences of migrant children and their parents post-migration, including their views of statutory health provision.

1.1 Theoretical framework: Social capital, ethnic ties and migrants' health

Our conceptual framework builds on concepts from two sets of literature: social capital and social network theory. Social capital, as developed more systematically by Coleman (1988), is seen as a resource which people derive from their social ties, within and outside the family, which 'makes possible the achievement of certain ends that in its absence would not be possible' (Coleman, 1988: S98). Eve (2010) sees migration as 'a special case of the development of social networks' (2010: 1236), as it shapes social ties and forces migrants to reorganise their relations depending on the needs they have post-migration, which are not always shared by locals. In the case of health, locals may be well familiarised with pathways of access to healthcare and cultural practices in terms of service providers' expectations and

rules of engagement, while migrants may need to learn how services operate in their new destination. Migrants often talk about the difficulties they encounter in accessing networks of locals and as a result, a tendency to form ties mostly with people from their own nationality group (Li, 2013; McGhee *et al.,* 2013). Other research highlights migrants' trust in ethnic ties, through shared language, cultural values and expectations of services and the creation of informal networks of support among diaspora groups (Son, 2013; Ryan, 2011). Anthias (2007) suggests that networks and ties need to be 'mobilisable for the pursuit of advantage, or the mitigation of disadvantage' (2008: 788) in order to translate into benefits for migrants. In other words, not all social networks constitute social capital, and many can become detrimental, as they occupy individuals and keep them into negatively functioning networks. This can lead, for example, to self-exclusion and distrust of health services through perpetuated myths or beliefs about alternative or 'better' health practices than those recommended by statutory services (Son, 2013).

In addition to social capital, other forms of capital, such as financial (i.e. income), human (i.e. education or skills) or cultural (i.e. knowledge and values) contribute significantly to individuals' health outcomes. One difficulty of researching multiculturalism is the homogenisation of minority groups on the assumption that a shared ethnicity or national identity means also shared health practices and beliefs. Evidence also suggests that the social determinants of health (Dahlgren and Whitehead, 1991), from individual characteristics (such as age, gender, constitution), to environmental conditions (such as education, housing, work) play a key role in explaining health outcomes. Within ethnic groups, there are clear distinctions between individuals and these distinctions also influence health practices post-migration. Neal and Vincent (2013) have explored the intersection between social class and ethnicity, showing the class separations in socially diverse urban localities and the polarisations within ethnic groups, with the emergence of more affluent ethnic minority middle classes. The characteristics of individuals' social class and neighbourhoods in which they live (Weishaar, 2010; McGhee et al., 2013) influence the opportunities they have to build advantageous social networks and their sense of engagement or alienation within the local area is key to health outcomes. Wilkinson and Pickett (2009), among others, have provided evidence on the effect of area poverty and social inequalities on health outcomes.

Despite the long-standing interest in social capital theory, concerns have been raised that we know relatively little about its relationship with individuals' well-being (Bassani, 2007), especially in relation to young people's health and well-being (Morrow, 1999). Children are

dependant on adults' financial capital, and parents' income post-migration will influence, for example, their access to good quality housing (Rolfe and Metcalf, 2009) or the type of neighbourhoods in which they live (McGhee *et al*., 2013). They are also strongly influenced by their families' human and cultural capitals, as ideas about health will be transmitted from adults to children (Coleman, 1998). Bassani (2007) emphasises the role of shared values among individuals for the creation of social capital. In the case of migrant families, their cultural values and knowledge will shape their beliefs about health and health practices. While some authors claim that unchanged dietary habits, health believes and practices in migrants may be indicative of an emotional attachment to their culture (Son, 2013), others have emphasised the socioeconomic factors which make positive health practices expensive and only affordable to the middle classes (Portes and Rumbault, 2001; Devine *et al*., 2004).

