MIND THE GAP

HOW CAN HEALTH CARE PROFESSIONALS ALLEVIATE THE EFFECT OF POVERTY-RELATED HEALTH DISPARITIES IN NIJMEGEN, THE NETHERLANDS?

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# Preface

## Who are we?

Our group consists of the following seven Radboud University Bachelor students: Ann-Sophie (Business Communication), Ellen (Artificial Intelligence), Kristina (Psychology), Lisanne (Public Administration), Nadina (Psychology), Romano (Law), and Stefan (Law and Economics). Besides our regular studies, we are following the one-year extracurricular interdisciplinary course “Health Disparities” that is offered within the Honours Academy track “Global Problems”.

## The course we followed

Starting off in September 2018, we took part in a series of lectures on the topic of health disparities. These lectures provided us with many interesting insights on topics such as socioeconomic backgrounds and how these affect health outcomes. Since February 2019, we are engaged in a think tank that focuses on the consequences living in poor financial circumstances has on one’s health. In this context, we were asked to organize a symposium to provide information about the topic. In addition, we are developing an educational module for health care professionals on how to alleviate health disparities related to poverty as our end product.
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When taking a look at your friends, family and others; when looking around within your city, province or country: What becomes clear is the fact that health is quite variable. This is true for individuals but also across different population groups. Not only between countries but even within a country there are significant health differences between subgroups of the population. For instance, a report on health inequalities from the UK showed that people with mild learning disabilities have earlier mortality rates than the general population (Naaldenberg et al, 2015).

The differences in health outcome can be linked to many factors. Crucial factors are demographics such as age, sex or other genetic factors as well as behaviour and lifestyle, e.g. whether people smoke, are physically active and how their diet looks like, and the conditions in which people are born, grow, live, work and age with specific focus on e.g. social networks, socioeconomic status and environmental conditions. These factors are collectively called the social determinants of health (Ule & Kamin, 2012). The diversity of health outcomes is called health disparities and health inequalities.

Amongst the groups that are most likely to suffer from health disparities are people with migration backgrounds, people from low socioeconomic status and people with low education (Satcher, 2013). Research has shown that the single strongest social determinant of health is poverty. Thus, people who live below the poverty line suffer the highest risk of experiencing inequalities in health (Olden & White, 2005).

Numerous studies have been done on the topic of health disparities with regards to poverty, showing the effects of socioeconomic status on life expectancy, mental health and chronic disease (Adler et al., 1994; Winkleby, Jatulis, Frank & Fortmann, 1992). Moreover, several papers have been written by researchers with suggestions to help with health disparities regarding poverty (Cheng, Johnson, & Goodman, 2016). Therefore, ways of improvement have been addressed already. However, most of these solutions are idealistic of nature and are often not feasible due to numerous reasons. Furthermore, literature lacks advice for tailored problem-solving in the Netherlands. One should keep in mind that even a good welfare system such as in the Netherlands has its flaws that might nurture health-related disadvantages for people living in poverty. Therefore, the goal of this paper is to provide information on how health care professionals can
alleviate health disparities regarding poverty in Nijmegen, the Netherlands. The focus on information regarding Nijmegen aims to promote a concrete and feasible realization of the project. Based on the research that was done, the paper presents practical implementations that general practitioners could use in their daily practice to combat health disparities.

Our research was conducted in three parts. We started with literature research to detect the effects that social determinants regarding poverty have on one’s health outcomes. Secondly, we conducted interviews with general practitioners to learn about the severity of health disparities in Nijmegen. We were specifically interested in how practitioners tackle health disparities at this point and what is still missing. Lastly, we interviewed patients with a low socioeconomic status to further expose sources and points of improvement regarding health disparities in Nijmegen. Combined this lead to the eventual advice we provide for practitioners in the conclusion.

