Culture specific health care organizations (CSHCOs)

An explorative research on the position of CSHCOs in Dutch regular health care sector

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Preface

Before you lies my master thesis on culture specific health care organizations. This thesis is my last step for obtaining my master degree in Comparative Politics, Administration and Society (Compass) at the Radboud University Nijmegen.

The subject of this master thesis resulted from my internship at the Verwey-Jonker Institute, where my supervisor Hans Bellaart introduced me to culture specific health care. Without the help and inspiration I got from this internship, this master thesis would not have happened, and therefore, I want to thank Hans for all his guidance and support.

Thereby, the writing process did not always go smoothly, but luckily my thesis supervisor Jan-Kees Helderman had the patience to guide me towards the right direction, which I am very thankful for. Furthermore, I want to thank my best friend Anke Moret for her support, who is now very happy she does not have to hear me about my thesis anymore.

I hope you enjoy the read.

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Chapter 1 Introduction

1.1 Introduction

The last few years, more and more culture specific organizations have emerged in the Dutch health care sector, so called culture specific health care organizations (CSHCOs) (Vilans, 2019). Dozens of CSHCOs have emerged especially in mental health care, elderly health care and home care (van Berkum & Smulders, 2010). These CSHCOs provide health care for people with a migration background, the number of which is growing in the Netherlands (CBS, 2017). It is unclear what kind of position these CSHCOs have in the Dutch health care sector. Therefore, this thesis asks the question in what way CSHCOs contribute to the social inclusion of migrants in the Dutch health care sector.

1.1.1 Brief history societal context before 1960s

Organizational and institutional segmentation of the Dutch society based on culture is not new. Before the 1960s, the Dutch society was pillarized, which meant that Dutch society was divided in different cultural groups based on religion and political background (Ellian et al., 2018; Lijphart, 2008). To every pillar a certain group of the population belonged (Lijphart, 2008). Not only were these pillars separated based on religion and culture, but also on social cleavages. The different pillars, the different "blocs" represented different social classes in Dutch society, including the minority groups. A classification could be made between upper middle, lower middle and lower classes (Lijphart, 2008).

In the time of pillarization, on the basis of ethnicity, society was homogeneous, but on the grounds of religion, society was diverse (Avest-de Jonge, 2003). Society could be divided into Catholics, Reformed, Liberals and the Social Democrats (Ellian et al., 2008). The ethnic homogeneity had as a consequence that society was a unity. The pillars were a societal way of structuring that unity, all connected through the same ethnicity (Ellian et al., 2008). The ethnic unity resulted into a feeling of nationalism and solidarity and the pillars made every citizen, even minorities, feel part of the Dutch society (Ellian et al., 2008).

Every pillar had its own political party and its own organizations and institutions, like hospitals or schools (Ellian et al., 2018). In these institutions, there was no room for people who did not share the same values and ideas (Hoogenboom & Scholten, 2008). It made Dutch citizens conform to a pillar. There were five major political parties that represented the four-pillar structure. This resulted into the pacification of politics. People in the pillars did not actively participate in politics anymore because they felt well represented by the political party belonging to their pillar. They followed the leaders of the pillars and therefore they were themselves no longer active in politics (Lijphart, 2008). The leaders of the pillars in their turn worked together, preventing conflict (Lijphart, 2008).

As a consequence of this pillarized system, the government's role in the time of pillarization was to support the pillars (Sunier & Landman, 2014). The pillars received the freedom from the government to structurize and organize their private initiatives. The Dutch government would only intervene in cases where the private initiatives of the pillars could not provide what was needed, also called the night-watchman state (*nachtwakersstaat*) (Sunier & Landman, 2014). It was a system where civil society, consisting of all civil society organizations, received the freedom from the government to organize themselves (Sunier & Landman, 2014). Civil society organizations are organizations that are uncontrolled or undirected by government or the market, where people organize themselves outside of the family on the basis of shared interests (Unerman et al., 2006).

1.1.2 Brief history societal context after 1960s

After the 1960s, secularization made these original pillars disappear. Education, wellbeing and health care were no longer a task of the pillars, but became funded and organized by government. It led to a centrally organized welfare state. Even though the secularization made many private initiatives and some culture-based organizations disappear, not all culture-based organizations disappeared fully (Sunier & Landman, 2014).

In the 1960s, migrants arrived in large numbers in the Netherlands, which made the country cultural heterogeneous, a multicultural society. A multicultural society is a society where people with different national, ethnic, religious and cultural backgrounds live side by side which ensures a cultural heterogeneous society (Ellian et all., 2018). In the 1970s and 1980s, the migrants that came to the Netherlands, often taken care of by family who already lived in the Netherlands due to the labor migration in the 1960s (family reunification), developed their own informal networks. These networks created local culture based organizations, pragmatically supported by the Dutch government (Sunier & Landman, 2014). The government responded to the migration flux with policies focused on multiculturalism, which gave the new ethnic minorities within the Dutch society the space to organize themselves (Joppke, 2007). Multiculturalism refers to "the attitude in which groups value and actively support mutual cultural differences and equal chances and opportunities" (Arends-Tóth & van de Vijver, 2007, p.252).

This multicultural policy resulted into the ethnic minorities developing their own institutions (like ethnic schools, ethnic hospitals and ethnic media) that were "parallel to the institutions of the majority society" like a parallel society (Ellian et al., 2018, p.35; Joppke, 2007). Parallel societies are societies that develop themselves outside and exclude themselves from the majority society (Ellian et al., 2018). Unlike the culture specific organizations in the time of pillarization, the culture specific organizations after the 1960s were not linked to a pillar that was in turn linked to the other pillars which was the case before the 1960s. It resulted into the emergence of new closed and parallel societies within Dutch society, where groups (especially minorities) shared the same culture and language (Ellian et al., 2018).

The integration policies based on multiculturalism changed at the end of the 20th century, caused by what became known as the 'integration failure' (Joppke, 2007). The multiculturalism policy failed to integrate the immigrants into the labor market, which resulted into the majority of the immigrants being largely dependent on the welfare state. Thereby, the high number of high school dropouts of immigrant children, the residential segregation and the prisons being overrepresented with immigrants, the conclusion was that integration had failed (Joppke, 2007). Therefore, new integration goals were set, more focused on autonomy and on participation of migrants in the mainstream institutions instead of their own ethnic institutions. In 2002, after the death of populist Pim Fortuyn, the Dutch integration policies hardened, stressing the importance of Dutch values rather than supporting diversity (Joppke, 2007).

In the 21th century, the Dutch politicians now often refer to parallel societies when talking about ethnic minorities (Sunier & Landman, 2014). Organizations or institutions from a specific ethnocultural group often get accused of revealing the existence of a parallel society. The ambiguity of the concept of a parallel society causes that the concept is a breeding ground for public debates concerning the integration of migrants on one hand and "the boundaries … for a closed community on the other hand" (Ellian et al., 2018, p.29). Within the current Dutch participation society, which entails a society where every citizen is expected to take responsibilities for taking care of itself or others, the government struggles to support the autonomy of citizens to organize themselves without resulting into integration failure (Sunier & Landman, 2014). The participation society does rely on responsibilities of

citizens and civil society organizations, however, not isolated, like is the case in parallel societies, but in co-operation (Sunier & Landman, 2014).

The Dutch open society, which characterizes as "a democratic society in which social cohesion and mutual solidarity are formed on the basis of reciprocity beyond religious or ethnic demarcations", often battles with the danger of closed communities within its open society (Ellian et al., 2018, p.7). "Parallel societies" is a concept often used in the public Dutch debate to refer to closed communities. Closed communities are consciously or unconsciously organized based on (unchangeable) beliefs. On the one hand, these communities can fill the social cohesion gap present in the open society by creating communities where minorities feel like they belong. On the other hand, for the open society it is a challenge to balance the democratic values of freedom and equality together with the closed communities fixed beliefs (Ellian et al., 2018). It is a conflict between the diversity a democracy tries to unveil and a cohesive society (Sunier & Landman, 2014).

1.2 Problematization and central question

In the time of pillerization, parallel societies were not an issue of debate, even though culture specific organizations segregated the whole of society. Currently, in the debates about integration of migrants, the creation of culture specific organizations is often linked to the danger of creating parallel societies (Couzy, 2019).

The definition of *integration* according to the Council of the European Union is "a dynamic, two-way process of mutual accommodation by all immigrants and residents of Member States" (2004, p.17). According to the Dutch government, integration in practice means that a migrant takes its own responsibility, society gives the migrant opportunities to explore its own talents, the migrant learns the Dutch language, works, participates in society and respects the Dutch liberties and equalities (Rijksoverheid, n.d.a.). According to the Dutch government, successful integration is about the migrant participating in the Dutch society (Rijksoverheid, n.d.a.) which is linked to one core aspect of integration: *social inclusion*.

Social inclusion means that a citizen is capable to participate in all parts of society without any constraints and should be able to get access to all (public) resources. It is one of the core indicators of integration (Maître & Russell, 2017; Arnold et al., 2017). Social inclusion is just one side of the coin, *social exclusion* is the other. Social inclusion and social exclusion are concepts that cannot be fully separated, but defining social exclusion makes it possible to point out exclusionary processes in a society that make full participation difficult. *Social exclusion* occurs when there is "unequal access to resources, capabilities and rights which leads to health inequalities" (Popay et al., 2008, p.2). Social in/exclusion will be further elaborated in the theoretical chapter of this thesis.

Studying social in/exclusion can be done by identifying exclusionary processes (or risk factors) in a society, which can help formulate inclusive policies (O'Donnell et al., 2018). In the context of this thesis, social inclusion in health care would mean that the regular health care provided by the Dutch government should be accessible and suited to all Dutch citizens.

CSHCOs are in this thesis health care organizations that focus on the cultural background of the patient and are fully, from the ground up, organized to be culture sensitive through all aspects of the organization (KIS, 2019). This means that the organization is mainly steered from the demand of the patient (Struijs, 2003). CSHCOs focus on citizens with a cultural background different than the majority culture of the host society. A citizen with a migration background in the Netherlands is a person that has at least one parent that is not born in the Netherlands (CBS, n.d.).

CSHCOs provide culture specific health care, which is health care that is altered to the culturally based health care needs of the patient, which leads to more patient-centered

care and policy making that is more demand-driven (Djalan Pieter, n.d.; Struijs, 2003). The approach of culture specific health care is focused on culture, which is implemented through all parts of the organization by taking into account the life rules and customs of the patient (I-psy, 2016; V&VN, 2017). In practice this means that CSHCOs give among others treatments that are adapted to the discrete culture of their patients, have teams that are multilingual and possibly have the same cultural background as the patient and have health care providers have intercultural knowledge (I-psy, 2016).

Studies have shown that minority groups in a society often come across a lot of barriers to get the health care that they need. One of the possible barriers for these minorities is the fact that health care providers are not aware of cultural differences, including possible health care traditions associated with a certain culture or specific values related to health care. This can negatively influence the quality of the health care received by the patient because the treatment simply does not fit the health care need of the patient (Given et al., 2008). Taking into account the culture of a patient is therefore important, because health care needs and expectations are, among other things, determined by the cultural background of the patient. It influences the way patients express their symptoms, which type of treatment they prefer and who they let provide the care (Given et al., 2008, p.30). Also, the epidemiology between people with a migration background and people without a migration background differ (Stronks, 2013).

When health care does not consider language and cultural barriers for patients, racial and ethnic health disparities can cause health problems (Wilson-Stronks et al., 2008). Exclusion in health care influences health by exclusion in the health care system or because exclusion causes other inequalities that influence health (O'Donnell et al., 2018). Especially in the Netherlands, with the growing number of citizens with a migrant background, a more culture specific approach in health care will become more important (Bakas, 2018).

Unlike other culture specific organizations, like schools, these CSHCOs have not triggered any public debate. The position that these CSHCOs hold in the Dutch health care system is unknown. It seems like these CSHCOs have emerged parallel to regular health care organizations. It is important to study the position of these CSHCOs, because whenever these CHSCOs are not connected with regular health care and placed outside society, this could be an exclusionary process negatively influencing the social inclusion of migrants. For social inclusion it is important that minorities can participate in mainstream institutions like health care. However, whenever the Dutch health care sector includes CSHCOs into the health care sector, this could improve the social inclusion of minorities considering that they get their health care inside of the mainstream institutions. When the latter is the case, migrants do get their health care from other organizations then regular health care organizations, but are still connected to regular health care through these CSHCOs, which is better for their social inclusion. In this case, at the same time, regular health care can learn from these CSHCOs about migrant needs in health care, improving regular health care as a whole.

This leads us to the central question of this thesis:

→ *How do CSHCOs contribute to the social inclusion of minorities in the Dutch regular health care?*

To help answer this central question of this thesis, there are three sub-questions:

1) *To what extent is there social inclusion of minorities in the Dutch regular health care sector?*

2) *In what way does the Dutch national health care policy consider CSHCOs and culture specific health care?*

3) *How is the national health care policy implemented locally and how does this affect CSHCOs?*

4) *How do CSHCOs relate to the Dutch regular health care sector?*

These sub-questions make a distinction between the dominant culture (national policy, regular health care organizations, municipalities and health insurance companies) and the non-dominant cultures (the CSHCOs). Answering these sub-questions will result into more insight in the relationship between the dominant and non-dominant cultures in health care, also the Dutch health care sector and the CSHCOs, which will help answer the central question of this thesis.

To answer the sub-questions, first will be analyzed if there are exclusionary processes in place in the Dutch regular health care sector. This can shed light on the possible contribution CSHCOs could have in the Dutch regular health care sector. This will be studied using the four criteria of the AAAQ framework of the World Health Organization that determine if there is exclusion in a health care sector of a state (2008a; 2008b).

Furthermore, the attitude and position of the CSHCOs towards the Dutch health care sector and the attitude and position of the Dutch health care sector towards CSHCOs will be analyzed. For this, the *acculturation model* of Berry (1997) is used, which is a model that helps to study the attitude and behavior of the non-dominant and dominant cultures towards each other within a society. The model will give insight into what the relationship is between CSHCOs and the Dutch regular health care sector. The acculturation outcome will reflect if there is more an inclusive or exclusive relationship.

1.3 Case study

The goal of this research is to shed light on the contribution of CSHCOs on the social inclusion of minorities in the Dutch regular health care. In this exploratory qualitative study, a total of eight CSHCOs and regular health care organizations were interviewed in a case study. Furthermore, two open interviews were conducted with representants of the Dutch Ministry of Health, Well-Being and Sports, and a representant of the Foundation for Healthcare of Migrants in the Netherlands (SGAN). These interviews gave insight in the national view on CSHCOs from two perspectives: the Dutch government perspective and the migrant perspective. Lastly, the national policies of the Dutch health care system (Ministerie voor Volksgezondheid, Welzijn en Sport, 2016) and the most recent review of the OECD on the Dutch health care system (OECD, 2017) are used to analyze the Dutch health care sector.

In the selection of the health care organizations that were interviewed, the focus was on elderly health care and mental health care (GGZ), because most CSHCOs emerged in these two areas. Elderly health care is in general health care that is targeted at people with an age above 70 (Nationale Zorggids, n.d.). The health care can be delivered at home (residential care), by for example helping the elderly with their house chores or with providing them care at home, or health care can be delivered outside the home, for example by daily activities or living in a nursing home (extramural care). Health care at home is for the elderly that can still

live at home with a little help from a caretaker, like personal care or domestic help (Nationale Zorggids, n.d.). Mental health care is health care that focuses on mental illnesses and the precaution, treatment and care of these illnesses (GGZ Nederland, n.d.).