Migration poses a unique set of pressures on individuals' networks and the social fields which configure their opportunities to rely on others for support, including information on services, emotional or practical support (De Lima *et al*., 2007; Rolfe and Metcalf, 2009). The value of migrants' social networks has been explored mainly in relation to social mobility (Migge and Gilmartin, 2011; Ryan, 2011) and less in relation to migrants' health. The significant changes to individuals' networks after migration, place them in often contradictory socio-cultural contexts (Thomas, 2010). While they may be under pressure to engage in new networks and comply with expectations of health behaviours customary in their new country, their intra-ethnic ties may encourage them to retain health practices from their homeland. Research has shown that migrants' ties tend to be dynamic, changing in time and moving from mainly 'bonding networks' (inter-ethnic) immediately after migration to more 'bridging networks' (intra-ethnic) later on (Ryan, 2011). However, while adults have more agency in choosing the types of networks and ties which influence them, children's choices are more constrained (Morrow, 1999). Young people from different social backgrounds are often separated in schools and communities through their own patterns of identification and disidentification (Reay, 2007) and also through social stratifications by neighbourhoods segregated mainly on the basis of affluence and social class (Neal and Vincent, 2013). Therefore, in examining families' attitudes to health services in Scotland and their health-related behaviours, we need to consider individuals' flexibility in making their own decisions in relation to health behaviours and opportunities that local areas offer young people to access available resources through the mobilisation of useful social ties (Anthias, 2007).

The significance of migrants' social capital and networks needs also to be seen through a transnational perspective (Glinos et al., 2010; Thomas, 2010). In this paper, we adopt Vertovec's (2009) definition of migrant transnationalism as 'a broad category referring to a range of practices and institutions linking migrants, people and organisations in their homelands and elsewhere in a diaspora' (2009:13). As migrants navigate various networks, we are interested in examining how practices around health and healthcare are shaped by their ongoing engagement with people and services in various fields, including through ties maintained with family members and services in the homeland. The strength of transnational family and friendship ties has been shown to weaken over time and especially young people have been shown to acculturate more quickly than their parents and, more willingly, adopt health practices from their new country (Chuang and Moreno, 2011). This process is however not free from tension, as young people can suffer from psychological distress caused by the need to negotiate the differences between the two cultures and the potentially conflicting values they are exposed to at home and in the community. Transnational ties are therefore significant to exploring migrants' health beliefs and practices, especially in the context of affordable travel, which allows Eastern European migrants frequent direct contact with their homeland and families left behind. In this study, by taking into account families' social networks, we aim to account for both individuals' agency and their constraints in terms of social and relational structures and examine migrants' social networks across social fields, including transnationally.

2   Research questions

The study on which this paper is based looked at the experiences of children of Eastern European migrant workers arrived in Scotland, focussing on the impact of being a new migrant on children's family and peer relationships, factors affecting children's integration and their experiences of accessing services (Sime and Fox, 2014 a,b). Informed by the concepts of social capital and social networks, the collection of the data on migrant families' experiences of health and their health practices was guided by two main questions: *What are Eastern European migrant children's and their parents' views and experiences of health service provision in Scotland?* and *What are the main barriers encountered by them when engaging with health services and how do migrants overcome these?*

By producing evidence to answer the above questions, we were interested in informing policy and practice on how services can better support the integration of newly arrived migrants and bring into alignment patient self-defined and professionally defined needs.