The design of the paper is as follows: Chapter 2 is concerned with discussing the relevant literature. The methods chosen to conduct our research are explained in chapter 3. In chapter 4 the outcomes of the research are discussed and finally, chapter 5 concludes the research. In the appendix one can find a recommended implementation of the given outcomes of the research.
2. **THEORY**

The relationship between poverty and health disparities is the subject of many research papers (Lipina & Colombo, 2009; Isaacs, 2016). This chapter provides an overview of the relevant literature on the topic. First, the possible health outcomes of having a low socioeconomic status are discussed, followed by the effects of stereotypes and biases in health care on medical treatment. Lastly, we draw the focus on the specific case of Nijmegen.

### 2.1 POVERTY-RELATED HEALTH DISPARITIES

The impact of poverty on health starts already prenatally. When the mother experiences stress, has a poor diet or lacks good sleep this greatly influences the foetus. The situation of living in a poor financial situation can cause these factors. Children from low socioeconomic status (SES) families are at greater risk to be born prematurely, have a low birth weight and encounter prenatal complications which increase the risk for adult chronic diseases (Fiscella, 2010). Living in poverty is also associated with developing depression. Moreover, studies have found that people from low SES tend to smoke more, exercise less, and have a generally less healthy lifestyle relative to groups with higher income (Freeman, 2004). Additionally, people who live below the poverty line are often subject to social exclusion and have fewer opportunities to develop cognitively and socially (Boon & Farnsworth, 2011). For example, children from poorer neighbourhoods have less access to sports, education, and extracurricular activities which would help them work on important skills and improve their self-esteem. An additional pathway through which poverty has an unfavourable effect on the individual is its aggravating effect on problems within the family. Money issues are a constant source of stress, which is related to alcohol abuse and conflicts (Ferrarelli, 2016). The findings of various papers have been summarized in the flowchart on the following page. It illustrates some of the many ways in which low socioeconomic status influences health outcomes.
Figure 1: Flowchart Effect Socio-economic Status on health outcomes

2.2 STEREOTYPES AND BIASES IN HEALTH CARE

Another important implication of poverty is that people from low SES can become subjects of stereotyping and biases. Therefore, we will elaborate on that topic in the following section. Many people have to deal with the negative effects of stereotypes and biases on a daily basis, be it in the working place, school or on the street. Unfortunately, these are not the only places where biases and stereotypes influence the way people are treated. Various research has shown that stereotypes and biases often also affect the medical treatment of a patient (Chapman, Kaatz, & Carnes, 2013; Green et al., 2007).
However, most of the time health care professionals intend to treat patients equally. Why is it then that patients still experience differences in treatment? According to Chapman, cultural stereotypes and biases unconsciously influence the decision-making in many cases. Thus, even if health care professionals try to treat every patient the same way, stereotypes and biases influence treatment unintentionally. This kind of bias is called implicit bias. It might be the most harmful type of bias since health care professionals themselves are not aware that they act biased while they risk letting this bias influence their diagnoses and treatment. Thus, “implicit bias may contribute to health care disparities by shaping physician behaviour and producing differences in medical treatment along the lines of race, ethnicity, gender or other characteristics” (Chapman, Kaatz, & Carnes, 2013). The effects of implicit bias on a patient’s treatment might be promoted by “uncertainty and time pressure surrounding the diagnostic process”, as the health care professional might tend to fall back on stereotypes for efficient decision making (Chapman, Kaatz, & Carnes, 2013).

Studies

A study conducted by Green et al. (2007) used an implicit association task to show pro-White bias in practitioners that did not report being explicitly biased. Many researchers commented that showing that physicians are biased does not show that this bias also affects the treatment of a patient. However, various research shows a correlation between patient care and physician bias. For example, a study showed that physicians pro-White bias correlated with Black patients’ perception of poorer communication and lower quality treatment (Chapman, Kaatz, & Carnes, 2013). The higher the practitioner scored on the implicit bias test, the worse the Black patient perceived the treatment. Another study showed that Hispanic patients were seven times less likely to receive painkillers in the emergency room than Non-Hispanic patients with similar injuries (Chapman, Kaatz, & Carnes, 2013). These findings were duplicated for dark-skinned patients. Taken together, the findings prove that implicit bias affects a patient's medical treatment. It is important to note that implicit bias is not only directed towards race but can also be directed towards other characteristics such as age, weight and gender.
WHAT CAN PRACTITIONERS DO?