1.4 Scientific relevance

This research contributes to both theoretical and societal knowledge. It has become clear that Dutch CSHCOs have not been studied much. Whenever there is written about culture specific health care provided by health care organizations, the focus is on cultural competent health care and interculturalization, which are both ways of making regular health care more receptive towards different cultural backgrounds of patients. However, this is different than culture specific health care provided by CSHCOs (RVZ, 2000; Seeleman, 2014). This shows the importance of researching CSHCOs, because they strongly differ from the organizational approaches like cultural competent health care and interculturalization. There is not much literature available about CSHCOs, and no literature about how regular health care and government (should) respond to the emergence of such health care organizations. Analyzing the actual contribution of these CHSCOs can shed a light on why these kind of health care organizations have risen, how they are positioned in the Dutch health care system and how they contribute to the social inclusion of migrants in regular health care. Until now, these organizations have risen without getting much attention and no questions are asked what this means for the possible social exclusion of migrants from regular health care.

1.5 Societal relevance

The Dutch society is changing into a society with more and more people with a migration background. The backgrounds of the Dutch with a migration background is also getting more diverse (CBS, 2018). Thereby, the Dutch society is aging and with that there are more elderly with a non-western background (Vilans, 2019). This also means more patients with a migration background which makes paying attention to cultural backgrounds more important (Vilans, 2019). With the rising number of migrants in the Netherlands, it is important to study how the Dutch health care reacts towards these new cultures. This thesis can show if there is an exclusionary process in place in the Dutch regular health care regarding CSHCOs. Whenever this is the case, this could mean that CSHCOs contribute to creating parallel societies, which can have societal consequences.

1.6 Reading guide

To answer the central question, the thesis is structured as follows: in the second part of this thesis, the theoretical foundation will be elaborated, where the concepts social in/exclusion will be explained together with the AAAQ framework of the World Health Organization and the acculturation model of Berry. Subsequently, in the third section, the thesis will continue with the methodology of this thesis along with the case selection. In the fourth part, the results will be presented from the analysis of the data. Finally, in the fifth part of this thesis, a conclusion will be drawn following from the findings in the fourth chapter. This chapter will also reflect on the research and give further recommendations for future research.

Chapter 2 Theoretical framework

In this chapter, the theoretical foundation of this thesis will be developed. The chapter starts with explaining the relationship between the dependent and first independent variable. The chapter then continues to explain the moderating variable that can have an effect on the dependent variable and independent variable.

2.1 Social in/exclusion

The main question of this research is about the social in/exclusion of migrants in the Dutch regular health care. Social inclusion and social exclusion are interrelated concepts, which makes social exclusion a relevant concept to develop as well, despite the fact that a real distinction cannot be made between the two. Even though social exclusion and social inclusion are two sides of the same coin, elaborating social exclusion makes it possible to indicate inclusionary or exclusionary processes within a society (Edwards et al., 2001).

In the existing literature, there are various definitions of social inclusion, which can be divided into two approaches. The first approach is a rights-based approach, which "focuses on social exclusion and the deprivation of rights as a member or citizen of a particular community or society" (Baumgartner & Burns, 2013, p.356). The other approach focuses on "social inclusion as the opportunity to participate in key activities of the society in question" (Baumgartner & Burns, 2013, p.356). The similarity between these two approaches is the idea that social inclusion is not only about participating in society, but also about being able to participate in the way a person would like to participate (Baumgartner & Burns, 2013). In this study, social inclusion means that a citizen is capable to participate in all parts of society without any constraints and should be able to get access to all (public) resources (Maître & Russell, 2017). This definition of social inclusion can be seen as a combination of the two schools of thought.

For social exclusion, there are also a lot of different definitions in existing literature. There are three different schools of thought about social exclusion in the scientific literature (Agulnik, 2002). The first school of thought places individuals' behavior and moral values at center stage (Agulnik, 2002, p.3). The second school focuses on the role that institutions and systems have on social exclusion and the third and last school of thought highlights rights and practices of discrimination (Agulnik, 2002, p.3). The three schools of thought are represented in the following broad definition of social exclusion:

"Social exclusion is a complex and multi-dimensional process. It involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities, available to the majority of people in a society, whether in economic, social, cultural or political arenas. It affects both the quality of life of individuals and the equity and cohesion of society as a whole" (Levitas et al., 2007, p.9).

This definition will be used in this study because it covers all aspects of social exclusion. Social exclusion is clearly about the disadvantage of one group in comparison to the majority society (Levitas et al., 2007). The definition shows that social in/exclusion is a complex puzzle with multiple exclusionary processes prevailing in a society divided over four societal dimensions.

The four dimensions mentioned in the definition are: social, political, cultural and economic (Popay et al., 2008). The social dimension is about feeling like you belong in the social system of your country (Popay et al., 2008). It is about bonding with your community, your neighborhood and about having relationships that are supportive and having a feeling of solidarity. The second dimension is the political dimension, which focuses on power dynamics "which generates unequal patterns of both formal rights embedded in legislation,

constitutions, policies and practices and the conditions in which rights are exercised" (Popay et al., 2008, p.37). This dimension is about access to public resources like health care and "about the unequal distribution of opportunities to participate in public life, to express desires and interests, to have interests taken into account and to have access to services" (Popay et al., 2008, p.37). The third dimension, the cultural dimension, is about "which diverse values, norms and ways of living are accepted and respected" and to what degree diversity is accepted or how/ if discrimination plays a role (Popay et al., 2008, p.37). The fourth and last dimension is economic, which is about access to resources like housing or income (Popay et al., 2008).

It is important to mention that these dimensions are intertwined and should therefore be seen as analytical constructs (Popay et al., 2008). The distinction between these four dimensions is merely for making it possible to analyze exclusionary or inclusive processes within these dimensions. This study focuses on the political and cultural dimension of social in/exclusion. Both the cultural and the political dimension is about the willingness to accept other groups and cultures into (the majority) society (Popay et al., 2008).

2.1.1 Relevance of studying social in/exclusion

Studying exclusionary processes in a society is important, because social exclusion of certain groups or individuals in society has its consequences. Research shows that excluded groups endure more (mental) health care problems (Sayce, 2001). Also, social exclusion often goes together with other factors like low income, lack of social networks or joblessness, creating complex societal problems (Sayce, 2001). It causes economic and social imbalances along with inequalities and marginalization in a society, which pressures democracies (Edwards et al., 2001). Social exclusion is about individuals or groups in society that have a disadvantage on one or multiple factors compared to the general population. By studying what kind of exclusionary processes are enacted in a society, and how, policies that do include can be made and implemented. Consequently, this can help to develop focused inclusive policies to improve the social inclusion of certain disadvantaged groups. Studying social in/exclusion sheds light on potential improvements of the social inclusion of certain groups in society. It is about "the removal of institutional barriers and enhancement of incentives to increase the access of … excluded groups" to create an inclusive society (Bennett, 2002, p.13).

However, studying social in/exclusion is challenging, because every research on social in/exclusion is built upon its own indicators, which results in each study measuring different aspects of social in/exclusion (Baumgartner & Burns, 2013). Possible measurable parts of social inclusion are income, poverty, home ownership and health (Maître & Russell, 2017). Furthermore, studying social inclusion is also challenging because full social inclusion cannot be reached. It is a dichotomous term, which means that every inclusive practice has a part that brings exclusion with it (Edwards et al., 2001). Whenever inclusion is a topic of discussion, exclusion will always play a part. This makes studying social inclusion complex, because social inclusion and exclusion cannot be fully independent.

Therefore, social inclusion is often viewed as a lifelong learning policy, similar to a process without an end (The World Bank, n.d.). Social inclusion can be viewed as a "process of improving the terms for individuals and groups to take part in society" and "the process of improving the ability, opportunity, and dignity of those disadvantaged on the basis of their identity to take part in society" (The World Bank, n.d.). This means that social inclusion as a policy goal cannot be met but is a more continuous learning cycle.

Researching social inclusion can be done by deconstructing social inclusion into measurable parts and study whether they foster in/exclusion. Considering social inclusion cannot be met entirely as a policy goal, it becomes more important to define in which scenarios there is exclusion (Edwards et al., 2001). These scenarios, or exclusionary

processes, are *risk factors* that foster social exclusion. These risk factors can be present on multiple societal levels: individual level (micro-level), in/formal organizational level and social settings (meso-level) and at society and government level (macro-level) (O'Donnell et al., 2018, p.18).

The focus of studying social in/exclusion is on how changes can be made on the system level (policies and institutional reform) to improve the individual or group situation on the micro level (Bennett, 2002). The position of power lays on the system level, that can positively influence the position on the micro level. It is vital that people in charge on the system level acknowledge their role of fostering inclusion and should be actively involved in wanting to improve the social inclusion of minorities on the micro level. Otherwise, institutional change can be tried to be accomplished by micro level change. Yet, change from below takes more time and does not always lead to system level change, considering that the system level has to support the change not forgetting that "the institutions which control the rules of distribution are themselves controlled by those who benefit from the current pattern" (Bennett, 2002, p.25). This exposes the power and importance of the system level on the social in/exclusion of minorities in a society.

2.1.2 The AAAQ framework

One of the common base principles for integration of the Council of the European Union is "Access for immigrants to institutions, as well as to public and private goods and services, on a basis equal to national citizens and in a non-discriminatory way is a critical foundation for better integration" (2004, p.18). An important aspect of integration is thus participating in the host society, which is the focal point of the social in/exclusion definitions. Therefore, social in/exclusion is used as an indicator for studying the (successful) integration of minority groups within a society (Arnold et al., 2017).

One of the indicators of social in/exclusion relevant for this thesis is access to health care (Lloyd et al., 2006). Social exclusion in health care occurs when health care is not accessible for specific groups and when it does not respond to the health care needs of discrete groups of patients (O'Donnell et al., 2018; Silver & Miller, 2003). Article 12.1 of the International Covenant on Economic, Social and Cultural Rights from the UN General Assembly assures that every state makes an effort to ensure that every citizen attains the highest standard of psychological and physical health, also known as *the right to health* (1966, p.4). The responsibility to respect this covenant is up to the state by making sure state health care policies are inclusive (UNHR, n.d.). The right to health is translated into four criteria (the AAAQ framework) that need to be respected in a health care system of a state in order to provide the right to health to every citizen (World Health Organization, 2008a; World Health Organization, 2008b).

The first criteria is *availability*, which entails that all facilities, goods, services and programs within a public health care sector of a state have to be available for every citizen. The quantity of health care has to be sufficient (World Health Organization, 2008a). The implementation of this element depends on the capacity of the state and its state of development (UN Economic and Social Council, 2000). Availability also refers to *geographic availability*, which is about the location of the health care services and the mobility of the patient to be able to go to the health care services (Gulliford et al., 2002). For the workforce in health care organizations, this means that they are able to adhere to the health needs of the population (World Health Organization, n.d.).

The second criteria is *accessibility*, which means accessible health care facilities, goods and services for all citizens of a state (World Health Organization, 2008b). Access to health care is about equity, which means that the health care sector of a state is capable to meet the health care demands of different groups within the population (Gulliford et al.,

2002). It is also about all groups of society having access to and being able to participate in the decision-making process at the national and local level about health care policies (World Health Organization, 2008b). This dimension furthermore contains of four criterion:

1. Non-discrimination: all health facilities should be accessible to all citizens of a state, also to minorities or marginalized groups.
2. Physical accessibility: the health facilities should be physically accessible.
3. Economic accessibility (affordability): all citizens of a state should be able to afford health care. All health care services, public or private, should be affordable for all citizens of the state based on the principle of equity, making sure that disadvantaged groups also can gain access to those resources.
4. Information accessibility: all citizens should be able to get information on health issues (UN Economic and Social Council, 2000).

The third criteria of the AAAQ framework is *acceptability*, which means that "All health facilities, goods and services must be *acceptable* to users in terms of being respectful of medical ethics, culturally appropriate and sensitive to gender and life-cycle requirements, and through being designed to respect confidentiality and improve the health status of those concerned" (World Health Organization, 2010, p.12). Especially culturally appropriateness is relevant for this thesis, considering it is related to CSHCOs, under the denominator *cultural acceptability*. This is a very subjective connotation of individuals, minority groups and communities' perceptions on health care (Jensen et al., 2014). This means that in some cultures, aspects related to health care are considered normal that in other cultures are not considered as normal.

The fourth and final criteria is *quality,* which entails that "Health facilities, goods and services must be scientifically and medically *appropriate* and of good quality" (Popay et al., 2008, p.10). This dimension is about the health care sector providing quality health care that adheres to certain rules and regulations of good quality health care.

The AAAQ framework provides indicators that states can use to ensure international human rights, not only for the right to health, but also in other areas where human rights have to be ensured. The right to health means that every citizen of a certain state should have access to health care and the four criteria can be used to examine barriers that marginalized groups or minorities face in obtaining health care in a certain state (World Health Organization, 2008b) and therefore can be used to study social in/exclusion in health care. The barriers found using these criteria can give insight into possible exclusionary processes in health care. Whenever one criteria cannot be fully met, this can be used to formalize inclusive policies to improve the social inclusion of the excluded groups (World Health Organization, 2008b; Silver & Miller, 2015). Applying the AAAQ framework on health care, based on a previous operationalization of the framework to the right of water, is portrayed in *table 1*.

Availability Sufficient quantity of health care and geographic availability	**Accessibility** Physical accessibility, economic accessibility, non-discrimination and information accessibility
Acceptability Consumer acceptability; cultural acceptability and sensitivity to marginalized groups	**Quality** Health care has to be of sufficient quality

Table 1: The AAAQ framework applied to health care (Jensen et al., 2014; World Health Organization, 2008a; World Health Organization, 2008b).

The framework links the individual rights holder to national legislation and policies. Even though the framework is comprehensive, by providing a context-specific indicator system and methodology to state institutions, private service providers and civil society, there are no specific and measurable targets linked to the indicators to measure the compliance of a certain state with the indicators (Jensen et al., 2014). The four criteria are benchmarks. The framework enables "actors to understand, analyze and assess public service delivery" to ensure that it reaches the whole of the population (Jensen et al., 2014, p.1). There are multiple actors within a state that are responsible for the interpretation and implementation of the four criteria. Not only the state and its institutions, but also private sector actors and civil society are responsible for the implementation of the criteria (Jensen et al., 2014).

The emergence of CSHCOs is seen as a response of people with a migration background to the regular health care sector (van Berkum & Smulders, 2010). It is expected that the more a regular health care sector is capable to include all citizens of a population that the number of culture specific health care organizations will shrink (van Berkum & Smulders, 2010). The AAAQ framework can help to determine on which aspects the Dutch regular health care misses inclusivity and if and on which aspects CSHCOs contribute to inclusivity.

This all leads to the dependent and first independent variable of this thesis, with the dependent variable being *social inclusion of minorities in the Dutch regular health care sector* and the first independent variable *social exclusion of minorities in the Dutch regular health care sector.* These variables will help analyze if there are exclusionary processes in the Dutch health care sector to which CSHCOs possibly contribute to which is the first step towards answering the research question.

2.1.3 Summary

In sum, social in/exclusion are concepts that cannot be fully separated, but a degree of separation is necessary to be able to point out exclusionary processes in a society. Social in/exclusion can occur in four dimensions: political, cultural, social and economic. Studying social in/exclusion means discovering exclusionary processes within these four dimensions, using these to formulate more inclusive policies trying to improve the social inclusion of disadvantaged groups. Social inclusion as a policy goal can never be fully accomplished, but is a never-ending learning process. For inclusionary policies to form in a society, it is important that the system level (policies, institutions) are aware of their important role in influencing the micro-level's (individuals, groups) social exclusion.