3 Methods

3.1 *Sample and data collection*

Empirical data collection took place between May 2008 - June 2010 across a range of urban, semi-urban and rural locations in Scotland and started with 19 interviews with service providers, from education, health and the voluntary sector. We then used service providers as 'gatekeepers' to recruit newly arrived Eastern European children for focus groups. Children were informed of the study through translated leaflets, which outlined their expected participation and they signed a consent form. Focus groups have been shown to work well with children (Hennesy and Heary, 2005), as they allow them to stimulate each other's ideas, and also allow the researcher to assess the extent to which the group share beliefs and experiences. In total, 57 children took part in focus groups, of which 48 were Polish, the main migratory group to the UK since 2004. They were of both genders (31 girls and 26 boys), between 7 and 16 years of age and from a range of socio-economic backgrounds. The focus groups were conducted either in children's own language (for Polish and Romanian), or with interpreters present for other groups. Children were encouraged to discuss the experiences of a 'typical migrant family', a technique which we developed in order to reduce the pressure of sharing personal stories, but still drawing on their knowledge and beliefs about migrants' lives. We also used images of services children were likely to access and hands-on activities, to enrol children's enthusiasm and engagement (Christensen and James, 2000).

Following on from the focus groups, 23 in-depth family case studies were completed across several locations in Scotland, including 29 children (6 pairs of siblings were involved) and at least one parent in each family. The case studies included a majority of Polish children (n=13), most recruited through the focus groups. The other cases involved 5 Lithuanian, 4 Slovaks, 2 Bulgarian and 2 Romanian children, as well as 1 Hungarian, 1 Russian and 1 Czech family. In total, 15 girls and 14 boys were involved in case studies, with an average age of 11 (age range was 8-16 years old). Each family was visited at least twice and interviews were conducted in children's own language (Polish, Romanian), and in English or with an interpreter for the other nationalities, depending on families' preference. Children were invited to keep a diary of their activities or take photographs and these were used as prompts for interviews. Thomson (2008) has outlined the advantages of doing visual research with children, as it allows them to take some control of the research process and influence its impact.

3.1 Data analysis

In recent years, qualitative research with children has gained more recognition in the health arena (Sandelowski, 2004). There is increased focus on how quality can be ensured when working with qualitative sets of data (Tracy, 2010), mainly by implementing rigour and transparency of the approach used (Flick, 2007). All interviews, focus groups and case study visits were tape recorded with the participants' consent, translated into English when necessary, transcribed and analysed using a grid analysis approach and thematic coding (Boyatzis, 1988). An overview thematic grid was produced to map out the descriptive summaries of the issues emerging, which led to a range of common key themes to develop across the data set. Relevant sections of the data from transcripts were then assigned appropriate thematic codes and refined sub-categories emerged and were allocated to text in the transcripts. An NVivo 7 package was used to facilitate the process of organising and classifying the data and two researchers coded every transcript for increased reliability.

4   Results

The results are presented under three main themes, as emerging from the data analysis. The first discusses migrant families' experiences of health care and their views of service provision available. The second part looks at the main barriers to health service use; the third reports on the factors that motivate migrants' transnational use of health services. We conclude with a discussion on the implications of the research findings for the provision of health care for migrant families with children and health policy, especially in relation to Eastern European groups.

4.1 Migrant children's experiences and views of service provision in Scotland

As mentioned above, there is some evidence to suggest that migrants make more use of acute health care services and lower consumption of routine health care. In our study, although the majority of the families said that they were registered with a doctor or dentist, there were some who did not register, and mentioned A&E as their route to treatment in case of an emergency.

> "We haven't been here long, so we didn't register yet with a doctor, but mum said we can go to the hospital in case of anything. But we are usually quite healthy." (Marta, Polish, 12)

"Janek: I don't have a doctor.

Interviewer: You don't have a doctor? You are not registered anywhere?

Janek: No, I only have a dentist." (Janek, 12, Polish)

"I've heard it's quite hard to get an appointment, but I've not been yet." (Zsolt, 13, Hungarian)

When we asked children to talk about their views of the health service in the UK, many commented that the health services were 'fine', and the comparison with services in their homeland took into account aspects such as access, practitioners' perceived levels of competence and quality:

"Zuzanna (12): Maybe the dentist and medication for kids is free here, so that's better. But maybe in Poland you get to see better doctors, not only GPs.

Esther (13): I think that Polish doctors are better.

Dzulieta (14): I think that it is the same here and there.