Although awareness is important it is not sufficient to reduce the automatic, habitual activation of stereotypes and the subsequent impact of implicit bias in medical decision-making (Chapman, Kaatz, & Carnes, 2013). According to Chapman, one strategy that seems to be effective in reducing implicit bias is *individuating*. “Individuating involves conscious effort to focus on specific information about an individual, making it more salient in decision making than that person’s social category information” (Chapman, Kaatz, & Carnes, 2013).

Another effective strategy is *perspective-taking*. Research has shown that active attempts to take a patient’s perspective lead to reduced disparities, for example in pain treatment (Chapman, Kaatz, & Carnes, 2013).

*Individuating* and *perspective-taking* seem to be the most promising and accessible strategies to reduce implicit bias in health care. Unfortunately, most general practitioners do not seem to be aware that their decision-making might be implicitly biased, or they do not know about the two strategies mentioned. Thus, there is a clear need to inform GPs about the topic.

2.3 HEALTH DISPARITIES IN THE NETHERLANDS

When contrasting the health disparity statistics in Nijmegen to the Netherlands at large, there are clearly several aspects of health disparities that are significantly poorer in Nijmegen compared to the national average. The following provides a brief overview of some these aspects.

The percentage of children under 18 in families living from social assistance benefit is higher in Nijmegen (10.08%) compared to the whole of the country (6.58%). Related to this, households with social assistance benefit is 7.5% and therefore higher than the national 5.4%.

Concerning physical health, obesity is a problem in both city and country, 38.9% of adults in Nijmegen being overweight and 48.9% nationally. Enough exercise, a vital component of physical health, is also an aspect where improvement is needed. Only 63% of Dutch adults meet the recommended amount of exercise and only 65.8% of the citizens in Nijmegen. On the positive side, use of general practitioner care is relatively high both in Nijmegen 79.0 % and in the
Netherlands with 78.4% which highlights the importance of GPs as crucial contact persons to alleviate health disparities.

Regarding education, literacy scores, that is people in Nijmegen that are classified as low literate, lies between 8 to 11%. Early school leavers, students who drop out of education without basic qualifications, is 2.3% (1.9% across the Netherlands). Youth assistance usage is 9.9% in Nijmegen, the national figure being 10.4%. Loneliness scores are varying throughout the country, Nijmegen being 43.2% and the Netherlands being 42.9%. Finally, pregnancy counselling per 100 births is quite high on both levels (83.3 in Nijmegen, 84.5 in the Netherlands).

In conclusion, the aforementioned numbers provide the statistical backbone for the relevance of studying and combating health disparities in the Netherlands, particularly in Nijmegen.

3. Methods

At the beginning of our research, we decided to get an overview of the information that is available and to get to know what is still missing by exploring the literature that was already available. In addition, we used the summaries of the expert lectures that we attended in the first semester of our programme. We organized the information in several mind maps and discussed the overlaps. We concluded that the relationship between health disparities and poverty is complex as there are multiple factors which work simultaneously to produce intertwined effects. Moreover, there are also many viewpoints on the topic, so that looking at the issue from various angles was considered an important next step. At the end of the literature research, we were still missing personal experiences of health-related problems with regards to poverty. Also, concrete suggestions on how health care professionals could alleviate these problems were lacking. Therefore, we decided to take a bottom-up approach to our research. We conducted interviews with both people living in low socioeconomic conditions and health care professionals. For the latter, we decided to concentrate on general practitioners, as these are the first contact persons for health issues in the Netherlands. In order to standardize our data collection as much as possible, we created one interview protocol for each of our groups - GPs and people from low SES. We included mostly open questions, as our main goal was to hear the personal experiences of both parties. When possible, we recorded the interviews and transcribed them afterwards in order to create a coherent story with our most important findings.
4. THE PRACTITIONERS’ SIDE

To further research the topic of health disparities in Nijmegen we have interviewed several doctors from different specialization backgrounds, some operating as general practitioners and others who worked in refugee camps or developing countries. We asked about their experiences with health disparities in their practice and about their ideas to combat the problems regarding it. This section summarizes the main findings of our interviews with health care professionals in the municipality of Nijmegen.