As an indicator of integration, social inclusion emphasizes being able to participate in the host society without any constraints. One of the indicators of social inclusion is having access to health care. Studying if there is an exclusionary process in place in the health care sector of a state, the four indicators of the World Health Organization can be used:

Availability, accessibility, acceptability and quality. These indicators of social in/exclusion in a health care sector of a state can be useful to determine if there are exclusionary processes in the health care sector, which can be used to form inclusionary policies to better the social inclusion of minorities.

2.2 Acculturation model

As formerly mentioned, more and more CSHCOs have emerged in the Dutch health care sector. In the Dutch debate about integration of migrants, culture specific organizations have often been linked to creating parallel societies. A parallel society is viewed as the counterpart of integration considering that they are societies that are not connected to the dominant society (Sunier & Landman, 2014). The emergence of white versus black health care providers have societal effects that are not desirable (van Berkum & Smulders, 2010). Parallel societies exclude themselves from the majority society, which has consequences. They risk alienating from the culture and religion of the majority society as well with the democratic principles that are often, in the case of migrants, fairly different from their home country (Ellian et al., 2018). These parallel societies also pose a risk of socio-economic backlog. Another consequence of closed parallel societies is that the groups that form these parallel societies will not be included into policies. This results into no policy developed for those groups, which results into further segregation of these minorities with groups of society living next to each other without having contact (Ellian et al., 2018).

2.2.1 Acculturation model Berry

The relationship between cultural groups and the host society can be studied using the *acculturation model* of Berry (1997), which will now be elaborated.

Due to migration, societies like the Netherlands became culturally plural. A plural society is a society composed of citizens with various cultural backgrounds together in the same political and social framework (Berry, 2011). These ethnocultural groups suffer from political and economic inequalities, together with the fact that some groups are smaller than other groups (Berry, 1997). Berry therefore refers to the dominant and non-dominant cultural group, also the majority society and the minority group, to emphasize the power relations between the cultural groups in a society (Berry, 1997).

Non-dominant cultural groups choose how they want to *acculturate* when coming into a new society (Berry, 2011). Acculturation is "the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members" (Berry, 2005, p.698). Acculturation is a process and an outcome of cultures interacting with each other (Berry, 1997). It is not only the non-dominant culture that acculturates, but also the dominant culture.

The ethnocultural groups in a plural society can have different ways of engaging with each other, also known as *intercultural strategies*. The core of these intercultural strategies is that every ethnocultural group within a society has its own preference or views towards the way they want to engage with other ethnocultural groups (Berry, 2011).

The acculturation preferences of the non-dominant ethnocultural groups and the dominant group are based on two indicators (issues) according to the *acculturation model* of Berry (1997): the preference to maintain "one's heritage culture and identity" or not to maintain them, and "a relative preference for "seeking relationships with other groups"" and "participating in the larger society versus avoiding such relationships" (Berry, 2008, p.331; Berry, 2011). The larger society is the host country's social framework of institutions and can also be seen as the dominant culture (Berry, 2011). More concrete, the two indicators can be summarized as "cultural maintenance" referring to the preference of cultural assimilation or not and "contact and participation", referring to more structural assimilation, which is about

having contact and participating in the larger society (Berry, 1997). The preferences on these indicators are based on how a culture views its own culture and how it views other cultures (Berry, 2008).

The assumption of the model of Berry is that these two indicators are independent from each other, independently determining the acculturation preference of the non-dominant and dominant group. This means that if an ethnocultural group wants to maintain its culture, this does not mean that it automatically does not want to adapt to the dominant culture (Berry, 2005). These two indicators of acculturation preferences underline that ethnocultural groups can react in different ways to other ethnocultural groups (Berry, 2005).

The outcomes of the preferences of the non-dominant ethnocultural group on the two issues result into *acculturation strategies* (see *figure 2*) (Berry, 2011). They are called strategies, because strategies combine attitudes and behaviors, the preference and the outcome, together (Berry, 2011). For the non-dominant ethnocultural group, acculturation is about how they prefer to be in contact with the dominant group (Berry, 2008).

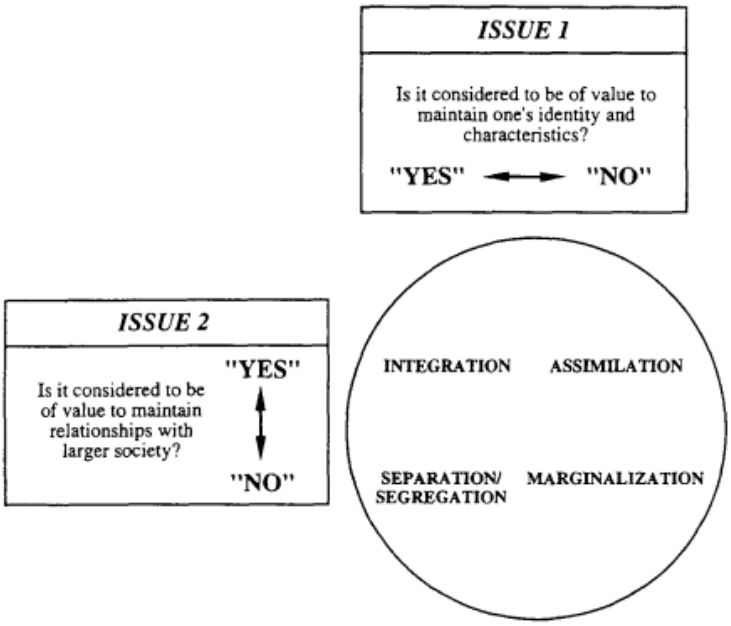

Figure 1: Acculturation strategies (Berry, 1997, p.10).

There are four possible acculturation strategies that emerge from the preferences of the non-dominant ethnocultural group on the two issues, as is shown in *figure 1*. The first acculturation strategy a non-dominant culture can follow is the assimilation strategy. This applies when individuals within a certain cultural group do not wish to maintain their own cultural identity and are open to get in contact with other cultures (Berry, 2008). It means that newcomers into a new society take over the cultural norms of the dominant culture and give up their own culture. The migrants in that case adhere to the majority culture whilst rejecting their own (Berry, 2011). The second acculturation strategy is the separation strategy. A separation strategy is applied when individuals in an ethnocultural group hold on to their own culture and avoid any contact with other cultures (Berry, 2008). The third strategy is the integration strategy, which refers to a strategy where the ethnocultural group wants to preserve its own culture but is at the same time open for other cultures (Berry, 2008). This strategy is a two-way process, considering that the dominant culture group has to be open to adapt to the non-dominant cultures as well. The final acculturation strategy a non-dominant group can have is the marginalization strategy. In this strategy, the non-dominant culture cannot be preserved by the non-dominant group due to for example enforced cultural loss and

at the same the preference is to not have contact with other cultures. This is often the case when there is a risk of exclusion or discrimination (Berry, 2008).

Even though these four strategies make it seem like the non-dominant culture can choose its own acculturation strategy based on its preferences, this is not the case (Berry, 2008). The dominant culture, the larger society, can determine from which acculturation strategies the non-dominant culture can choose from. This is why Berry refers to the larger society as the dominant culture, because it has the power to determine the acculturation strategy of the non-dominant culture. For example, for the integration strategy of the non-dominant culture to be successful, the dominant group has to be open and inclusive towards the non-dominant cultures, otherwise, the integration strategy cannot be performed (Berry, 2011). For the integration strategy to be successful, there has to be a two way process between the dominant culture and the non-dominant cultures, with the non-dominant cultures adopting the values of the larger society and the larger society adapting its institutions (education, health, labor) to the non-dominant groups. Therefore, the success of the integration strategy of the non-dominant group or even its availability is dependent on the strategy of the dominant group (Berry, 2011).

The dominant culture has its own acculturation preferences on the two issues in *figure 2*, which are based on the dominant culture's *acculturation expectations* and its *multicultural ideology* (Berry, 2011). The acculturation expectations of the dominant group refers to how the dominant group expects the non-dominant group to acculturate, which means that the dominant group has expectations on what the non-dominant culture prefers in terms of the two issues of the acculturation model of Berry (see *figure 2*). The multicultural ideology refers to how the dominant ethnocultural group views its own role in the contact with other ethnocultural groups (Berry, 2011). It is about if the larger society prefers cultural pluralism or not. This is important, because the ideologies of the dominant society on the cultural diversity within the society will define which kind of policies will be in place, which will in turn determine which kind of constraints there are on the acculturation process of the non-dominant groups (Berry, 2001; Arends-Tóth & van de Vijver, 2007). The larger society can have a positive view towards cultural pluralism (a positive multicultural ideology), which means that the dominant culture is less likely to enforce the non-dominant culture to assimilate or exclude/marginalize, which a negative view towards cultural pluralism would. Together with that, a positive multicultural ideology in the larger society makes it more likely that it will "provide social support both from the institutions of the larger society (e.g., culturally sensitive health care and multicultural curricula in schools), and from the continuing and evolving ethnocultural communities that usually make up pluralistic societies" (Berry, 2005, p.703). Societies where cultural pluralism is viewed negatively, policies will focus on reducing cultural diversity, promoting assimilation, and some societies will even try to segregate or marginalize ethnocultural groups (Berry, 2005). Therefore, the multicultural ideology of the dominant society will determine, together with the acculturation preferences, what the outcome of the acculturation process will be.

These preferences result into views on the two indicators of acculturation: preferred contact and participation and cultural maintenance (see issue 1 and issue 2 in *figure 2*). The role that the dominant culture's preferences play in the acculturation strategy of the non-dominant culture resulted into five different *intercultural strategies* based on the acculturation preferences and multicultural ideology of the dominant culture:

- Melting pot strategy: The assimilation strategy of the non-dominant culture can be done out of free will. In this case, when the dominant culture does not enforce assimilation, this strategy is called the melting pot. However, when assimilation is done under pressure by the dominant culture on the non-

dominant one, it becomes a *pressure cooker* strategy of the dominant culture (Berry, 1997).

- ➢ Exclusion strategy: This strategy is linked to the marginalization strategy of the non-dominant culture. Marginalization is usually not a strategy that a non-dominant culture chooses for without being pressured. The exclusion strategy is enforced on the non-dominant culture by the dominant culture when marginalization of the non-dominant culture is enforced (Berry, 1997).
- ➢ Multiculturalism strategy: For this strategy to be successful, it is important that the majority society is open for other cultures. It is a strategy that needs all cultural groups within the larger society to accept cultural diversity. The integration strategy "requires non-dominant groups to adopt the basic values of the larger society, while at the same time the dominant group must be prepared to adapt national institutions (e.g. education, health, labor) to better meet the needs of all groups now living together in the plural society" (Berry, 1997, p.11).
- ➢ Segregation strategy: This strategy forces the non-dominant culture to separate itself from the dominant society (Berry, 1997). It results into the separation strategy for the non-dominant culture, a strategy that is not much chosen free-willed by a non-dominant culture (Berry, 1997).

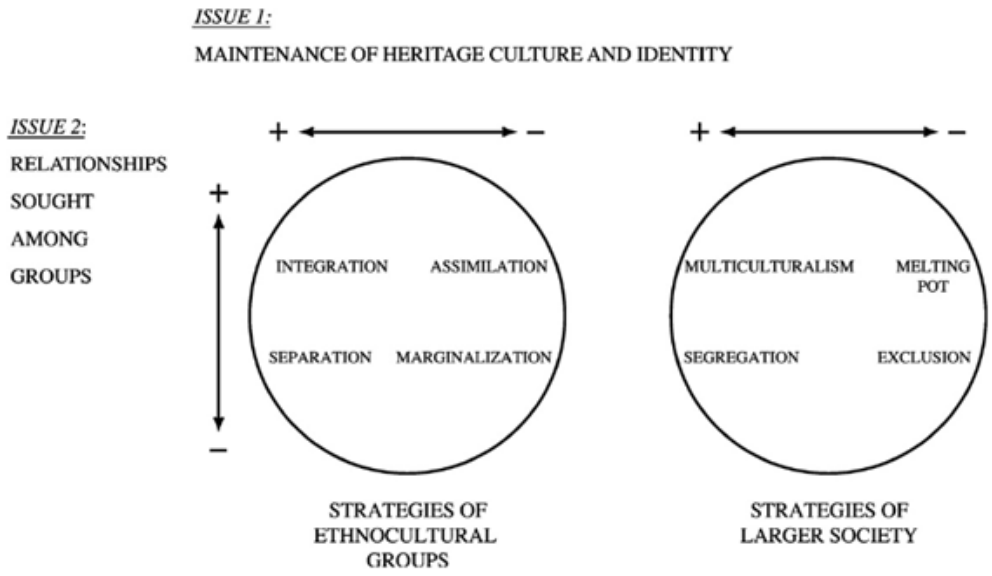

Figure 2: Intercultural Strategies of Ethnocultural Groups and the Larger Society (Berry, 2008, p.332).

As previously mentioned, *figure 2* shows that the preferences of the larger society and ethnocultural groups on the two issues define the intercultural strategies of the dominant and non-dominant culture (Berry, 2008). Considering that the acculturation strategy of the non-dominant culture can be determined by the preferences of the larger society, the outcome of the acculturation process relies more on the preferences of the dominant culture due to the fact that it has the power to enforce a certain acculturation strategy. Therefore, the acculturation outcome is one of the four acculturation strategies of the non-dominant culture (assimilation, separation, marginalization and integration) (Berry, 1997).

In acculturation studies, the integration strategy (multiculturalism strategy) has been found to be the most successful strategy for both the non-dominant and the dominant culture, and marginalization the least, to include new cultures into a society. The success of the

integration strategy can be explained by the fact that it is not only the new culture that is actively adapting to the dominant culture, but the dominant society also engages in adapting to the culture of the newcomer as well (Berry, 1997). With other strategies like assimilation, the culture of the newcomer gets discarded, and separation results into no contact between the different cultures which leads to not accepting the dominant culture by the migrants (Berry, 1997). Integration has two positive sides, active involvement of the non-dominant culture and of the dominant society, which is preferable over assimilation and separation, which have one positive and one negative side, and marginalization, which is only negative (no involvement of the non-dominant culture and dominant culture) (Berry, 1997).

The outcome of the acculturation process can give insight into two possible implicit relationships between the larger society and the ethnocultural groups. In the case of the acculturation process resulting into separation or marginalization, there is no relationship between the two. Whenever there is assimilation or integration, there are two relationships possible: the *mainstream-minority* and the *multicultural society* relationships (*figure 3*) (Berry, 2011). The first implicit type is the mainstream-minority, connected to the assimilation strategy, which entails that minority groups are on the margins of one dominant society. It is a type where reducing cultural pluralism is preferred and sometimes even preferred to be eliminated by the mainstream society. The minority groups disappear when they fully emerge into the mainstream society (Berry, 2011). The second possible implicit type is the multicultural society, connected to the integration (multiculturalism) strategy, which is a society where the ethnocultural groups are incorporated into the majority culture, where cultural pluralism is viewed more positively and where "inclusiveness should be nurtured with supportive policies and programs" (Berry, 2011, p.23). In this type, there are no minorities but rather ethnocultural groups that are part of the larger society. In this view, the larger society is "a national social framework of institutions… that accommodates the interests and needs of the numerous cultural groups, and which are fully incorporated as ethnocultural groups into this national framework" (Berry, 2011, p.23).