Wioleta (14): They have better equipment here." (Polish focus group)

Children also commented on different approaches to treatment, including approaches to management of chronic illnesses and doctors' reluctance to prescribe antibiotics and the apparent reliance on mild painkillers:

"I had some treatment from Poland for my condition, but then they [doctor in Scotland] said leave that, and gave me something else." (Olga, 13, Slovakian)

"My mum had a sore throat, so in Poland they usually gave you antibiotics, but here the doctor ask her to gargle with water and salt." (Klaudia, 13, Polish)

"I was very sick last year, and they only gave me paracetamol, although I was ill for two months. It was something with my throat, I couldn't speak. I was in the hospital and they just give me that." (Agnieska, 15, Polish)

Comparisons with provision in the homeland country were often made by parents and children, although there was no consensus on which aspects of the healthcare were 'better' in the UK or their country of origin:

"Well, in Bulgaria it's organised better, because you can get access to a specialist quicker – almost the next day. The bad thing in Bulgaria is that there is a big mixture

between things you pay for. And here [in the UK] you don't pay for things, but it's difficult to get an appointment, and you wait a long time." (Ana, Bulgarian mother)

"My mum's friend had had appendicitis, and they took her immediately [to the hospital]. I think that in this case it is much better here, all the medical equipment is much better than in Poland and they are quick in an emergency." (Martha, 12, Polish)

Young participants in our study commented on the perception that healthcare workers were more child-centred in their approach and that, in general, they felt included in the conversations about their treatment, something they experienced less of in their homeland:

"I feel they talk to you more here [in the UK] and they ask you what you want, [they do] not just [ask] your mother." (Ana, 13, Bulgarian)

"I went to the dentist in Poland, and he didn't say anything, he just put like a big needle or something in my mouth, and I was scared to go to dentist again. Here, they tell you what they are going to do, I like it more." (Agatha, 14, Polish)

4.2 Barriers to service use

While families appeared relatively content with the accessibility and availability of health services in their area, they highlighted underlying barriers that often prevented them from accessing health services as often as they would like or at all. Many talked about uncertainty over their families' entitlement to health care and treatment, differences in provision and approaches to treatment which made them untrusting of the system and the language barrier, which often made treatment confusing and visits to health practitioners stressful. Other studies (Glinos *et al*., 2010; Miggee and Gilmartin, 2011) have highlighted how migrants' feelings of unease about local care provision due to perceived social, cultural, religious and linguistic differences prompt people to seek care through familiar social networks, such as providers from their country of origin.

Lack of adequate information

Participants were aware that being a newcomer may not always imply direct access to health services, although health services in the UK appear 'free' at point of use. However, children from the so-called A2 countries (Romania and Bulgaria), which had limited rights in terms of access to the employment market and welfare at the time of the study, commented that their families were hesitant when having to access healthcare:

"I don't think we have the right [to register with a GP]. My mum says we just have to not get ill (laughs)." (Mihaela, 14, Romanian)

In some of the families, who arrived in the UK illegally or overstayed the terms of their visa, having to provide documentary evidence of residence was enough to put them off from accessing health care, due to fear of deportation. Maria, a Romanian Roma pregnant woman, explained how she was not accessing any health care for herself or her children:

"They [the health practitioners] can call immigration, 'cause we shouldn't really be here [in the UK]. So I just keep well and I hope at hospital they don't ask anything. And the kids are fine, not ill, although the boy has a bit of a breathing problem." (Maria, Romanian mother)

When we asked children if they accessed other healthcare services available in the community, such as specialist or well-being clinics, pharmacies, or spaces for leisure which could help promote better health, we identified their overall limited knowledge about services available locally. In many cases, families needed time to access 'insider information' in the neighbourhood, highlighting their position as outsiders and their limited social networks to access information. Children were often in the position of translating leaflets for their parents and finding out about services available locally, thus becoming health care brokers for their families:

"When you don't understand, it's hard to know [what is available], like my mum when the nurses were visiting her, she said that she doesn't understand and they try to translate it, point it out until she will understand. Or if I am home, then I do it for her, tell her what they said, read the paperwork for her." (Klaudia, 13, Polish).