Most of the practitioners see between 15 and 25 patients per day and generally work with patients from many different parts of society. In their practice, they see patients with a migration background, people with a low SES but also patients from non-vulnerable groups. When talking to them about health disparities, most of them are familiar with the topic. However, they do not fully know how to deal with it, particularly given the time constraint of approximately ten minutes per consultation. As it seems that there is a clear divide between the problems caused by poverty and by migration backgrounds, these topics will be discussed separately below.

PROBLEMS REGARDING POVERTY

A major problem that we have noticed during our interviews is that practitioners cannot do a lot themselves against the problems regarding poverty. This is not because they lack the will or the resources but because they cannot treat the underlying cause of the symptoms. As shown in the introduction, many health problems can result from low socioeconomic status. For example, problems such as cardiovascular problems, lung problems and various other chronic diseases are linked to low income. Therefore, practitioners can help with tackling the symptoms and the health problems that arise due to living in poverty, although they cannot help people get out of their financial situation. Practitioners, therefore, call for a network of relevant organizations that can help patients with their financial situation and educate them on financial management and related issues such as coping with stress caused by living in poor circumstances. This could provide a long-lasting solution to the health disparities that arise due to poverty.
PROBLEMS REGARDING MIGRATION BACKGROUND

People with a migrant background might experience similar problems as the previously mentioned group as many of them do also live in low socioeconomic circumstances. However, there is one problem almost exclusive to people with a migration background: The language barrier. Unfortunately, many migrants have a poor command of Dutch and they do not have sufficient knowledge of English either. This is why practitioners who work with people from a migration background experience a lot of problems with communicating with the patients. Problems arise because the patients cannot clearly describe the health problems they are experiencing, and the practitioners cannot properly help them with their problem nor can he or she sufficiently explain the solutions to the patient. A possible solution to this problem would be to invite a translator into their practice. However, this would cost time and resources.

As mentioned earlier, practitioners call for a network of social workers, translators and organizations specialized in dealing with poverty to make the most of the 10-15 minutes given per patient. Having such a network makes referring patients to helpful instances easier. These individuals or organizations could provide education on self-care and financial management.
5. THE PATIENTS’ SIDE

During our research, we interviewed several patients living in poverty in Nijmegen about their experiences with the general practitioner. In this section, the main remarks and points of improvement from the patient’s side are discussed.

TIME AND FINANCES

The first point that was mentioned by almost every respondent is the lack of time. This is a structural problem that was mentioned by patients and GPs concurrently. Many patients told us that they tend to make double appointments but still wish they could have more time with their GP. Especially when there is a language barrier, patients might feel they do not know enough about their condition when leaving the practice. Patients acknowledge that this lack of time might be due to a lack of finances in the health care sector. This lack of finances also plays a significant role in referrals to specialists and tests as part of physical examination (see point ‘referrals and early treatment’).

‘WHAT CAN I DO FOR YOU?’

A frustrating aspect that many patients encounter when visiting the GP is the first question they are asked by him/her: ‘what can I do for you today?’. Patients can experience this question as irritating and unwanted since they do not know themselves what the GP can do for them. One patient told us: ‘The GP asks me ‘what would you like me to do?’, but I have no clue what can be done, it’s not my job’. The respondents think that it is obvious that they want the GP to tell them what to do, not the other way around. Otherwise, they would not be visiting the GP. Patients would rather have the GP ask them about the problem they are having, not the possible solutions.