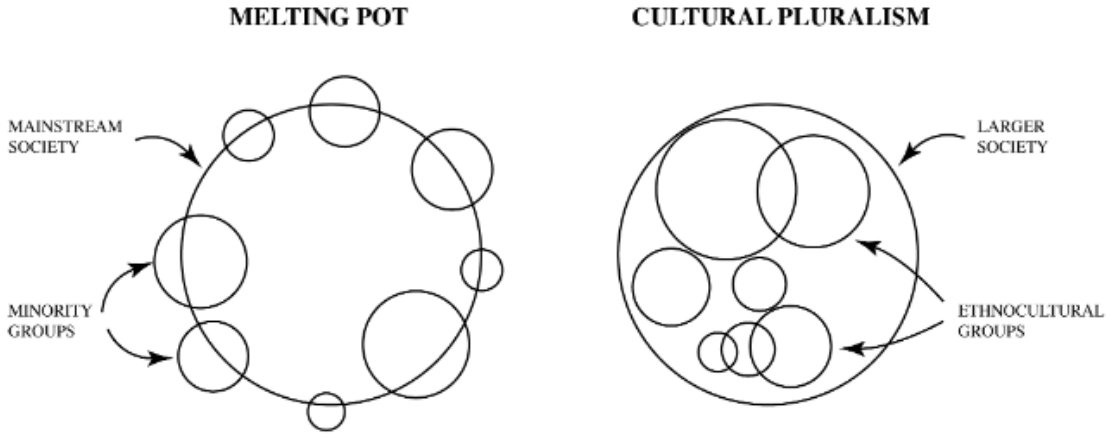

Figure 3: Intercultural relationship larger society and minority groups (Berry, 2011, p.24).

The acculturation model of Berry presented in *figure 2* pictures the idea that the intercultural strategies of the dominant and non-dominant culture always fit together. This is not always the case, because whenever there is a difference in intercultural strategy between the ethnocultural groups and the larger society (there is no fit), this causes *acculturative stress* (Berry, 2008). Acculturative stress refers to the difficulties individuals within an ethnocultural group face having to acculturate or when the acculturation process results into conflict between the ethnocultural group and the dominant culture (Berry, 2011). A well-known acculturative stress concept is a "cultural shock" where the individuals or groups that

have to acculturate have different acculturation preferences than the larger society and they cannot adapt to the expectations and preferences of the larger society (Berry, 1997). This has psychological consequences, like stress and mental health issues (Berry, 2011). Acculturative stress occurs when national policies within the larger society are in conflict with the acculturation preferences of the individual or ethnocultural group. It usually results into the separation or marginalization strategy of the ethnocultural group because a fit between dominant culture and ethnocultural group cannot be made (Berry, 1997).

2.2.2 Using the acculturation model

The acculturation model of Berry is often used in (social) psychology to study individual attitudes towards acculturation within an ethnocultural group, but can also be used to study acculturation preferences on (an ethnocultural) group level (Arends-Tóth & Van de Vijver, 2007; Berry et al., 1987). The model is also used to study (national) policies and programs (Berry et al., 1997). This because the acculturation preferences of ethnocultural groups can shine through the policies and programs of its formal organizations (Berry et al., 1987). Through organizations, an ethnocultural group can separate itself from the larger society or can try to integrate through its organization.

The policies of organizations can be linked to the possible intercultural strategies. First of all, policies can be integrationist, which means that policies are open to integrate all groups with their own cultural terms (Berry et al, 1997). Integration can be achieved in a society whenever there are sufficient public policies and there is public willingness to advocate for equity (Berry, 2011). Policies can also be assimilationist, which means that the majority society expects that new cultural groups change their ways similar to the dominant society (Berry, 1997). This shows that the dominant culture is also the politically dominant group, because through national policies, the dominant culture can enforce assimilation (Berry et al., 1987). Furthermore, policies can be segregationist, which separates new groups from the majority society. At last, policies can foster marginalization, which means that new cultures are not considered important thus not represented in policies (Berry, 1997).

This leads us to the moderating variable, *acculturation outcome.* The acculturation model of Berry can be used to determine what the intercultural strategies are of the Dutch health care sector and of the CSHCOs. The acculturation outcome can shed light on which kind of relationship CSHCOs and the Dutch health care sector have, which can answer the research question on how CSHCOs contribute to the Dutch health care sector. This independent variable is a moderating variable, considering that the acculturation outcome can have a positive or negative effect on the exclusionary processes in the Dutch health care sector.

2.2.3 Summary

In conclusion, acculturation is an interplay between two (or more) cultures within a society. Acculturation is about how different cultural groups in a society react to each other and what they do or do not take over from each other's culture. The acculturation model of Berry reflects that different cultural groups can have different preferences on how they would like to acculturate. These preferences are based on two indicators: cultural maintenance and preferred contact and participation. This results into intercultural strategies for both the non-dominant and dominant culture. In this acculturation process, the dominant culture (larger society) has the power to determine the acculturation strategy of the non-dominant culture (minority ethnocultural group). This means that the acculturation outcome can be different than the preference of the non-dominant culture. Whenever the intercultural strategies of the non-dominant culture and dominant culture are not coherent, this causes acculturative stress. There are four possible outcomes of acculturation: assimilation, integration, separation and

marginalization, which results in two possible relationships between the larger society and the ethnocultural group: melting pot and cultural pluralism.
The acculturation model of Berry can be used to study formal organizations. They reflect acculturation strategies of the represented ethnocultural group(s) in their policies.

2.3 General conclusion

This theoretical chapter results into the dependent variable *social inclusion of minorities in the Dutch health care sector* and the two independent variables *social exclusion of minorities in the Dutch health care sector* and *acculturation outcome*. The theory of the chapter is translated into a conceptual framework, where the variables are represented with their relations (*figure 4*). The conceptual framework will now be further explained.

What is important for this thesis is to study what kind of exclusionary processes are in place in the Dutch health care sector (IV1). This independent variable is studied using three indicators that can be used to study exclusionary processes within a health care sector of a state, as is shown in *figure 4*. Having more insight into these possible exclusionary processes in the Dutch health care sector can show how and if CSHCOs contribute to the social inclusion of minorities. If this is an inclusive or exclusive contribution (where inclusive means that CSHCOs are connected in a way to the Dutch regular health care and exclusive means that CSHCOs are separated from the health care sector) is represented by the moderating variable, *acculturation outcome.* This moderating variable can have an effect on the social in/ exclusion of minorities in the Dutch health care sector, as *figure 4* shows. This moderating variable is the outcome of the acculturation strategies of the non-dominant and dominant culture within the Dutch society, as previously explained.

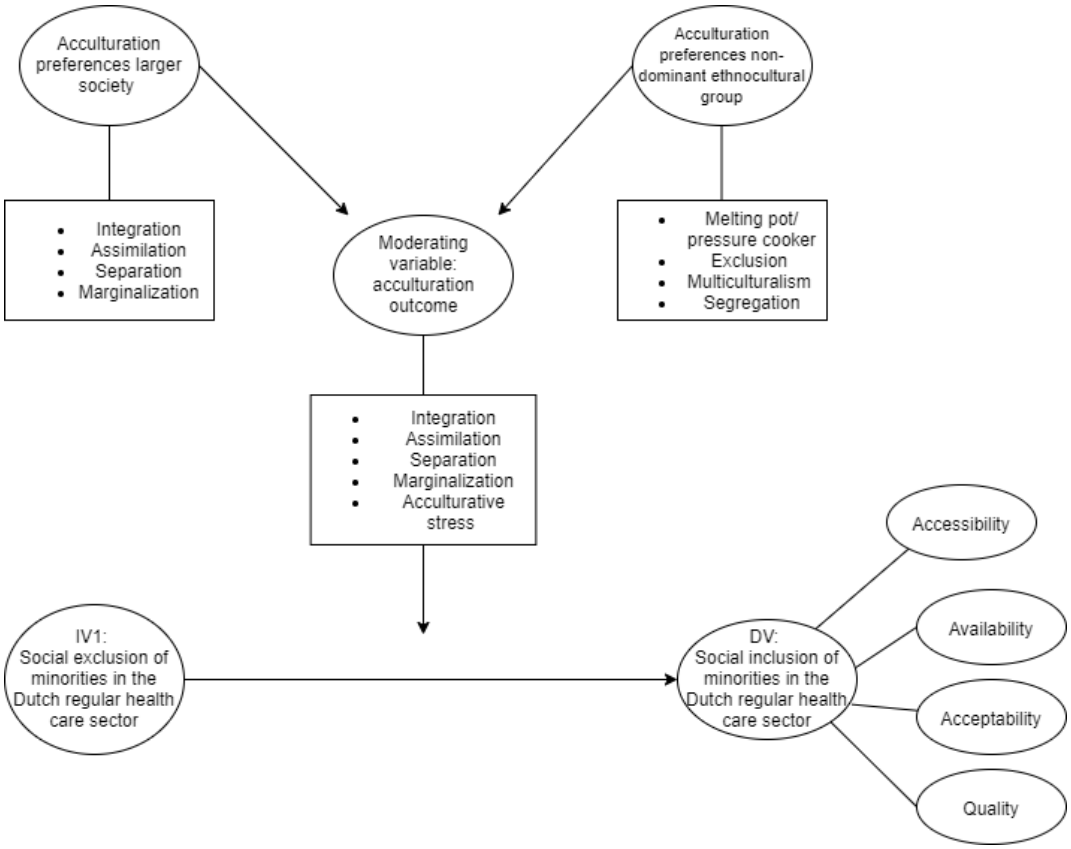

Figure 4: Conceptual framework

Chapter 3 Methodology

This chapter will start with explaining the research design of this study. Following, the main concepts of this research will be operationalized based on the theory in chapter 2. The chapter will finish with explaining the method of analyzing the data.

3.1 Research design

In this thesis, how CSHCOs contribute to the social inclusion of minorities in the Dutch regular health care will be researched. It is an explorative research, considering that although there are theories about studying social in/exclusion in regular health care and studying acculturation strategies, the effect of CSHCOs on the social inclusion of migrants has not been studied yet.

Scientific research can be divided into two different ways of researching: quantitative and qualitative research. In this thesis, a qualitative research will be conducted. Qualitative research is "all forms of research that are focused on collecting and interpreting linguistic material to make statements about a (social) phenomenon in reality on that basis" (Bleijenbergh, 2013, p.10). The empirical material that is used in qualitative research consists of transcriptions of interview data, notes of observations and documents (Bleijenberg, 2013). The number of cases in a qualitative study are lower than in quantitative studies, making it possible to study those cases more in depth. Another distinction can be made between inductive and deductive research. Qualitative research is generally inductive research, which means that about the subject that is being research, only little or some theory exists (Taylor & Søndergaard, 2017). "Using an inductive process the researcher can begin to discern possible relationships between aspects of the case study data" (Taylor & Søndergaard, 2017, p.37). Inductive research can help to better understand the social phenomenon. A deductive method is applicable whenever a social phenomenon has been widely studied which has led to theories regarding that subject (Taylor & Søndergaard, 2017). Even though there are no studies about CSHCOs and their effect on the social inclusion of minorities, the theories in the theoretical chapter two make it possible to connect CSHCOs to already existing theories about acculturation. Therefore, this study is in between inductive and deductive, known as theory confirmation/disconfirmation, where some theory exists which forms the study, but the study can still be flexible and have inductive features (Taylor & Søndergaard, 2017).

For qualitative research, as data-gathering methodologies, there are different methods to choose from. In this study is chosen for a case study, which is researching one or more carriers of a social phenomenon (Bleijenbergh, 2013). Characteristics of a case study are that it is qualitative research and that the number of cases, the N, is small. Case study research often has as a purpose to be descriptive or exploratory, which fits the purpose of this research (Taylor & Søndergaard, 2017). Researching a case means also considering the context of the case, not only describing the phenomenon, but researching it in the field (Bleijenbergh, 2013). A case study is suitable for research when wanting to gain a lot of information about the relationship between your independent variables and your dependent variables (Gerring, 2004). In a case study, multiple methods of data gathering are used, which makes it possible to research the social phenomenon in depth (Bleijenberg, 2013). This is why in this thesis is chosen for a case study, considering it is an explorative research and uses multiple data resources to better understand the phenomenon.

This thesis effectuates a multiple case study, which means that multiple cases are being studied. This makes it possible to see the differences and similarities between the cases, which can give insight in the social phenomenon. For this case study, cases are selected that are similar to each other, also known as the method of accordance approach (Taylor & Søndergaard, 2017).

3.2 Operationalization

To answer the main question of this thesis, the dependent variable *social inclusion of minorities in the Dutch health care sector* and the two independent variables, *social exclusion of minorities in the Dutch health care sector* and *acculturation outcome* will be operationalized.

3.2.1 Social in/exclusion in the Dutch health care sector

The dependent variable (social inclusion in the Dutch health care sector) and first independent variable (social exclusion of minorities in the Dutch health care sector) are interrelated variables, as explained in the theoretical chapter. This means that outcomes on the study of the independent variable explains the dependent variable as well.

The independent variable *social exclusion of minorities in the Dutch health care sector* is operationalized in two dimensions where social in/exclusion can be studied: the political and cultural dimension. These two dimensions are thereafter operationalized using the indicators for an inclusive health care sector of a state according to the AAAQ framework of the World Health Organization (2008a), elaborated in the second chapter of this thesis (see *table 2*).

The four indicators are operationalized in *table 3* into items that are used to study the primary and secondary data. The items are in turn linked to a code. These codes are used during the content analysis whenever a paragraph corresponds to the items that represent the code. This makes it possible to study if the data reflects certain exclusionary processes in the Dutch health care sector based on the AAAQ framework.

Independent variable: social exclusion of minorities in the Dutch health care sector	**Dimensions**	**Indicators**
Definition social exclusion in health care: when health care is not accessible for specific groups and when it does not respond to the health care needs of discrete groups of patients (O'Donnell et al., 2018; Silver & Mill, 2015).	➢ Political dimension of social in/exclusion: The political dimension is about having access to public resources like health care and "about the unequal distribution of opportunities to participate in public life, to express desires and interests, to have interests taken into account and to have access to services" (Popay et al., 2008, p.37).	➢ Poor accessibility ➢ Non availability (World Health Organization, 2008a)
	- Cultural dimension of social in/exclusion: "which diverse values, norms and ways of living are accepted and respected" and is about to what degree diversity is accepted or how/ if discrimination plays a role (Popay et al., 2008, p.37).	➢ No acceptability (World Health Organization, 2008a) ➢ Bad quality (World Health Organization, 2008a)

Table 2: Social exclusion of minorities in the Dutch health care sector

Indicators	Items	Codes
➢ Poor accessibility	- Non-discrimination - Physical accessibility - Economic accessibility - Information accessibility (World Health Organization, 2008b)	Accessibility
➢ Non availability	- Sufficient quantity of public health care facilities - Geographic availability (Gulliford et al., 2002)	Availability
➢ No acceptability	- Culturally appropriate (World Health Organization, 2010)	Acceptability
➢ Bad quality	- Scientifically and medically appropriate health care (Popay et al., 2008)	Quality

Table 3: Operationalization social exclusion of minorities in the Dutch health care sector

3.2.2 Acculturation outcome

In order to explore how CSHCOs contribute to the social inclusion of minorities in the Dutch health care sector, the intercultural strategies of both the CSHCOs and the Dutch health care sector should be studied. The intercultural strategies are derived from the answers on the second, third and fourth sub-questions of this thesis. The acculturation outcome, the second independent variable of this thesis, will reflect if the relationship between the CSHCSOs and the Dutch health care sector is more inclusive or exclusive, which will help answer the research question of this thesis.

The acculturation model of Berry is normally used to study one specific ethnocultural group. In this thesis, however, the acculturation model is used to study ethnocultural focused health care organizations *an sich*, without making a distinction between ethnocultural groups. In this thesis, it is not about how one ethnocultural group acculturates, but about how CSHCOs are positioned within the Dutch health care sector, which shed light on how CSHCOs contribute to the social inclusion of minorities in the Dutch regular health care. Therefore, in the acculturation model of Berry, the CSHCOs represent the ethnocultural groups. The CSHCOs are therefore in the acculturation model of Berry the ethnocultural groups, considering that according to Berry, formal organizations can reflect the acculturation strategies of ethnocultural groups. In line with the acculturation model of Berry, in this thesis, the Dutch health care sector is considered as the larger society or dominant culture, since the Dutch health care sector has the power to make (national and local) policies.