Often, access to health services was mediated by schools, who were sending home information, bringing interpreters in to explain to parents what other services were available locally or actively mediating access for the families:

"When my wee one got sick, quite seriously, it was at school, he had a very high fever; I couldn't get him registered at the surgery and only the intervention of his teacher helped." (Ana, Polish mother)

Differences in provision

Previous experiences of the health system in the homeland were often linked to perceived differences in provision, in terms of how the system was accessed, expectations about service access and perceptions of the medical staff. Practitioners commented on how differences between national health systems impacted on migrants' expectations and engagement with the service in the UK:

> "The thing with Eastern Europeans- their perception of illness and health is different and what they want from us. Sometimes, they see their doctor in Poland and come to us for a second opinion, so there is a clash of cultures." (GP, Rural area)

Practitioners commented on 'unrealistic expectations' of migrants, mapped on homeland provision, which often might have involved a more immediate access to health practitioners or access to specialists:

> "Culturally, back home they will just go wait for the GP, and they will just sit until they are seen, and that doesn't go well here, when we say, come back next week, with an appointment." (Regional Health Manager, Urban Area)

> "Sometimes, they come and say 'I want a referral to the allergy specialist' or whatever, and it just isn't clinically indicated, well not here [in the UK]." (GP, Urban area)

These differences in provision led to disappointment among migrants, who often complained about the waiting time for appointments, restricted access to specialists and approaches to treatment. The experiences of how the health service was delivered in their homeland also led some families to adopt more informal approaches towards solving a health problem. It was sometimes seen as more natural to receive help through informal networks than to turn to the professional sector. One of the mothers explained how she disregarded the advice from the medical practitioner and got help from a friend:

> "My son got an allergy after swimming, so I went to emergency. The doctor looked at photos on the internet and then she prescribed a cream. When I read it was for scabies, I called my friend, because her son had a similar problem, and I borrowed from her the cream that she got in Poland and that helped." (Dagmara, Polish mother)

This may be one explanation as to why public care is used less by migrants. Networks, like family, relatives and neighbours, available in the UK or transnationally, can be used as resources when routine health care problems are to be solved. Some parents, often with a better understanding of the system which they developed over time, also talked about the importance of learning how the system 'worked' and adapting to ensure they got the service they wanted:

> "In time, I learnt that you should go and really insist on something. You go back, maybe ask to see another GP, then ask for a referral." (Ana, Bulgarian mother)

The language barrier

Language was a key barrier to migrants' access to health services. Families' limited competence in English affected their ability to get information on services, their experience of interacting with medical practitioners and also their ability to follow treatment instructions. On several occasions, families felt more reassured when they had medical tests in their homeland or got in touch with health practitioners back home, to confirm the diagnosis given in the UK. The language and the familiarity with the system were the main reasons given for this:

> "When my sister was sick, they [Scottish doctors] didn't want to give us the, erm, antibiotic and we phoned the doctor in Poland she said that my sister needs an antibiotic." (Sylvia, 16, Polish).

> "Sometimes, when we go to Poland for a holiday, then we get checked and then my aunt is a doctor, so she can explain things better and also do tests, like blood tests, which they don't do here that much." (Lydia, 11, Polish)

In a few cases, parents talked about the lack of clarity of prescriptions and how, by not having sophisticated language skills in English, they would be confused about the treatment:

> "I got home once and I wasn't sure if she [the doctor] said four times a spoon or one time a day, but four spoons. They probably said, but with the interpreter there and my baby crying, I didn't remember." (Joanna, Slovak mother)