REFERRALS AND EARLY TREATMENT

Many patients told us that they would like to experience a more active approach from their GP. Some interviewees have the feeling that their GP is too reserved when it comes to scans, tests and other medical examination. An example of this is that patients are irritated by the fact that their GP keeps prescribing to take paracetamol for many complaints and illnesses. They feel that the GP does this for too long, instead of looking ahead and examining if there is a more serious cause
for their pain. Especially patients with a migrant background are frustrated by this approach, mainly because they are used to a different approach in their country of origin. They would like more regular check-ups and the GP telling them about their health status. This is also linked to the frustration about the ‘What can I do for you?’ question.

**COMMUNICATION AND BONDING**

The communication between GP and patient is one that can be very vulnerable. On the one hand, patients that have the feeling that their GP is truly interested in getting to know them are more satisfied with their GP and more likely to trust their treatment. On the other hand, some patients mentioned that they find it inappropriate for a GP to ask personal questions when there is no prior bond or personal interest. Even though they seem to disagree on this point, all interviewed patients agreed that it is most important to them to be taken seriously by their GP.

Another point of improvement which was mentioned very often is the role of the computer during a consult. Many patients experience that the GP is looking more at their screen than at them. Patients want to have their diagnosis based on a physical examination, not from the computer screen. Patients seem to trust a diagnosis more when the GP examined their body rather than looking at a screen. Furthermore, they have the impression that the time the GP is taking to type is reducing the already short time they have for the consultation.

**EDUCATION**

Other patients also showed interest in having more conversation about their personal lifestyle. They believe some problems could have been prevented if they knew about their habits being the cause of their health issues earlier. It may seem obvious for many GPs that, for example, eating vegetables every day is good for your health whereas eating fries all day is not. However, some patients might not know these things and would like to have more education about topics like nutrition, exercise, sleep and so forth. One patient told us during an interview that her stomach issues got worse after her GP told her to eat more vegetables. The reason for this turned out to be that she always fried her vegetables, but did not know this was bad. GPs could help by giving advice to the patient during the consultation, or by referring the patient to organizations and people that can help them.
PREJUDICES AND CULTURE RELATED PROBLEMS

Patients with a migrant background living in poverty seem to experience more problems during their GP visits compared to native Dutch patients. Some encounter prejudices and stereotyping (see chapter 2.2). Although it is important to be aware of the patient’s background, there is also a danger in giving the patients background too much weight. Again, what is most important is that the patient feels taken seriously. Patients with a migrant background mentioned they feel taken less seriously due to their origin. Some patients feel that GPs have prejudices against them based on their background, habits and knowledge and, thus, do not take their complaints seriously. One woman told us in an interview that she felt she had to exaggerate her problems for her GP to take her seriously. In another interview with a GP, the GP told us that he felt patients with a certain background (including the background of the interviewed patient mentioned above) exaggerate their problems and therefore take them a little less seriously. This example shows this problem has two sides. For some patients, the language barrier is a problem as well. Patients who are not on the same level of speech as their GP need more time to receive and process the information. This can have consequences such as that they miss out on important information during the visit.

OWN RESPONSIBILITY AND SHAME

GPs can do more to help people in poverty overcome their problems and send them in the right direction. They can also change the views of their patients and help them tackle their issues and handle situations responsibly. Yet, people in poverty are responsible for their own well-being, too. While most people are aware of this, a big issue that is stopping them from taking action is shame. This was reflected by the small number of respondents that were willing to take part in an interview. Patients should be encouraged to take their problems to the GP and they should not feel ashamed of it. It is important that they feel safe and secure at the GP. The more they share about their circumstances, the more the GP is able to help. However, a strategy many interviewees make use of already is searching for self-help via the internet. One thing that could be improved is the access to such information in easy language. Some patients told they would like to look up minor complaints online but, unfortunately, are not literate enough to understand everything.
6. CONCLUSION AND RECOMMENDATION

Alarming differences regarding mental and physical health between subgroups of the population might certainly depend on social factors such as one’s socioeconomic status. People living in poverty might thus find themselves in unfavourable positions that lead to, amongst others, a higher prevalence of chronic diseases. We have made it our task to investigate this problem by linking existing literature to own interviews we conducted with affected individuals and health care providers in the city of Nijmegen. By doing so, unique insights were extracted.