The independent variable *acculturation outcome* consists of two dimensions, the acculturation preferences of the dominant ethnocultural group (the larger society) and the ethnocultural group's acculturation preferences, as is shown in *table 4.* The indicators for the acculturation preferences of the larger society are the acculturation expectations and the multicultural ideology of the larger society, further operationalized into items in *table 5*. The acculturation preference of the larger society results into an intercultural strategy of the dominant ethnocultural group, explained in chapter 2. *Table 6* shows in the first row the possible intercultural strategies of the larger society.

Moderating variable: acculturation outcome	Dimensions	Indicators
Definition: Acculturation is "the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members" (Berry, 2005, p.698)	➢ Dominant ethnocultural group's (larger society's) acculturation preferences (Berry, 1997)	➢ Acculturation expectations: expectations on the acculturation preferences of the ethnocultural group (Berry, 2011) ➢ Multicultural ideology: how the dominant ethnocultural group views its own role in the contact with other ethnocultural groups
	- Ethnocultural group's acculturation preferences (non-dominant group/ minority group) (Berry, 1997)	➢ Preferred cultural maintenance: wanting to maintain (not assimilate) or not maintain (assimilate) its own culture (Berry, 1997) ➢ Preferred contact and participation: wanting to or not wanting to participate and be in contact with the larger society (Berry, 1997)

Table 4: *Moderating variable: acculturation outcome*

For the second dimension, the ethnocultural group's acculturation preferences, there are two indicators: preferred cultural maintenance and preferred contact and participation (*table 4).* These two indicators are further operationalized into items in *table 5.* The acculturation preference of the ethnocultural group results into an acculturation strategy, shown in the second row of *table 6.*

Indicators	Items	Codes
➢ Acculturation expectations: expectations on the acculturation preferences of the ethnocultural group (Berry, 2011)	- Assimilate (free-willed) - Assimilate (forced) - Separate - Marginalize (Berry, 2011)	*Expectations*
➢ Multicultural ideology: how the dominant ethnocultural group views its own role in the contact with other ethnocultural groups (Berry, 2011)	- Positive multicultural ideology - Negative cultural ideology (Berry, 2005)	*Ideology*
➢ Preferred cultural maintenance: wanting to maintain (not assimilate) or not maintain (assimilate) culture of origin (Berry, 1997)	- Maintaining heritage culture - Not maintaining heritage culture (Berry, 2008)	*Maintenance*
➢ Preferred contact and participation: wanting to or not wanting to participate and be in contact with the larger society (Berry, 1997)	- Participate and in contact with larger society - Not participating and not in contact with larger society (Berry, 2008)	*Adaptation*

Table 5: Operationalization acculturation outcome variable

It is important to mention that the non-dominant culture does not always have a choice which acculturation strategy it can choose, which *table 4* does not show. *Table 6* shows that the acculturation outcome can differ from the acculturation strategy of the non-dominant culture, because of the intercultural strategy of the dominant culture. Marginalization, separation and sometimes the assimilation strategy can be strategies that are enforced by the dominant culture, as explained in the theoretical chapter. In the case that the intercultural strategies of the dominant and non-dominant culture do not fit, this results into acculturative stress, as shown in the last row of *table 6.*

The acculturation outcome resulting from both the acculturation preferences of the larger society and the acculturation preferences of the ethnocultural group is shown in the third row of *table 6.* The last row in the table represents what kind of relationship the acculturation outcome reflects between the larger society and the ethnocultural group.

The codes in the last row of *table 5* are used to analyze the primary and secondary data on possible traces of intercultural strategies. These codes will be assigned to every paragraph in the data that correspond to the items adherend to the codes. The next step is then, in the case of the larger society, to link the expectations and ideology to the corresponding intercultural strategy, explained in chapter 2. The same thing applies to the preferences of the ethnocultural groups where the preferred contact and participation and preferred cultural maintenance together reflect one of the acculturation strategies elaborated in chapter 2. The intercultural strategies of both the larger society and the ethnocultural group together result into an acculturation outcome, as is shown in *table 6.* This acculturation outcome reflects in turn what kind of relationship the CSHCOs and the Dutch health care sector have, which indicates if this is an inclusive or exclusive relationship.

Intercultural strategy Dutch health care sector	**Acculturation strategy CSHCOs**	**Acculturation outcome**	**Relationship larger society and ethnocultural groups**
Multiculturalism	Integration	Integration	Multicultural society (Inclusion)
Melting pot	Assimilation	Assimilation	Mainstream-minority (inclusion)
Pressure cooker	Assimilation	Assimilation	Mainstream-minority (forced inclusion)
Segregation	Separation	Separation	No relationship (exclusion)
Marginalization	Marginalization	Marginalization	No relationship (exclusion)
Multiculturalism/Melting pot/Pressure Cooker/Exclusion/ Marginalization	Cannot acculturate according the expectations/ preferences larger society	Acculturative stress - Marginalization or Separation	No relationship (exclusion)

Table 6: Acculturation outcomes

3.3 Data collection

The primary data used in this research comes from a study done in collaboration with a platform of the *Verwey-Jonker institute (VJI).* VJI is an independent research organization based in Utrecht that researches social issues in different domains. Within the institute, there is a platform (Knowledge Platform Integration and Society, KIS) where researchers of Verwey-Jonker often work together with *Movisie*, another research organization that also researches social issues. KIS focuses on all issues around integration, migration and diversity (KIS, n.d.).

As formerly mentioned, in a case study, there are multiple sources of data. There can be made a distinction between primary data and secondary data. Primary data is data that the researcher gets directly from its respondent, like transcripts. Secondary data is data that is available for everyone, not just for the researcher, for example information on public websites (Taylor & Søndergaard, 2017). The following data is used in this study.

3.3.1 Primary data

The primary data gathered for this study consists of 7 interviews of 8 respondents, 6 respondents from CSHCOs and two from regular health care organizations. These interviews will give insight into the intercultural strategy of the CSHCOs. Transcripts of the interviews are used as primary data. The interviews were semi-structured, which means that questions were already formulated before the interviews took place, but the order of the questions were not fixed (Bleijenbergh, 2013). The questions were open which gave the interviewees space to answer the question freely. The questions were formulated beforehand, which enhances the reliability of the research considering that the different respondents answer the same questions which makes comparing answers possible (Bleijenbergh, 2013). The interview questions were fairly the same for the regular health care organizations and the culture specific health care organizations. A few questions were formulated differently for the regular health care organizations than for the culture specific health care organizations in order to adjust the question to the respondent.

The respondents all gave an oral informed consent for using their interview data. An overview of the respondents is given in *Appendix 1.* In this appendix, the function of the respondent in the health care organization is given. The interviews were all conducted face-to-face and lasted between a half an hour and an hour and a half and were all recorded, transcribed and anonymized. The interviews were transcribed by typing out what has been said during the interview. With this, only what has been said was transcribed, not every pause, expletive or other details (also known as *non-verbatim*) (Wittenstein et al., 2012). A verbatim transcript is namely not always necessary. Non-verbatim can be more useful when the study is more about content analysis or thematic, wanting to find out common ideas about a certain topic (Halcomb & Davidson, 2006). The interviews were structured by two interview guides (see *Appendix 2).* There was one interview guide for CSHCOs and one for regular health care organizations. The questions in the interview guides are linked to the theoretical foundations of this research, developed in chapter 2. This will be further elaborated in the operationalization section of this chapter.

As previously stated, the respondents of the health care organizations represented an organization that provided (among others) either mental health care or elderly health care. These two categories of health care were chosen because in recent years, more CSHCOs have emerged in these two areas (van Berkum & Smulders, 2010). Three respondents of CSHCOs are from a health care organization that provides elderly health care, and one respondent is from a regular health care organization that provides elderly health care. Two respondents from CSHCOs are from health care organizations that provide mental health care and one respondent is from regular mental health care organizations. Organization 5 (see *table 1*) categorizes itself as both a regular health care organization and a culture specific health care organization, but is considered as a culture specific health care during the analysis. The other CSHCOs are chosen as CSHCOs considering that they present themselves as culture specific or focused on patients with a migration background. The two regular health care organizations were randomly chosen, based on the health care they provided (elderly or mental health care). Some specific characteristics worth mentioning about the respondents is that respondent 6 had previously worked at a culture specific health care organization and

currently works at a regular health care organization, providing information about both organizations. Thereby, respondents 4 and 5 were interviewed at the same time, due to lack of time.

All health care organizations were contacted by the researchers of Verwey-Jonker and Movisie, Hans Bellaart (Verwey-Jonker) and Jamila Achahchah (Movisie) by e-mail or phone. *Table 7* shows the anonymized organizations from which respondents were interviewed and shows the characteristics of the organizations.

Health care organization	Regular or culture specific health care	Basic or specialistic care	Target group	Characteristics
1	Culture specific	Specialistic mental health care	Elderly, adults and children with different social and cultural backgrounds	Intercultural mental healthcare
2	Regular health care	Specialistic mental health care	For people with psychiatric illnesses	Fixates on the most complicated mental health care cases
3	Culture specific	Basic and specialistic health care	Provides elderly health care, health care for people with physical or intellectual disabilities, people with psychological problems and chronically ill people	Customer-oriented health care that fits the client's cultural background
4	Culture specific health care	Basic and specialistic health care	A team specialized in the treatment of people with different cultural backgrounds, for psychiatric problems	Part of and originated from a regular health care organization
5	Regular health care	Basic and specialistic health care	Provide care for among other the elderly, for every person that needs long term care, guidance or support at home or extramural	
6 (no longer active)	Culture specific health care	Basic care	Care for the multicultural community	Specialized in home care, trained caregivers to be able to work and care at the same time
7	Regular health care and culture specific health care	Basic and specialized care	Specialize in elderly home care, regardless of cultural or religious background	Employees speak multiple languages
8	Culture specific	Basic care	Specialized in assistance of refugees and migrants	Guidance for migrants and refugees, culture sensitive assistance, employees with various cultural backgrounds, daytime activities

Table 7 Characteristics of the health care organizations

The organizations are made anonymous, because the functions of the respondents could help trace back to who was interviewed. The fourth organization cannot fully be seen as an independent organization, because it is a culture specific team within in a regular health care organization. The sixth organization is a CSHCO that does not exist anymore, but a former employee could give information about this organization which was interesting for this thesis considering their way of working was culture specific and inventive.

Next to these 8 interviews, two open interviews are conducted at the Ministry of Health, Wellbeing and Sports (VWS) and at the foundation for Healthcare of Migrants in the

Netherlands (SGAN) (Respondent 9 and respondent 10). The interviews were unstructured, trying to gain information about CSHCOs and culture specific health care. This unstructured way of interviewing gives the respondent the space to talk about a certain phenomenon in its own way (Taylor & Søndergaard, 2017). The interviews were not recorded, but notes were taken during the interviews, which are added to the primary data for this thesis. The interview at the Ministry of Health was face-to-face, the interview with SGAN was by phone. These interviews give insight in the national view on CSHCOs from two perspectives: the Dutch government perspective and the minorities' perspective.

3.3.2 Secondary data

The second source of data used in this research is the gathering of relevant documents. This method consists of gathering documents that are relevant to the subject of the study and are documents that already exist (Bleijenbergh, 2013). First, a literary study is carried out to find existing literature about the current inclusiveness of the Dutch regular health care sector for people with a migration background. This literary study will focus on the four quality indicators of the World Health Organization. This will give insight into which of the four quality indicators for social inclusion in the Dutch health care sector CSHCOs can contribute to.

Subsequently, a literary study on the national policy of the Dutch health care system is carried out, with among others the Dutch national health policy (Ministerie van Volksgezondheid, Welzijn en Sport, 2016) and the most recent review of the OECD on the Dutch health care system (OECD, 2017). This found literature on the national health policy will be used to analyze the Dutch health care sector, which will able to define the intercultural strategy of the dominant culture (the Dutch health care sector). The larger society and dominant culture is also represented by local institutions, like municipalities and health insurance companies. The implementation of the national health policy will be analyzed on its influence on CSHCOs and will be used to see if an intercultural strategy can be derived from how the national policy influences the local level.

Additionally, 5 annual reports of 2018 or 2017 of the health care organizations that have been interviewed, will be used to gather more information about the positions of CSHCOs and regular health care organizations towards each other. *Appendix 3* shows from which organizations from *table 7* the annual reports are used. Three reports are from CSHCOs, two reports from regular health care organizations. These reports will help to define the intercultural strategy of the CSHCOs.

3.4 Method of analysis

The method of analysis in this thesis is a qualitative content analysis. In a qualitative content analysis, the data that is collected gets interpreted from the empirical question perspective by giving labels to the data. This happens in different stages, where in the labelling stage, the data gets a meaning (Bleijenberg, 2013). A qualitative content analysis has two approaches, an inductive and deductive approach. Considering that this research is based on existing scientific research, a deductive approach is suitable. This means that the researcher has expectations while analyzing the data, based on scientific literature and the codes that are used to label the fragments are derived from scientific research. It means that the analysis is theory driven (Bleijenberg, 2013). This means that before analyzing the data, the researcher develops a code scheme which will be used to code the data. By giving the same codes to text fragments of the data, the researcher is able to compare different fragments. The codes in *table 3* were used to answer the first research question, the codes in *table 5* to answer the second, third and fourth sub-questions.

The codes were made more the most compact as possible, because codes are

preferably single terms (Bleijenbergh, 2013). This is important, because otherwise, the texts are not reduced enough. With compact labels a researcher can link more aspects in the fragments to the code, which makes it possible to compare fragments. This makes it possible to look for similarities and differences between cases. The texts were analyzed multiple time to be sure that the right fragments had gotten the right codes and no fragments were overlooked. This was important to see if the codes would be consistently labelled with the same code.

The fourth sub-question of this thesis is partly answered using an inductive content analysis approach on the interview data of the CSHCOs. An inductive approach is based on empirical data. It is about recognizing patterns in the data by systematically labelling observations and comparing them with each other. The researcher has to perceive the data openly without any expectations (Bleijenbergh, 2013).

3.5 Validity and reliability

For conducting scientific research, the two criteria validity and reliability of the research are important. There are two types of validity: internal and external validity. Internal validity is about the research really measuring what is intended to be measured (Bleijenbergh, 2013). This is important, because when this is not the case, the researcher is not measuring what he or she intended to measure and the findings are then invalid for concluding about the phenomenon in question. In qualitative research, the internal validity is more important than external validity and is in general quite high, considering that the case studies are being studied thoroughly and in detail.

For ensuring the internal validity of this research, the concepts that are studied are thoroughly elaborated by scientific literature in the theoretical chapter. This makes it possible to operationalize the concepts in the methodological chapter, ensuring that the study studies what is intended to be studied. In addition, there is triangulation of sources in this study, which means that findings from different kinds of sources from the same data gathering method are compared, which makes it possible to study the subject from different viewpoints. This study uses interviews from different viewpoints, which erases bias in the study that can result from only using a single viewpoint. The interviews with the health care organizations are also semi-structured, which meant that there is room for the interviewer to ask further questions, ensuring that the interviewer gets all the information on the subject, enhancing the validity.

External validity of a research is about the generalizability of the results. The external validity in qualitative research is quite low, considering the number of cases being studied is small (Bleijenbergh, 2013). It is therefore not possible to generalize the results to the general population. This thesis conducts a small case study and as an explorative research, the external validity of this thesis is limited.