4.3 Transnational use of health services

An important aspect of the practices identified among the participants in the study was the transnational use of health services. Low cost flights and established patient/doctor relationships in migrants' homeland meant that many families maintained registration with

family doctors and dentists in their homeland, while also registering with practices in the UK. Often, families' reasons for transnational service use were linked to their uncertainty about their long-term settlement in the UK and the possibility of an eventual return:

> "My mum said we might go back, so we keep the doctor there, just in case." (Bartek, 12, Polish)

> "My Polish friends always go to Poland to see the dentist. People just do, maybe because they think they'll eventually go back." (Magda, Polish mother)

In other cases, accessing services back in the homeland was linked to the perceived structural barriers to how services were organized in the UK. Ana explained how her visiting the doctor in Bulgaria was mainly motivated by the trust in her consultant status and the length of waiting time to see a consultant in Scotland:

> "Ana: Well, here, you wait like months to get to a doctor…which is annoying… boring… you know you have an appointment, but it's so far away that you forget about it and just live your life and by the time your appointment comes, you are ok.
>
> Interviewer: So your eye is fine now?
>
> Ana: Yeah, but we went to see the Bulgarian doctor, the one that operated on me. And she said it's ok if we wait and see how it goes, because it might get worse if they operate again. And I trust her more, I feel safer with her." (Ana, 13, Bulgarian)

Long waiting lists or limited access to specialists were mentioned on several occasions by parents who took their families back to their homeland to see specialists:

> "The GP here gave us a referral for Marta for an X-ray, but the nurse in the hospital was shocked, because she said you can't do an X-ray of a child's head, so we went to Poland and we did it." (Aneta, Polish Mother)

> "I mean I tried to make a dentist appointment and they'd told me that there were 300 people before me. I'd have to wait 4 months or pay about 200 pounds. So we decided to go to Poland and get everything done there. With the flights and everything, it cost about the same, but it was quick and we saw our family, too." (Malgorzata, Polish mother)

The increased available financial capital of some migrants meant also that they would return to their homeland able to pay for private healthcare, seen as a marker of status, but also as a perceived guarantee of better care. One of the mothers explained how she accessed private care in her homeland and facilitating this for her parents, too:

> "You'll go and say, I want to see a dermatologist, and they'll say, fine, it's £10, come tomorrow. And you know they are the best doctors, because only the best get to work in the private clinics. So I take my children and my parents, too, something we couldn't do before." (Irina, Romanian mother)

For families who were healthy, travelling home for summer or religious holidays was often seen as an opportunity to check in with family doctors, dentists or just stock up on medications they thought they might need in the future, and which they could not readily get in Scotland. They relied thus on formal and informal networks that were familiar and trusted:

> "Well, you can't buy antibiotics in Scotland, but you can in Romania, so my mum always buys stuff when we go back." (Maria, Romanian, 10)

5   Discussion

This study addresses a gap in knowledge on newly arrived migrant children and their parents' experiences of accessing health care provision post-migration. In so doing, we applied a social capital and social networks framework to examine the key aspects of migrants' engagement with health services. Their narratives confirmed the complex characteristics of migrants' engagement with the health provision systems post-migration. Although, overall, families were aware of differences in provision between Scotland and their homeland, they seemed to lack full knowledge of entitlements to treatment and of community-based facilities available to them. This finding is consistent with other evidence (Collins *et al.*, 2011; Migee and Gilmartin, 2011) and suggests that health care provision for new minority ethnic groups may fail to entirely meet their needs.

While cultural differences might exist in how the health service is structured and delivered, migrant families' limited inter-ethnic social networks in their destination country impacts on their access to information and is likely to initially make them untrusting of services. Many participants emphasised the differences in processes in terms of getting appointments, administrating treatment and accessing specialists. The role of GPs as 'gatekeepers' to specialists and the reliance on mild painkillers was sometimes seen as a cost-cutting measure and a sign of inefficiency. These perceptions had an impact on subsequent

decisions to seek health care. Participants reported that they sometimes gave up seeing a doctor after waiting for too long or resorted to informal or transnational access to care (see also Migee and Gilmartin, 2011). These views of the health care available and expectations, often mapped on prior experiences of health care, must be considered by healthcare professionals when working with migrant groups.