An overarching problem within the health care system that was repeatedly mentioned by our interviewees was the lack of time during consultations. Unfortunately, this is a factor that cannot be changed that easily in the scope of our project. That is why we focused on factors that can be changed by health care providers or clients in this regard.

On the side of the patients, points of improvement were made regarding the way general practitioners approached them during consultations. Our interviewees called for a more proactive attitude of the GP when it comes to the testing of medical conditions. They also ask the GPs to be more open and less prejudiced when listening to their patients’ stories and to adapt to their individual needs. Moreover, a welcoming attitude of GPs could help to diminish the shame of patients when the need to talk about personal problems such as living in poverty. In addition, patients themselves are asked to take steps to overcome their shame and seek out for help whenever they need it. In sum, this paragraph provides a summary of practical suggestions that interviewees on the side of the patients made in order to alleviate health disparities in the primary health care sector.

The main conclusion derived from the interviews with general practitioners is the fact that GPs see themselves unable to tackle the underlying cause of health disparities. Therefore, they call for some sort of network that includes other professionals and organisations which they can use to refer their patients to with needs outside of the GP’s own field of competence. This is why we included such a list to the appendix of the present paper.
7. **Solution Website**

In accordance with the foregoing, we came up with the idea of a website to translate the knowledge we gathered via literature search and the interviews into a concise and accessible source of information directed on health care professionals in the city of Nijmegen.

**Our End Project**

By creating a website with useful information on health disparities with regards to poverty, we aim to implement an educational module in an easily accessible and long-lasting manner. We plan to upload coherent inferences from literature search and interviews as well as practical content such as a list of contact details focused on the help of people living in poverty. Included as an appendix to this report, you can find the content of the website that we worked out up until this moment visualized in a way in which it could be implemented on a website. In terms of implementation, we considered the option to include our ideas of a website to the already existing website of the Thijmgenootschap or Pharos. In this way, maintenance of the website could be ensured, and visitors of both websites could benefit from a more exhaustive collection of information.

**Why a Website?**

By choosing a digital tool we ensure that our educational module is easily accessible to all parties. If GPs want to read more about the problem of Health Disparities, or if they need a relevant contact for their patient, this information would be just a click away. This would be the first website which simultaneously serves as a general educational tool for health disparities, tackles specific problems in the area of Nijmegen, and is based on both a top-down and a bottom-up approach. In addition, our section of ‘Points of contact’, specifically requested by the majority of the interviewed general practitioners, provides a unique list of the most important individuals and institutions that a patient could be referred to.

**The Network**

Two-third of the general practitioners we interviewed complained about the lack of information regarding the referral of patients. They would like to know about individuals and organisations that could help their patients with issues such as financial management or living a healthy lifestyle. By including this section on our website, we aim to eliminate this lack of information. The
appendix contains a not limitative list with contact details of care providers for patients with a low socioeconomic status in Nijmegen.
8. Appendix

The front page: From here you will be able to navigate the website to all its different parts.

Bias and stereotypes: Here you can find the information gathered from our literature research.

Implicit bias and stereotypes in healthcare

Many people have to deal with the negative effects of stereotypes and biases on a daily basis, be it in the working place, school or on the street. Unfortunately, these are not the only places where biases and stereotypes influence the way people are treated. Various research has shown that stereotypes and biases often also affect the medical treatment of a patient [Chapman][Green]. However, the main problem is not that physicians willingly treat their patients unequally, but that cultural biases and stereotypes influence decision-making unconsciously.

So what can physicians do against acting biased?

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<td>02</td>
<td>Perspective-taking</td>
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The Patient’s side: This page will display all the information gathered from our interviews with patients.

The Patient’s Side

During the research, interviews were held with different patients living in poverty. They shared their experiences at the general practitioner (GP) and created an insight in what can be done to improve GP visits for the patient’s side. The main remarks are collected and brought together in 7 points of improvement.