For qualitative research, reliability of the research is less important. Reliability is about the findings not being distorted by accidental deviations, which is a difficult criteria to meet in qualitative research considering the number of cases in qualitative research is relatively low (Bleijenbergh, 2013). This low reliability can be compensated by making the choices of respondents and documents for the research insightful and by making transcripts of the interviews, which makes the research process for others more traceable (Bleijenbergh, 2013). Therefore, in this thesis, the choice for respondents is explained in the methodological chapter and of all the interviews for this thesis, transcripts are made.

Chapter 4 Results

In the following chapter, the findings are elaborated and divided under the corresponding sub-question. The chapter starts with elaborating on which of the four criteria of the World Health Organization's AAAQ framework CSHCOs can contribute to. Subsequently, the possible intercultural strategy of the larger society and of the CSHCOs will be developed. At last, the acculturation outcome of these two intercultural strategies is given, with its implications on how CSHCOs then can contribute to the social inclusion of minorities in the Dutch regular health care sector.

4.1 To what extent is there social inclusion of minorities in the Dutch regular health care sector?

In the following section, the dependent variable *social inclusion of minorities in the Dutch regular health care sector* is elaborated. The findings of the literary study on the inclusiveness of the Dutch health care sector based on the four criteria of the AAAQ framework of the World Health Organization will show which exclusionary processes are in place in the Dutch regular health care sector.

4.1.1 Availability regular health care

- *Sufficient quantity*
  The health care sector is one of the biggest sectors in the Netherlands. Currently in the Netherlands, there is a deficit of nurses throughout the whole of the Netherlands (Maes, 2017). Rising health care demands and rising employment opportunities resulted in a deficit in health care employees (Kalkhoven & van der Aalst, 2018). The effects of this on patients has not yet been researched but the waiting times are increasing (OECD, 2017). The OECD reports in its analysis on the Dutch health care sector that there is only a small group of patients whose health care needs are unmet (2017). There are no signs of shortages which means that there is a sufficient quantity of health care (OECD, 2017).

- *Geographic availability*
  The geographic availability of health care in the Netherlands is among others measured by looking at the distance between hospitals and citizens. In 2018, the National Institute for Health and Environment of the Ministry of Health concludes that for almost everyone, daily hospital care is good accessible (RIVM, 2018). This means that for 99% of all the Dutch citizens, a hospital can be reached in between 30 minutes with a car. The 30 minutes count for secluded areas. There are regional deficits of general practitioners in certain Nordic regions and Southern regions. The general practitioners are not well divided in contrast to medical specialists (Maes, 2017). Overall, the OECD concludes that the geographic availability of health care in the Netherlands is good due to "a dense network of providers" (OECD, p.12, 2017). Whenever a citizen needs accurate health care, the health care organizations are in easy reach for almost all citizens (Kroneman et al., 2016).

4.1.2 Accessibility regular health care

- *Non-discrimination*
  Non-discrimination is about all groups of society having equal access to regular health care (World Health Organization, 2008b). According to the OECD, the overall accessibility of the Dutch health care organizations is good (2017). The OECD does

not mention any discriminatory practices. In a qualitative survey research to experiences of discrimination in among others health care, a bit more than 1% of the surveyed Turkish, Moroccans, Surinamese and Antilleans have had experiences with discrimination in health care in 2009 (Coenders et al., 2010). However, this study also emphasizes that the majority of experiences discrimination will not be reported because the majority of citizens think that it will not make any difference.

This thesis focuses on elderly health care and mental health care. In 2014, the National Institute for Health and Environment concludes that mental health care is evenly accessible for native Dutch people as for people with a migration background (Langendijk-Van den Berg et al., 2014). Nonetheless, another study concludes that kids and youth with a migration background use less youth mental health care facilities than native Dutch kids and youth even though they endure the same mental health problems as native Dutch kids and youth (Boon et al., 2011). An online knowledge base with all Dutch health care standards, guidelines and generic modules for professionals working in the health care sector, states that people with a migration background do endure more problems with seeking mental health care, for example because of language barriers or because they do not fully understand how the system works (GGZ Standaarden, 2018).

For elderly health care, the Dutch Social Cultural Planning Agency (SCP) concludes in 2011 that elderly migrants use less health care facilities then native Dutch elderly (den Draak & de Kerk, 2011). The SCP mentions that there is an augmentation of CSHCOs for elderly migrants which shows that there is a demand for a more cultural sensitive approach in elderly health care (den Draak & de Kerk, 2011). The elderly migrants experience accessibility issues due to a lack of information, health care administration, language and expectation of health care costs. Thereby, there are other treatment expectations and needs due to cultural differences (den Draak & de Kerk, 2011). This all shows that there are accessibility issues signaled for elderly migrants and for migrants in mental health care.

- *Economic accessibility*

  In comparison to the native Dutch, people with a non-western migration background have more health care costs, especially for mental health care and medicines (CBS, 2018). In 2018, 8 percent of all adults refrained from health care due to costs (NIVEL, 2018). This is a lower percentage in comparison to 2017. 4 percent of adults with extreme mental health issues did not get the health care that he or she needed due to financial difficulties (De Staat van Volksgezondheid en Zorg, 2018). These numbers do not make a distinction between people with or without a migration background. Furthermore, the OECD report signals the rise of out-of-pocket payments. Whenever a patient wants to seek health care from a provider that does not have an agreement with a health insurance company, only 75% of the health care costs are covered by the health insurance company (OECD, 2017, p.12). The other 25% the patient has to pay out of its own pocket. The report is critical about this, because “ability to pay” is becoming a factor in the use of health care services (OECD, 2017, p.12). More out-of-pocket payments means that patients seek more health care away from the providers that have contracts with health insurance companies, also known as “out of network” providers (OECD, 2017, p.12). It is not clear what kind of “out of network” providers these patients choose. However, “out-of-pocket payments are rising but do not translate into elevated unmet need” (OECD, 2017, p.11). Therefore, it seems that the economic accessibility is not intervening with getting the needed health care which

shows a good economic accessibility of the Dutch health care sector.

- *Physical accessibility*
  Accessibility of health care organizations is seen extra important by the Dutch government and they try to realize accessibility by trying to make sure that health care is situated in neighborhoods. For example, there are community service centers where different civil society organizations as well as health care organizations provide services that are close to the citizen (Storm & Post, 2012). This to better the accessibility of health care. A Dutch national regulation called the Building Decree (*Bouwbesluit)* ensures that the physical accessibility of health care organizations is ensured, making them accessible for everyone, even for people in a wheelchair (Kroneman et al., 2016).

- *Information accessibility*
  As a Dutch citizen, in order to choose for a health insurance company or health care provider, it is essential to have information (Kroneman et al., 2016). There are some problems with transparency from insurers and health care providers in the Dutch health care sector. According to an analysis of the Dutch health system in 2016, "key concerns are the lack of reliable quality indicators that are available to citizens and the fragmentation, inadequacy, inaccessibility and lack of clarity of record systems" (Kroneman et al., 2016, p.xxvi).

  In a focus group about experiences in the Dutch health care sector with migrants from different educational and cultural backgrounds and age, the participants indicated that general practitioners and health care providers have to provide them with more information. They also indicated that they have insufficient insight into the functioning of the Dutch health care sector (van Berkum & Smulders, 2010). People with a migration background can endure accessibility problems due to lack of information about the functioning of the Dutch health care sector (GGZ Standaarden, 2018).

4.1.3 Acceptability regular health care

- *Culturally appropriate*
  The Ministry of Health states explicitly that there is no specific national policy made for culture specific health care. The health care sector should be inclusive, and therefore, the sector should be already accessible for people with a migration background. The Ministry of Health mentions in its interview that it does not get any national signals that regular health care cannot respond to the health care demands of people with a migration background. The Ministry of Health mentions in its interview that the responsibility of the culture sensitiveness of the health care sector is in the hands of the health care sector itself. A study of Pharos, a national expertise center on health care differences, also concluded that the Dutch national quality criteria for health care do not take diversity into consideration (van Berkum & Smulders, 2010). Even though cultural sensitive health care will become more important considering the growth of elderly with a migration background, in the daily practice, there is a lack of attention to this fact (Vilans, 2019). In a focus group about experiences in the Dutch health care sector with migrants from different educational and cultural backgrounds and age, the group mentions that the provided health care and the prevention offer does not suit them (van Berkum & Smulders, 2010). They mention that care givers and prevention staff need more knowledge about cultural differences

(van Berkum & Smulders, 2010). Thereby, they need to get more sensitive towards "diversity in behavior, way of living, how health is perceived and how people deal with complaints and illnesses" (van Berkum & Smulders, p.17, 2010).

More specifically, in elderly health care, patients with a migration background do not think elderly health care is cultural sensitive enough (Steunenberg & de Wit, 2013). This means that health care is "insufficiently in line with the health perception and experience of these groups" (Steunenberg & de Wit, 2013, p.41). There are more and more developments in elderly health care organizations that try to better the cultural sensitiveness of its health care, but in practice, the desires and needs of the elderly migrants themselves are not yet aligned with the changes (Steunenberg & de Wit, 2013).

4.1.4 Quality

The OECD report states that the Dutch health care system is effective considering the mortality is low and low numbers of hospitalizations that could be avoided (2017). Nevertheless, people with migrant background suffer more from diseases than native Dutch people (Kroneman et al., 2016). The overall health of people with a migration background is less good than that of native Dutch (van Berkum & Smulders, 2010).

Qualitative research with people with a migration background revealed that the quality of regular health care has been experienced as not always optimal for people with a migration background (Kosec, 2015, p.4). In addition, patients with a migration background are less satisfied than the native Dutch citizens (Kosec, 2015). Thereby, the number of drop-outs and no-shows of patients with a migration background is higher than that of native Dutch patients (GGZ Standaarden, 2018; Hilderink et al., 2009). This results into a lower effectiveness of health care for people with a migration background.

Furthermore, whenever quality of health care is measured, often people with a migration background are underrepresented (Kosec, 2015). To ensure the quality of health care to people with a migration background however, scientific research is needed. There is not much scientific research on providing health care to people with a migration background. In mental health care, studies that research the effectiveness of regular health care treatments on people with a migration background lacks (van Berkum & Smulders, 2010). Moreover, the evidence based interventions used in regular health care were proved to be less effective on patients with a migration background (Knipscheer, 2015). Nevertheless, these evidence based treatments seem to be effective whenever they are approached culturally sensitive, which shows the importance of cultural sensitivity in health care (Knipscheer, 2015).

In general, more research is needed towards people with a migration background and health care, because research shows that the treatment of an illness sometimes has to be different for a patient with a migration background (van Berkum & Smulders, 2010). For example in psychiatry, diagnostic instruments can result into an incorrect diagnosis with a wrong treatment as a result. This is also the case for elderly migrants, who are also an underrepresented group in scientific research, especially the first generation migrants (den Draak & de Klerk, 2011). When there are elderly migrants involved in a research, mostly they are a small group and therefore do not represent the whole group (den Draak & de Kerk, 2011).

Furthermore, the quality of health care for people with a migration background was negatively influenced by a policy change. Before 2012, the costs for translators in health care were reimbursed by the national government. This was abolished in 2012, which means that the costs now have to be covered by health care providers themselves or get passed on to the patient (Pharos, 2019). General practitioners still can get it partly reimbursed, but for the remaining health care providers, this is not the case. The idea behind this is that people who

live in the Netherlands ought to speak and understand Dutch (Pharos, 2019). Since 2012, the number of professional translators that were used in health care reduced, especially by general practitioners (Langendijk-van den Berg et al., 2014). More and more informal translators are used, but problems arise with the use of those unprofessional translators, as a research showed that during consults with pregnant women, informal translators did translate at least half of the questions badly or not at all (Langendijk-van den Berg et al., 2014). The quality of health care for people with a migration background is therefore under pressure, because a professional translator is needed in order for the patient to get quality health care (Langendijk-van den Berg et al., 2014).

4.1.5 Conclusion

The analysis of the AAAQ framework on the Dutch regular health care sector shows that there are some concerns regarding the social inclusion of people with a migration background in the Dutch regular health care sector. Especially the findings on the acceptability, quality and accessibility criteria indicate that there is room for improvement of the inclusivity. This room could possibly be filled up by CSHCOs, dependent on their relationship with the regular health care sector.

4.2 In what way does the Dutch national health care policy consider CSHCOs and culture specific health care?

As is stated above, CSHCOs contribute to the quality, acceptability and accessibility criteria of the AAAQ framework. However, in order to contribute to these three criteria and thereby positively contributing to the social inclusion of people with a migration background into the regular health care sector, the CSHCOs have to be connected to the regular health care sector. Otherwise, this cultural expertise only stays with the CSHCOs and people with a migration background seek health care away from regular health care, excluding them from the larger society, which ultimately contributes to a parallel society.

For that reason, in the upcoming section, the relationship between CSHCOs and the regular health care sector will be elaborated based on the intercultural strategies of both the Dutch health care sector and CSHCOs. These intercultural strategies are derived from the answers on the second, third and fourth sub-questions of this thesis, that were answered using the findings. This ultimately will lead to an acculturation outcome which will give insight into the inclusive or exclusive relationship between the CSHCOs and the regular health care sector.

First, the intercultural strategy of the larger society will be derived from the findings on the Dutch national health policy, which represents the larger society. The larger society can have four possible intercultural strategies, as is elaborated in chapter 3, that define which possible intercultural strategy the non-dominant culture can have. The intercultural strategy of the larger society is based on its multicultural ideology (preferring cultural pluralism or not preferring cultural pluralism) and its acculturation expectations of the non-dominant ethnocultural groups.

The first one is the *melting pot strategy.* This is a strategy where the larger society allows the non-dominant culture to assimilate out of free will. In the case it is enforce, it is called the *pressure cooker* strategy. The second strategy is the *exclusion strategy*, which is linked to the marginalization strategy of the non-dominant culture. This strategy is in place when the non-dominant culture is forced by the dominant culture to marginalize its culture. The third strategy is the *multiculturalism strategy* is also called the *integration strategy*, which means that the cultural groups within the larger society accept cultural diversity and is open for other cultures. It is a relationship where the non-dominant culture adapts to the values of the dominant culture and at the same time the dominant culture adapts its

institutions to the culture of the non-dominant culture. It is a reciprocal relationship. The last strategy is the *segregation strategy*. This is a strategy where the dominant culture forces the non-dominant culture to be separated from the larger society. In this case, the non-dominant culture does not have a choice other than the separation strategy (Berry, 1997).

4.2.1 National health care policy

The Dutch health care system is based on four laws, the Health Insurance Act (Zvw), the Long-Term Care Act (Wlz), the Social Support Act (Wmo) and the Youth Act. These laws all regulate a part of the health care sector, which means that a certain health care service falls under one of the four laws. When a health care organization provides certain health care services, it must abide the rules of the law where these health care services fall under. Relevant for this thesis, this means that the elderly health care organizations fall under the Wmo and the mental health care organizations fall under the Zvw (Ministerie van Volksgezondheid, Welzijn en Sport, 2016).

Stated by the Zvw, every Dutch citizen has to have a basic health insurance. This basic insurance insures them for their basic health care needs, like a stay in the hospital, going to the dentist or consulting a general practitioner. It is the government that determines what kind of health care is covered by the basic insurance and under which conditions. When a certain treatment or health care is not in the basic package, a citizen can take an additional health care insurance or has to cover the expenses out of their own pocket (Ministerie van Volksgezondheid, Welzijn en Sport, 2016).

The implementation of the Zvw is foremost constructed by regulated market forces (Ministerie van Volksgezondheid, Welzijn en Sport, 2016). The health care market consists of both health care organizations and health insurance companies, functioning as the supply side of the market. The health insurance companies are responsible for purchasing health care from health care providers. The demand side consists of the patients, who can choose between different health insurance companies according to their preferences. They are important market actors in this Dutch health care system (Ministerie van Volksgezondheid, Welzijn en Sport, 2016).

