

COMMENTARY

Immigration, Health Status, and Use of Primary Care Services

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The subject of the use of health services by the growing immigrant population coming from lower income countries to higher income ones is complex, and generally controversial. Contrary to what is believed, it is generally equal to or less than that of the population of the countries that accept them,^{1,2} in countries without universal health insurance (as in the United States), as well as those countries with universal health insurance (as in Spain).²

There are different reasons to explain this fact. An analysis carried out in the United States showed that, as was expected, due to lack of insurance cover and the generally low socioeconomic level of the immigrant population, the economic barriers, including the lack of insurance cover, was a significant factor, but also the lower average age and the relatively better state of health (found even after adjusting for age and only if the person was seen by a doctor) of the immigrant population played a role.¹ Even in countries with universal health systems, administrative problems can keep part of the immigrant population without insurance cover.³

As regards the state of health of immigrant populations from low income countries, the possible differences work in opposite directions. On the one hand, in these countries there are less health resources and diseases uncommon in developed countries are endemic.³ But, on the other hand, emigration brings a selection of people in a good state of health,¹ given that they do emigrate to work and earn money,⁴ which involves journeys with more risks than a healthy person is more likely to take.

Once in the receiver country, their socioeconomic level is usually low, and their working conditions, housing, etc, tend to be less favourable than that of the autochthonous population, factors which tend to worsen their level of health.^{1,4,5} However, immigrant populations often have more healthy life habits than the autochthonous population. For example, a recent study carried out in our country has demonstrated that tobacco and alcohol consumption of immigrants is less than the autochthonous population.²

As regards the use of health services, apart from economic barriers, it varies widely according to country. Different factors limit this, such as language difficulties,^{4,5} fear of losing income or an unfavourable impression in their work situation for the work time lost for medical reasons⁵ and, and in the case of immigrants in irregular situations, the fear that their situation may be discovered by the authorities⁴.

In this issue of *ATENCIÓN PRIMARIA*, an interesting study that compares the use of health resources by immigrants from low income countries with that made by the autochthonous population, in both cases restricted to a population who have contacted the health services on at least one occasion. The possibility of having made 3 or more visits is higher among immigrants, but less for nursing visits. Immigrants generally require a greater number of complementary tests.

As possible factors associated with these differences it should be mentioned, as the authors have considered, that

Key Points

- The frequency of use of primary care services by immigrants is less than that of the autochthonous population.
- This lower frequency seems to be partly due their better state of health and partly to having a higher threshold in seeking medical care.
- It would be interesting to know the importance of the better state of health and the higher threshold in seeking health care to better design improvements in care for immigrant groups.
- The better state of health appears to be due to the fact that the immigrant population is relatively young and have some comparatively healthy life habits.

perhaps immigrants, when they go to a clinic, do so due to more serious problems, which would explain the higher number of clinic visits as well as the higher use of complementary tests.

In agreement with these findings, in another study carried out in our country² a higher rate of hospitalisations was observed in the immigrant population, which, however required less drugs and did not have a higher use of other health resources. Other authors from different countries, such as the United States, have also reported the tendency of many immigrants not to seek medical treatment except in cases of acute illness.⁴

Likewise, the higher birth-rate for a given age in the immigrant group, probably magnified due to the larger number of women of reproductive age (the mean age of the immigrant population was 30 years compared to 45 years in the autochthonous population in the study commented on here), would explain the higher use of gynaecology services. This fact has also been observed by other authors. Thus, in a study carried out in the county of Los Angeles, in the United States,¹ the rate of hospitalisations associated with pregnancy in illegal immigrants was double that of the autochthonous population.

On the other hand, the lower use of nursing clinics could be due to ignorance or to a higher proportion of visits due to acute problems in a younger population.

Language barriers, although they are often mentioned,^{4,5} do not appear to be a quantitatively significant factor in the results of the present study, since the Latin American pop-

ulation had similar patterns to the rest of the immigrant population.

The results must lead to future research based on total population, not on population seen, to clarify if the higher number of visits and the use of complementary tests in the immigrant population is really due to a higher threshold to seek medical attention or due to other factors. By confirming the significance of the lower tendency to go to clinics in a questionnaire type study, would enable the reasons to be clarified.

Exact knowledge is needed on these differences and the factors which cause them, in order that health care planning can be improved for a significant part of the population.

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