1. Time and finances
2. “What can I do for you?”
3. Referrals and early treatment
4. Communication and bonding
5. Education
6. Prejudices and culture related problems
7. Own responsibility and shame

3. Referrals and early treatment
Patients like a more active approach from their GP. They would like more physical examination, regular check-ups and earlier referrals to specialists.

4. Communication and bonding
The most important for patients to establish trust in their GP is to feel taken seriously. A GP should not spend more time looking at their computer screen than at the patient.

5. Education
Many visits to the GP can be prevented by educating patients about their lifestyle, habits and care. This can be done by the GP or via referrals.

6. Prejudices and culture related problems
Patients with a migrant background encounter stereotyping and feel taken less seriously and prejudiced. Also language is a big obstacle for some.

1. Time and finances
Lack of time is a structural problem for both patients and GPs, especially with a language barrier.

2. “What can I do for you?”
This innocent first question that is often being asked by the GP during a visit is experienced by many patients as frustrating and unwanted. They want the GP to tell them what they can do.

7. Own responsibility and shame
Shame is stopping many patients from taking action in changing their situation. They should be encouraged to share more, so the GP can help more.
The Practitioners side: This page will display all the information gathered from our interviews with GPs.

During the research, interviews were held with different general practitioners from Nijmegen. They shared their experiences with health disparities in their practice and proposed possible solutions to alleviate health disparities regarding. The main findings are collected and brought together in 4 points of improvement.

1. Time
   Lack of time is a structural problem for practitioners, especially with people from a low-SES or migration background.

2. Language barriers
   When working with patients from different backgrounds, practitioners experience many different problems with making themselves understood and understanding the patient.

3. Referrals
   Many practitioners lack the contacts to refer their patients to the proper organizations that can help them with their financial situation.

4. Treating the symptoms
   Many practitioners can only do so much with health disparities regarding poverty, because they will never be able to resolve the underlying financial situation that has caused the physical or mental problems.

Providing solutions
Practitioners call for a network of social workers, poverty-related organizations and translators to help make as much of their 10 minutes with a patient
Facts and figures: This page will display facts and figures regarding health disparities in Nijmegen compared to the Netherlands. It is an interactive map where you can click your city to get all the relevant information.
When you click on the flag, all facts of Nijmegen will show up. By clicking on the entire map, described facts of the Netherlands will appear. Hence the text serves as a direct comparison between figures, whereas, the designed version shall show figures separately. Readers must not only focus on comparisons but also on the size of the number itself and therefore build an opinion about the seriousness of the number.
Contact list of organizations that are active in Nijmegen (not limitative)