As a health insurance package, about three third from the insured Dutch citizens have a so called *natura polis*. This means that whenever a patient that is insured by a certain health insurance company seeks health care at an health care provider that has a contract with their health insurance company, the health care costs are covered. However, whenever a patient seeks health care at a health care provider that does not have a contract with their health insurance company, the costs are only partly covered (Ministerie van Volksgezondheid, Welzijn en Sport, 2016). Health insurance companies can decide which health care organization they think provides the best quality and best suitable health care and can then sign a contract with that health care provider. In this way, the Dutch government tries to stimulate competition between health care organizations and between health insurance companies in order to obtain the highest possible quality of health care. The health insurance companies have to attract citizens to get insured by them and the health care organizations have to obtain contracts with health insurance companies. The Zvw is constructed this way because the demand of the citizen or patient should then shape what kind of health care is available. In the form of client councils, patients get the possibility to report their demands to health insurers. It is up to the health insurers to respond to the communicated needs of the insured (Ministerie van Volksgezondheid, Welzijn en Sport, 2016).

The other relevant law for this thesis, the Wmo, is a law that is executed by Dutch municipalities. The law is in place to make sure that people with certain living limitations still can participate fully in society, with the aim of forming an inclusive society. The Wmo supports people who need some extra help to be able to for example to stay and live at home

(Ministerie van Volksgezondheid, Welzijn en Sport, 2016). The procedure works as follows. The municipality has to determine the support demand of the patient and then has to find suitable health care. There are three support options for the patients provided by the Wmo. First, there is support that can be arranged by seeking help from people that are close to the person (informal care). Second, the support can come from the general facilities that municipalities are obliged to arrange that are open for every citizen in the municipality. These facilities are aimed at enabling citizens to participate in society. The municipality engages the help of health care providers in providing these facilities, with whom it concludes contracts, and it is the municipality that covers the expenses. The third and last option is customized provision. This means that the health care demand from the patient is translated into a personal budget (pgb). In the case of a personal budget, the patient has two choices. The municipality can arrange health care for the patient within the determined budget or the patient can purchase its own support with its own personal budget. It can be possible that the patient has to pay a personal contribution to its support whenever the chosen health care provider is more expensive than the given personal budget from the municipality (Ministerie van Volksgezondheid, Welzijn en Sport, 2016).

Municipalities and health insurance companies thus have the responsibility to choose which health care organizations they want to collaborate with and this way can shape the health care sector. The government has determined the quality requirements that have to be provided by the health care organizations, but it is up to the municipalities and the health care insurers who they want to contract. There are no demands concerning which kind of health care providers they have to contract, and also no demands on how cultural sensitive these health care providers have to be (Ministerie van Volksgezondheid, Welzijn en Sport, 2016).

In the interview with the Ministry of Health, the respondent states explicitly that there is no specific national policy made for culture specific health care. The health care sector should be inclusive, and therefore, the sector should be already accessible for people with a migration background. The sector should also be accessible for new health care organizations, that focus themselves on new target groups. There are no limitations in the Dutch law that prohibit CSHCOs to adhere to a certain demand. Whenever these newcomers meet the national admission requirements and quality guidelines, they can enter the sector. The Ministry emphasizes that even though CSHCOs can exist, it is vital that they are integrated and not separated from the health care sector. “People with a migration background can go to seek culture specific mental health care, but the time of pillarization in the health care sector does not have to come back” (Resp. 9). Referring to before the 1960s, the respondent of the Ministry indicates that temporarily, culture specific health care in the Dutch health care sector is acceptable, but in time, it is important that culture specific health care and regular health care will learn from each other. It would be desirable that CSHCOs work together with regular health care and that there would be an exchange of expertise. The Ministry emphasizes that in order for this to happen, yet some barriers have to be overcome. Even though this shows that the Ministry is open for cultural pluralism in the health care sector, cultural pluralism is not encouraged by actual national policy. The responsibility of the cultural sensitiveness of the health care sector is in the hands of the health care sector itself. “It is up to all the health care parties to ensure that the quality of the health care fits the health care needs of the patient”. Whenever certain health care needs are not met, it is up to the patient to indicate this need to the health insurance companies because it is the responsibility of the health insurance company to respond to health care demands.

In the interviews with the CSHCOs, three of 6 respondents of a CSHCO were critical about the national health policy. According to respondent 3 of a CSHCO, everything in health care has to happen in a “Dutch way”. The health care sector in the Netherlands has certain fixed ideas that every health care organization has to listen to. In the Dutch way, there is no

space for cultural aspects, according to this respondent. Respondent 1 of a CSHCO calls the Dutch culture homogenous, which results into other cultures having to adapt to the Dutch values, also in health care. Respondent 8 of CSHCO argues that the uniqueness of humans is not represented in the Dutch health care regulations. Regular health care is based on "white health care", based on 'white' ideas, which do not fit the needs of people with a migration background. It is the Dutch culture that dominates. According to respondent 7, the government should consider CSHCOs in their national health care policy in a way that whenever the demand for culture specific health care is there, CSHCOs can provide it. This in a way that quality is guaranteed, because now, CSHCOs can arise without proof of quality. There is no national policy about CSHCOs or culture specific health care, it is the health care sector itself that determines what it consists of. This leaves power in the hands of the municipalities and the health insurance companies. These answers of the CSHCOs show that the national health policy is considered as a representation of the dominant culture's values, where the dominant culture has the power to make other culture assimilate to their values, which does not favor cultural pluralism.

4.2.2 Larger society's intercultural strategy

The findings show that there is no national health care policy for CSHCOs and culture specific health care. From the perspective of the CSHCOs, the national health care policy does not take CSHCOs into account. The market structure of the Dutch health care sector is an opportunity structure for CSHCOs to arise on the basis of certain health care demands. However, the national health care policy has not adapted its policies to facilitate culture specific health care, nor does it promote culture specific health care. The larger society has a passive role creating diversity in the Dutch health care sector and there is no social support for CSHCOs. This all shows a negative view of the larger society towards cultural pluralism in the Dutch health care sector, considering that cultural pluralism in health care providers is not encouraged by the national health policy. This means that the larger society shows signs of a negative multicultural ideology, because there are no active policies that support cultural pluralism in health care providers.

Furthermore, the national health care policy expects all health care organizations to fit into the market structure. The national health policy is constructed in a way that health care organizations are obliged to take part in the market structure, which means that CSHCOs are forced to assimilate to the Dutch health care sector without any support. This can be associated with the acculturation preference of the larger society of *(forced) assimilation*. The CSHCOs are obliged to meet certain values that are developed at the national level by the dominant culture, and on the local level by municipalities and insurance companies, all three representing the dominant culture. If the CSHCOs do not assimilate to the Dutch values, they do not get contracted by health insurance companies and this would make seeking health care from a CSHCOs more expensive for patients, considering this would lead to more out-of-pocket spending. The negative multicultural ideology of the larger society and the acculturation expectation that forces CSHCOs to assimilate to the Dutch health care system results into signs of a *pressure cooker* intercultural strategy of the larger society.

4.3 How does the local implementation of the Dutch national health care policy affect CSHCOs?

The national health policy shows signs of a *pressure cooker* intercultural strategy of the larger society. In the following section, the findings about the local implementation of the national health policy by the dominant culture (municipalities and health insurance companies) will show some aspects of the *pressure cooker* intercultural strategy as well.

4.3.1 Local implementation national health policy

In the Dutch national health policy, municipalities and health insurance companies have an important position. Among others, they have the task to purchase health care. The health insurance companies have to purchase health care for the health care they have to provide according to the Zvw and municipalities for two laws, the Wmo and the Wlz.

Health insurers are obliged by the Zvw to provide the health care that is in this basic health insurance package. The insurers are free to determine which criteria they use where they base their health care purchases on, within a framework provided by the national government (Ministerie van Volksgezondheid, Welzijn en Sport, 2016). The market structure plays an important role in the Zvw. The selection of health care providers is through negotiation and selecting on the basis of quality, efficiency and customer experiences (Ministerie van Volksgezondheid, Welzijn en Sport, 2016). For the selection process, the health insurance companies possess a lot of information about health care providers that is not all open for the public. Getting a contract with a health insurance company is important, because without a contract, a patient would have to pay a lot more out of their own pocket in order to get the health care of that specific health care provider. This makes it very important to get contracted as a health care organization because it makes the health care affordable. The current health care market is dominated by four big health insurance companies with their associated health care organizations, who together cover almost 90% of the health market (OECD, 2017). Therefore, these four insurers hold a lot of power to shape the health care sector.

Next to health insurers, also municipalities purchase health care. In order to implement the Wmo, municipalities can choose to provide the health care themselves, or to outsource the health care to another health care provider. For the implementation of the Wmo, the municipalities get a budget from the government. The municipalities can decide themselves how they want to spend this budget (Ministerie van Volksgezondheid, Welzijn en Sport, 2016). There is a political aspect to this health care purchasing process, considering that the mayors and councilors have to justify to the city council how they spend the budget (Ministerie van Volksgezondheid, Welzijn en Sport, 2016). The purchasing of health care by municipalities according to the Wmo is fairly new for the Dutch municipalities. The municipalities got this responsibility in 2015, when the government decentralized health care (Rijksoverheid, n.d.b.). The municipalities are responsible for purchasing of health care without having to be accountable to the national government (van der Veer et al., 2011). They are free to fill in their health care policy (Rijksoverheid, n.d.b.).

Municipalities have different instruments that they can use in order to purchase health care. In 2018, the majority of municipalities (90%) chose for an “open house” way of purchasing Wmo health care. This means that the municipality sets certain standards, prizes and quality demands, and every health care provider that adheres to these standards and demands can get contracted (Uenk et al., 2018). It means that every health care organization has to adhere to the same demands. This means that there are no negotiations with the health care providers and the municipalities on the budget or quality. The municipality does not choose health care providers, it is then up to the patient to choose to which health care provider it wants to go to. The municipality signs an agreement with every health care provider that can adhere to the demands. Other municipalities (8%) chose in 2018 one or more health care providers based on their own criteria, which is called a public contract, and only contracted those they have chosen themselves (Uenk et al., 2018). It shows how much discretionary space municipalities have to implement the Wmo according to their preferences.

The OECD is critical about this market structure of purchasing health care in practice.

The OECD mentions that "so far purchasers have made little use of quality indicators" (OECD, 2017, p.6). The report emphasizes that in the Dutch health care system, competition is the driving force. Competition as the driving force makes it more difficult for health care organizations to integrate in the health care sector, because for integration, mutual trust and collaboration is needed (OECD, 2017). This is however not preferred in a culture of competition. The market structure in health care therefore, instead of integration, risks segregation in the health care sector (van Berkum & Smulders, 2010).

Out of the interview data came forward that the CSHCOs experience different things with the local implementation of the national health policy. There were two respondents of a CSHCO that experienced problems with getting contracts with health insurance companies, due to certain regulations and due to the fact that the health insurance company did not see the added value of a CSHCO because it considered regular health care organizations to be inclusive enough. They addressed the power of the insurers to determine who they want to contract. To get a contract from a insurer, health care providers have to meet many requirements and fulfill a lot of paperwork. Respondent 6 of CSHCO says "… the system is rigid, insurers are the people that gradually determine it all" and respondent 8 from a CSHCO says that insurers focus on the rules that you have to obey as a health care provider.

Furthermore, the power of municipalities came forward in multiple ways. First of all, it is the municipality who holds the budget for the spending of the Wmo, a budget where a lot of small health care organizations depend on. Three respondents of CSHCOs mention that the personal budgets have resulted into problems for the image of CSHCOs, because some organizations had taken advantage of this. Respondent 8 says this has resulted into distrust of regular health care institutions towards CSHCOs, which gives the respondent the feeling it has to prove its professionality more than regular health care organizations. Second of all, the municipalities can decide if they want to contract bigger and thus less health care organizations, to prevent paper work, or can choose to contract multiple health care organizations, which is in favor of the smaller health care providers like CSHCOs.

Moreover, the interview data showed that participating in the health care market structure like regular health care organizations seems to be more difficult for CSHCOs, considering that the health care needs of their patients are often more complex, for example for first generation migrants, or take more time due to cultural based needs. Thereby, the CSHCOs provide health care for minorities, which means that their potential client base is also smaller than for regular health care organizations. This can make the budget per patient higher, which could give them a weaker position in the culture of competition. Thereby, one CSHCO experienced problems because of the fragmentation of health care into different laws. According to this respondent, this makes collaborating with other health care organizations difficult, because they fall under a different law with different regulations. The migrant target audience often falls outside the fixed laws and protocols which makes it a challenge to properly help these patients.

In light of these findings, CSHCOs thus have to assimilate to the demands of the municipalities and insurers, both representants of the dominant culture and the larger society. CSHCOs are forced to assimilate to the market structure, otherwise, whenever they cannot get contracts with health insurance companies, the health care they provide will be more costly than other health care providers with a contract. Getting contracts with municipalities is also of great importance, in order to provide health care to citizens that fall under the Wmo within a municipality. If they do not get contracted with municipalities, they lose out on patients. Therefore, in order for CSHCOs to get considered to be contracted by the larger societies' institutions (the municipalities and insurers) and compete on the health care market, they have to assimilate. They are however dependent on the multicultural ideology of the insurers and the municipalities. The OECD writes in its report that competition rules the

health purchasing negotiations, not yet quality. It seems that the implementation of the market structure by municipalities and insurers on the local level does not favor cultural pluralism in health care, considering that competition is the driving force which works against integration. Together with that, the forced assimilation of CSHCOs to the Dutch local dominant culture's institutions shows again signs of an intercultural strategy *pressure cooker* of the larger society.

4.4 How do CSHCOs relate to the regular health care sector?

The last sub-question focusses on the intercultural strategy of the non-dominant cultures, the CSHCOs. The CSHCOs can have a preference towards an intercultural strategy, but it is the intercultural strategy of the dominant culture that determines what the acculturation strategy of the non-dominant cultures can be. The dominant culture has power over the acculturation outcome, therefore it is called the dominant culture.

There are four possible intercultural strategies, as elaborated in chapter 3. The first possible intercultural strategy of the non-dominant cultures is the assimilation strategy, which means that the non-dominant cultures is open to be in contact with other cultures and wants to take over the cultural norms of the dominant culture and give up their own. The second acculturation strategy is the separation strategy, where an ethnocultural group holds on to their own culture and therefore separates from the dominant culture. The third strategy is the integration strategy, where the ethnocultural groups preserves its own culture and is open for other cultures. This strategy is at place whenever the non-dominant cultures are open to be in contact with the dominant culture and are willing to assimilate. This strategy is only possible whenever the dominant culture is also open to adapt to the non-dominant cultures. The last possible strategy is the marginalization strategy. In this strategy, the non-dominant culture cannot be preserved by the non-dominant group due to for example enforced cultural loss and at the same the preference is to not have contact with other cultures (Berry, 2008; Berry, 2011).

4.4.1 Intercultural strategy CSHCOs

To start, the reasons why CSHCOs have emerged given in the interviews, gives insight into how CSHCOs are related to the regular health care sector. In the interviews with the CSHCOs, the respondents emphasize that the demand (or lack of supply) was an important factor of the emergence of their CSHCOs. The representant of SGAN also emphasizes that there is a marketization of culture specific health care and there are entrepreneurs who respond to this. The market structure of the Dutch regular health care sector is steered by supply and demand. On the supply side are health care providers, municipalities and insurers and on the demand side are the health care seekers. According to respondent 7 of a CSHCO, it is the same as in education and the commercial world, "where a gap arises, it is filled by others". Respondent 6 of a CSHCO mentioned that the health care sector has become a market and respondent 8 also from a CSHCO says that culture specific health care is a niche in this market. Respondent 2 from a regular health care organization thinks that this is good, that whenever there is a certain health care demand, this is supplied.