However, migrants' overall experiences with the health care system were not entirely negative; the more child-centred approach of the health care practitioners made children, for example, very satisfied. We did not ask participants to talk about their self-perceived level of health after migration, but some said that they had prior conditions diagnosed post-migration or they received better treatment for existing conditions. Other authors (Shi and Stevens, 2005) have mentioned that migrants overall may have low expectation of services because of their minority status, however, in our study, expectations were usually high. This means that although migrants might have limited local ties, their resourcefulness and previous experiences of health care, as well as the easy access to transnational networks, may mean that they maintain high expectations and are constantly negotiating access to health provision through a range of networks.

Several factors can explain variation in migrants' service use and attitudes to the health services, including families' cultural and social capital before migration, cultural distance, length of residence in the new country, socioeconomic position and adaptation in the new society. These are important factors when considering migrant families' transnational use of services across Europe and the 'health tourism' to their homeland, either timed to coincide with family holidays for non-urgent matters, such as checkups with dentists or family doctors, or organised at short notice, for situations seen as more urgent. Although we did not explore in-depth families' decision making processes in relation to transnational use of health care, certain factors were clearly important in these processes. With recent advances in affordable transportation and communication, not only is there greater availability of health products and services at European level, but migrants have more available income and choice in accessing these. The families in our study were obviously using the health care available in their homeland and their destination country, depending on which health care system was perceived as more likely to best meet their needs.

The migrant families brought with them certain beliefs about what makes a 'good' health service and continuously made comparisons with the health care in their homeland, and these

comparisons were also evident in children's accounts. The access to health care through a range of routes, including transnational, indicates the active role that migrants adopt in making decisions about their health service utilization, and that they are not passive receivers of services available. Especially when it came to children's health, migrant mothers evaluated and weighed carefully the decisions made by health care providers in the UK and often sought confirmation from doctors in their homeland or reassurance from family members with medical knowledge or members of their diaspora community, highlighting the key role of informal networks in the adoption of certain health behaviours. On other occasions, migrants showed less concern and proactive attitudes than the health care system in the UK would have expected.

In this context, young people from newly arrived migrant groups are at a crossroads of influences in terms of healthy behaviours they should adopt, attitudes about health service utilization and levels of trust in health practitioners. While their parents might value more the health care system they are familiar with and they understand better, children will be expected to engage in different health promoting behaviours by their schools and peers and will develop their own experience as users of the health care system. This has direct practice implications for family health practitioners working with new migrants, who should be mindful of the multiple influences which impact on migrant children's expectations and health beliefs and engage them in conversations to dispel any myths in order to achieve a genuine patient-centred care. As young people develop their understanding of how health care operates in their new country, it is likely that their perceptions and beliefs change, and they may become brokers of information on services for their families.

There is no question that differences between the health systems across countries, the language barrier, different cultural practices around health and illness and a certain element of distrust towards the effectiveness of care are all factors which can discourage migrants from making effective use of the UK health services. These may lead many migrants to view health care in transnational terms as a better and 'safer' approach, rather than rely on local provision, and occasionally, lead to undesirable health practices or outcomes. Glinos *et al.* (2010) have identified two dimensions which affect patients' transnational mobility, namely patient motivation and funding. Patient motivation includes reasons for seeking health care, such as availability of care, affordability, familiarity and perceived quality. For practitioners and policy makers, gaining a full understanding of migrants' use of health services and the motivations behind these choices, as well as a view of migrants as active agents in seeking

health care in a more mobile Europe, are keys to overcoming the structural and cultural barriers which may limit migrants' engagement with services.