<table>
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<th>Organization</th>
<th>Region(s)</th>
<th>Specialisms</th>
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<tr>
<td>VGGZ Nijmegen</td>
<td>Nijmegen</td>
<td>Child- and youth mental care</td>
<td><a href="http://www.vrijgevestigdejeugdggznijmegen.nl">www.vrijgevestigdejeugdggznijmegen.nl</a></td>
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<tr>
<td>Psyzorg Nijmegen</td>
<td>Nijmegen and surroundings</td>
<td>Mental care</td>
<td><a href="http://www.psyzorgnijmegen.nl">www.psyzorgnijmegen.nl</a></td>
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<tr>
<td>Sterker sociaal werk</td>
<td>Berg en Dal, Beuningen, Druten, Nijmegen, West Maas en Waal, Lingewaard, and Overbetuwe</td>
<td>Social care</td>
<td><a href="http://www.sterker.nl">www.sterker.nl</a></td>
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<tr>
<td>Huis van Compassie Nijmegen</td>
<td>Nijmegen</td>
<td>Social activities for people with a vulnerable background</td>
<td><a href="http://www.huisvancompassienijmegen.nl">www.huisvancompassienijmegen.nl</a></td>
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<tr>
<td>Pharos</td>
<td>Netherlands</td>
<td>Support on local approaches to health disparities, Prevention and Care for Chronic diseases, Safe and responsible use of medicines among people with poor (health) literacy and migrants, Youth Health Programme, Participation and patient self-determination, Female genital mutilation, Asylum seekers and refugees, Health for the Elderly, torture victims in asylum procedures in European countries</td>
<td><a href="http://www.pharos.nl">www.pharos.nl</a></td>
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<tr>
<td>Hoofdpijnpoli (CWZ Nijmegen)</td>
<td>Nijmegen</td>
<td>Headache treatment</td>
<td>Postbus 9015 6500 GS Nijmegen</td>
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Phone numbers:
- 088 00 11 333
- 024 322 8480
- 024 365 82 10
- 030 234 9800
- 020 137 14 00
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<th>Organization</th>
<th>Region</th>
<th>Specialism</th>
<th>Website</th>
<th>Address</th>
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<th>Email Address</th>
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<tr>
<td><strong>Huisarts-migrant.nl</strong></td>
<td>Netherlands</td>
<td>Information for health care professionals about health care for migrants, refugees, and patients with limited health skills</td>
<td>huisarts-migrant.nl</td>
<td></td>
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<tr>
<td><strong>Municipality of Nijmegen</strong></td>
<td>Nijmegen</td>
<td>advice and help about daily life and age, social care, health insurance, etc.</td>
<td><a href="http://www.nijmegen.nl">www.nijmegen.nl</a></td>
<td>Stadswinkel, Mariënburch 30</td>
<td>14 024</td>
<td><a href="mailto:gemeente@nijmegen.nl">gemeente@nijmegen.nl</a></td>
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<td><strong>Voedselbank Nijmegen</strong></td>
<td>Nijmegen</td>
<td>food for people living in poverty</td>
<td><a href="http://www.voedselbanknijmegen.nl">www.voedselbanknijmegen.nl</a></td>
<td>Winkelsteegsweeg 144 B, 6534 AR Nijmegen</td>
<td>06 221 34 130</td>
<td><a href="mailto:info@voedselbanknijmegen.nl">info@voedselbanknijmegen.nl</a></td>
</tr>
<tr>
<td><strong>Stichting Quiet Nijmegen</strong></td>
<td>Nijmegen</td>
<td>social services for people living in poverty</td>
<td>quiet.nl</td>
<td>Bronsgeeststraat 21, 6541 ZJ Nijmegen</td>
<td>06-18884600</td>
<td><a href="mailto:nijmegen@quiet.nl">nijmegen@quiet.nl</a></td>
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<td><strong>Kledingbank Nijmegen</strong></td>
<td>Nijmegen</td>
<td>clothing for people living in poverty</td>
<td><a href="http://www.kledingbanknijmegen.nl">www.kledingbanknijmegen.nl</a></td>
<td>Winkelsteegsweeg 144 6534 AR Nijmegen</td>
<td>0655865668</td>
<td><a href="mailto:info@kledingbanknijmegen.nl">info@kledingbanknijmegen.nl</a></td>
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<tr>
<td><strong>Vrijwilligersorganisatie Vincentius Nijmegen</strong></td>
<td>Nijmegen</td>
<td>healthy food, sports, and other social activities for people living in poverty</td>
<td><a href="http://www.vincentiusnijmegen.nl">www.vincentiusnijmegen.nl</a></td>
<td>Horstacker 1451 6546 EK Nijmegen</td>
<td></td>
<td><a href="mailto:info@vincentiusnijmegen.nl">info@vincentiusnijmegen.nl</a></td>
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<tr>
<td><strong>Stichting Leergeld Nijmegen</strong></td>
<td>Nijmegen</td>
<td>facilitating social activities for kids living in poverty</td>
<td><a href="http://www.leergeldnijmegen.nl">www.leergeldnijmegen.nl</a></td>
<td>Postbus 1111, 6501 BC Nijmegen</td>
<td>024 323 76 44</td>
<td><a href="mailto:info@leergeldnijmegen.nl">info@leergeldnijmegen.nl</a></td>
</tr>
</tbody>
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9. **REFERENCES**