6 Study strengths and limitations

This is, to our knowledge, one of the few qualitative studies undertaken within the UK exploring new migrants' views of health services, including those of children. By engaging young people in a meaningful way in the research, and by combining evidence from parents and children, the project enabled the research to provide evidence which can help practitioners understand the specific needs of newly arrived migrants, who may experience specific barriers to engagement. Although we felt that data saturation was reached in this cohort of people, it is possible that other newly arrived migrants may have different experiences of health services in Scotland or across the UK, given also differences in attitudes to migration across the UK and approaches to health service delivery. Our participants revealed the strategies they used to negotiate access to better health care and mitigate the negative impact of migration on their social ties and resources within their new communities. Further exploration of different nationalities and different groups of migrants (for example, by comparing EU and non-EU citizens) and across countries within the UK and setting would be helpful to encompass a wider range of experiences.

7 Implications for policy and practice

Barriers put in place by governments to restrict access to public services for certain migrant groups, together with some migrants' low socio-economic status, serve to compound disadvantage and contribute structurally and institutionally to difficulties faced by certain migrants in generating better social capital for themselves (Jayaweera, 2010). In our study, evidence suggests that contrary to public speculation of 'health tourism' to abuse the NHS system in the UK, migrants were more likely to distrust provision or be uncertain of entitlements and rely instead on transnational access to health care or informal networks of support. This suggests that policies which emphasise restrictions on provision of healthcare to migrants, combined with a generally negative portrayal of migrants in public debates, may result in migrants' uncertainty over entitlements and resistance to engage with services. For better off migrants, barriers to engaging with services may result from factors such as different expectations of health care and cultural beliefs which may make them reject expected health practices (Thomas, 2010). Political, social and economic forces will thus shape the conditions under which individual and community characteristics influence

people's health. In this context, migration can be seen as an additional layer to those already identified by existing models of social determinants of health. This requires health policies which ensure provision which is not implicitly discriminatory or inaccessible to migrants.

The findings also revealed complex and varied attitudes and approaches to engaging with services, which were often more sophisticated than the service providers might expect. This suggests that migrants' needs and beliefs in relation to what health services should provide and how they should operate need full consideration in order to inform healthcare policy and practitioners' behaviours when engaging with newly migrated patients. It is clear that culture-based expectations about the rules of engagement with the service need to be made more explicit, in order to engage migrants in health promoting behaviours and gain their trust. In some cases, beliefs about appropriate treatment were clearly not supported by recent evidence on best practice, yet parents chose the options which were familiar to them through previous experiences, even if this involved considerable effort, such as travelling abroad or having medicines sent to them by family members. Practitioners need to review what prevents children and their families living in their catchment area from making efficient use of the full range of health services available locally. This may also mean that practitioners need specialist training in order to address newly arrived migrants' gaps in knowledge and the cultural differences around expectations and health practices.

Healthcare providers must be sensitive and alert to the personal factors which affect migrant children and their families' decisions to engage with the healthcare provision available and work with them to tailor provision whenever possible. The task of accommodating the needs of an increasingly diverse population continues to pose a significant challenge for health services in all European countries. There is some evidence that health services in the UK might consider migrants as a homogenous group and not take into account their diverse needs, socio-economic backgrounds, experiences and attitudes to engagement with health services. In relation to migrant families, health policy needs to be developed to avoid a discriminatory system in relation to newly arrived migrants. At practice level, practitioners need to strive to make migrants' engagement with services a positive experience and take their past experiences and views into account when considering improvements in delivery. For research, a fuller, further interrogation of the nature of migrants' experiences and practices around health and their expectations of health care post-migration is needed.

Key highlights

- Being a migrant impacts on individuals' health and attitudes to health services.

- Experiences of health services pre-migration are a strong influence on migrants' expectations.

- Barriers to service use include differences between health systems, language barriers, and limited information.

- Transnational use of health services is a feature of family life for many European migrants.

- Practitioners need specialist training in working with new migrant groups.

Acknowledgments

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