Overall, the CSHCOs say that this demand has risen due to a lack of fit between regular health care and patients with a migration background. The "white health care", as respondent 8 of a CSHCO calls regular health care, does not fit the health care needs of people with a migration background. Respondent 7 says: "Regular health care organizations say they are accessible for everybody, but with everybody you do not have special attention for specific groups". The CSHCOs seem to think that not every treatment will be helpful for all patients but it has to be adapted to the patient. In regular health care, protocols guide but those treatments do not always fit the health care needs of people with a migration

background, according to the CSHCOs respondents. In CSHCOs, treatments will be adapted to better fit the health care need of the patient, because sometimes the treatment can go against certain cultural values of a patient. They try to study how treatments can be adapted and what fits the best. The quality of regular health care and CSHCOs is the same, but the approach is different. Sometimes more flexibility is needed of the health care provider in order to fit the treatment better to the health care needs of the patient.

The CSHCOs mention in the interviews to have certain cultural competences that regular health care seems to lack that helps them develop person-oriented care for people with a migration background. Considering that patients can have different cultural backgrounds, it is important that the health care provider develops a way of thinking with which every patient with a different cultural background than Dutch can be helped. Cultural competences mentioned in the interviews are not only speaking the same native language as the patient and having cultural knowledge, but it is also about being able to work experience-oriented and about having a certain (culturally based) recognizability with the patient which results into trust.

Furthermore, all the respondents in the interviews, from the CSHCOs and regular health care organizations to SGAN, emphasize the importance of collaboration, some even prefer integration, between CSHCOs and the regular health care sector. The respondent of SGAN mentions that it is important for patients with a migration background that they do not have to seek health care away from regular health care, "especially in times where there are tensions between certain groups". In the short-term, it is good that CSHCOs provide health care that people with a migration background need. However, according to SGAN, in the long-term, it is important that CSHCOs and regular health care organizations are going to work together to make regular health care able to meet the demands of patients with a migration background. Respondent 7 of a CSHCO also emphasizes that as a short-term solution, CSHCOs can be separate from regular health care, but in the long-term this is not favorable, because otherwise, CSHCOs would "contribute to segregation in society".

Out of the interviews with the CSHCOs also came forward that they all encourage collaboration between CSHCOs and regular health care organizations. Especially cross-pollination between CSHCOs and regular health care organizations is viewed as a fruitful idea for both parties. Despite that CSHCOs try to maintain certain cultures by adapting Dutch health care to the cultures of the patients, the CSHCOs indicated that they are willing to learn from regular health care organizations as well as sharing their cultural knowledge. The majority of the respondents, also the regular health care organizations, even prefer the integration of CSHCO into the regular health care sector. Nevertheless, one respondent of a CSHCO mentioned that its CSHCO has a niche and therefore, sharing knowledge would not be strategic for market reasons. Overall, all CSHCOs prefer collaboration with, some even integration in, the regular health care sector which shows that the CSHCOs are open to be in contact with other cultures and are willing to assimilate. The statements of the SGAN, as spokesperson for migrants in the Dutch health care sector, together with the statements of the CSHCOs, shows that integration, and thus contact with the dominant culture and assimilating to its health care values, is encouraged by the non-dominant cultures. Therefore, they show signs of the intercultural strategy of *integration*¸ where the non-dominant culture is open to assimilate to the dominant culture and willing to be in contact with the larger society.

Moreover, the CSHCOs mention to have connections with the regular health care sector and mention in the interviews different types. Collaboration occurs between CSHCOs and regular health care organizations on difficult cases or they contact each other for advice. Regular health care also refers patients to CSHCOs when they cannot provide the health care needs of the patient. The CSCHOs mention to have contracts with municipalities, health insurers and being connected to general practitioners, hospitals and social neighborhood

teams. One CSHCO had welcomed representants of the Ministry of Health to share knowledge. In the interviews, the two respondents of regular health care organizations mentioned that their organization thinks it can provide quality health care for people with a migration background. Collaboration with or referring the patient to a CSHCO would only take place, according to respondent 2 of a regular health care organization, whenever this would be in the best interest of the patient.

In addition, two annual reports of CSHCOs showed that they collaborate with regular health care organizations. The CSHCOs collaborate mostly with other (health care) organizations and foundations that focus op people with a migration background. One annual report of a CSHCO did not state which kind of collaborations took place. One annual report of a CSHCO mentioned that municipalities were the biggest clients of that CSHCO that year and got new contacts with municipalities. The other reports did not deliver that kind of information. The report of the regular health care organizations showed that a lot of collaboration took place between the regular health care organization and other regular health care organizations and institutions. The annual reports of the CSHCOs did not state that in the future collaboration with regular health care organizations is pursued and encouraged by the CSHCOs, which was emphasized during the interviews. The two annual reports of the interviewed respondents of regular health care organizations showed no collaboration between CSHCOs and the organization, only with regular health care organizations.

Besides, one annual report of a CSHCO showed an interesting connection between culture specific health care and regular health care. This is a CSHCO that is connected to a regular health care organization as it is one of the specialistic teams of the regular health care organization. This makes this CSHCO different from the other CSHCOs and is unique, because the others have risen independently and this one has been created within a regular health care organization because the organization recognized a certain demand among its patients. This team specializes in culture specific health care and therefore adds a certain available expertise to the regular health care organization. It is an example of how culture specific health care could be integrated into regular health care and in this case culture specific health care is place in the regular health care organization.

In conclusion, the CSHCOs indicated in the interviews that they arose due to a demand for culture specific health care, caused by a lack of supply. This demand seems to have risen due to a lack of fit between regular health care and the health care needs of people with a migration background. CSHCOs can respond to the needs of people with a migration background, because of certain cultural competences they possess. They are already sharing their cultural knowledge with the regular health care sector, and are willing to do that more. Overall, the results thus show signs of a preferred intercultural strategy of the CSHCOs of *integration*, which is a strategy where non-dominant ethnocultural groups are willing to assimilate to and be in contact with the dominant culture of the larger society. This is showed by the fact that the CSHCOs indicate to be willing to collaborate or even integrate into the regular health care sector. The interviews showed that the CSHCOs are open to collaborate with regular health care organizations by sharing knowledge and gaining knowledge. This means that they are open to be in contact with the dominant culture and willing to assimilate, which are both aspects of a preferred intercultural strategy of *integration*.

4.5 Acculturation outcome

The four sub-questions of this thesis have shed light on the intercultural strategies of the Dutch larger society and the ethnocultural groups. The first sub-question has showed that CSHCOs can contribute to the accessibility and acceptability of regular health care whenever the CSHCOs are not separated from the regular health care sector. The answers to the second and third sub-questions show that CSHCOs are forced to assimilate to the market structure

and values of the dominant culture. There is no national health policy that supports culture specific health care or CSHCOs. There is no national policy based social support for them which means that even on the local level, culture specific health care is not ensured. The national health policy gives a lot of power to municipalities and health insurance companies on the local level, who can decide themselves which health provider they would like to contract. This means that CSHCOs have to assimilate to the values and demands of municipalities and health insurance companies, who represent the dominant culture. CSHCOs have to compete as every other regular health care organization in the Dutch health care market structure has to do. On the local level, they are dependent on the multicultural ideology of municipalities and insurers, whenever they do prefer cultural pluralism in the health care providers they choose to contract, this is in favor of CSHCOs. If the focus whilst purchasing health care is more on competition, as the OECD concludes it is, this is not in favor of all smaller health care organizations like CSHCOs. It means that CSHCOs are dependent on what the dominant culture's multicultural ideology in local policies is which shows the power of the dominant culture transferred to the municipalities and health insurers. The CSHCOs have to assimilate to the dominant culture's national health policy and to its local implementation by the dominant culture's institutions. Given that the national health policy does not actively support CSHCOs and culture specific health care which supports a negative multicultural ideology, together with forced assimilation, shows signs of the larger society having a *pressure cooker* intercultural strategy.

As for the CSHCOs, the interview data shows that CSHCOs are open to work together with regular health care organizations and are open to share their cultural knowledge to the outside world. Collaboration is currently mostly occurring in the forms of sharing cultural knowledge to regular health care organizations or taking over patients for whom a regular health care organization cannot cover its needs. However, the intention to collaborate with regular health care is only pronounced in the interviews because it cannot be supported by the annual reports, where no intention to collaborate more with regular health care organizations was written down. Also, the annual reports did not show what kind of collaboration took place between the CSHCOs and regular health care organizations, what did took place according to the interview data. Nevertheless, integration into the regular health care sector is preferred by the majority of the CSHCOs and by SGAN. Therefore, the results show signs of the intercultural strategy *integration*.

These two intercultural strategies together, the *pressure cooker* strategy of the larger society and the *integration* strategy of the CSHCOs result into an acculturation outcome of *acculturative stress*. This means that the larger society and the CSHCOs have two non-corresponding intercultural strategies based on their preferences and the non-dominant ethnocultural groups (the CSHCOs) experience problems with the acculturation expectations and preferences of the larger society. Acculturative stress occurs when national policies within the larger society are in conflict with the acculturation preferences of the individual or ethnocultural group, which the results also show. The interviews show that the CSHCOs prefer to collaborate or even integrate into the regular health care sector, something which the national health policy does not encourage due to the marketization of health care and due to the fact that there is no national health policy actively supporting culture specific health care. Acculturative stress results into the separation or marginalization strategy of the ethnocultural group because a fit between dominant culture and ethnocultural group cannot be made (Berry, 1997). It means that there is no relationship between the larger society and CSHCOs.

4.6 Conclusion

This chapter starts with the results of the implementation of the AAAQ framework on the Dutch regular health care sector, which measures the dependent variable of this thesis. The findings show some concerns regarding the inclusivity, especially for the quality, acceptability and accessibility criteria of the framework. There seems to be room for improving the inclusivity of the regular health care sector, room which CSHCOs could possibly fill up, depending on their relationship with regular health care.

Following, this chapter dives into findings that give insight into the intercultural strategies of the CSHCOs and Dutch regular health care, which is the moderating variable of this thesis. First, the intercultural strategy of the larger society seems to be *forced assimilation*, given that the larger society's national health policy does not actively support cultural pluralism in health care and expects that every health care organization assimilates to the Dutch health care market structure. Even in the implementation of the national health policy, CSHCOs are forced to adhere to the demands of the dominant culture, which is represented on the local level by municipalities and health insurance companies. Second, the CSHCOs show signs of a preferred acculturation strategy of *integration*, considering they want to be and are open to be in contact with the larger society and are willing to assimilate. This is supported by statements of the CSHCOs that they are and are willing to share knowledge with regular health care organizations and are willing to learn from regular health care organizations. The majority even prefer full integration of CSHCOs into the regular health care sector.

These two intercultural strategies result into the acculturation outcome of *acculturative stress*. This outcome occurs due to a lack of fit between national policies and the acculturation preference of the ethnocultural group, in this case, the seemed preference of the CSHCOs to integrate and the national health policy that does not facilitate cultural pluralism in health care. The discordance of intercultural strategies leads to separation or marginalization of non-dominant cultures from the larger society, which results into no relationship between the larger society and the non-dominant cultures.

Chapter 5 Conclusion and discussion

With the growing number of migrants in the Netherlands and the growing number of CSHCOs, this thesis tries to answer the following central research question: *How do CSHCOs contribute to the social inclusion of minorities in the Dutch regular health care?* To answer this question, a qualitative explorative research has been conducted to shed light on the intercultural strategies of the Dutch larger society and the CSHCOs as representants of minority groups in Dutch health care.

First, the results show elements of an intercultural strategy of the larger society of *forced assimilation*. The national health policy does not take culture specific health care or CSHCOs in consideration. In practice, this means that municipalities and health insurers, the two main actors that shape the Dutch health care sector, are not obliged to take cultural sensitiveness into account when purchasing health care on the Dutch health care market. CSHCOs are forced to assimilate to the market structure of the Dutch health care sector and are dependent on the multicultural ideology of the municipalities and health insurers. The report of the OECD on the Dutch health care sector however revealed that the health purchasers mainly focus on budget, and not on quality, and that due to the culture of competition, integration of health care organizations into the regular health care sector is being bothered. It shows that the larger society's national policy does not actively support cultural pluralism in health care and expects that every health care organization assimilates to the Dutch health care values, both aspects of the *forced assimilation* intercultural strategy.

Second, the results showed that the interviewed CSHCOs were open to collaborate and share knowledge with the regular health care sector. They are open to assimilate to the Dutch values and demands in the health care sector and to be in contact with the larger society. The majority of the CSHCOs even emphasized in the interviews that integration of CSHCOs into the regular health care sector would be favorable, as is also favored by SGAN. This all shows an intercultural strategy of the CSHCOs of *integration,* where the non-dominant cultures are willing to assimilate to the dominant culture and willing to be in contact with other cultures.

Third, as a result of the two non-corresponding intercultural strategies of the larger society and the CSHCOs, this thesis shows that the acculturation outcome between the Dutch health care sector and CSHCOs results into *acculturative stress*. Acculturative stress occurs when national policies within the larger society are in conflict with the acculturation preferences of the ethnocultural groups, which is also the case in this study. It usually results into the separation or marginalization strategy of the ethnocultural groups because a fit between the dominant culture and ethnocultural groups cannot be made.

In conclusion, this shows that the contribution of CSHCOs to the social inclusion of minorities into regular health care remains limited. CSHCOs indirectly contribute to the social inclusion of minorities into regular health care by providing culture based health care knowledge to regular health care organizations, which improves their inclusiveness. However, CSHCOs could contribute much more to the social inclusion of minorities by improving the quality, accessibility and acceptability of the whole of the regular health care sector, whenever integration into regular health care would be encouraged by the national health care policy.

5.2 Discussion

This final part of the thesis will reflect on the theoretical framework, the method of analysis and the implications of this thesis. This part will finish with recommendations for further research.

5.2.1 Reflection of the theory, methodology and analysis

The theoretical foundation of this thesis, the acculturation model of Berry, is a model that is foremost used in psychology studies. It is also used to study policies and organizations that reflect intercultural strategies of ethnocultural groups, but there are no fixed measurement tools for doing so. Normally, intercultural strategies are measured using surveys. This meant for this thesis that the model had to be translated in a more workable model for studying policies, reports and interview data. The theoretical foundation was given by Berry, but the actual operationalization had to be shaped to the data available for this thesis. During this translation the model could have lost some validity, but during the operationalization, all aspects of the model were taken into consideration. The concrete application and outcome of the model turned out to be well suited for answering the central question of this thesis.

Thereby, the acculturation model of Berry is a two-dimensional model. There also exist models of acculturation that are built on more than two dimensions. The model of Berry is seen as a limited model to analyze acculturation because it only consists of two dimensions. Migration has become progressively more complex which causes the two-dimensional model to often fall short. The model does not take more contemporary migration issues linked to culture into consideration, like transnationalism (Van de Vijver, 2015). In the case of this thesis, the simplicity of the model made the model fit the data because the model was better operationalizable. However, this means that the analysis of the intercultural strategies is compact and does not take into account other possible factors that greater acculturations models do.

A methodological limitation in this thesis is the small number of interviews with regular health care organizations in comparison to the number of interviews with CSHCOs. This made making a comparison between the regular health care organizations and CSHCOs less feasible, considering that the regular health care organizations were outnumbered. The idea was to interview an equal amount of regular health care organizations and CSHCOs, but due to logistical reasons, this was not possible. In general, this study is not generalizable due to the small number of interviews, which is another methodological limitation of this thesis.

Furthermore, during the analysis of the data of this thesis, the codes fitted the content of the data well. The codes helped categorize the fragments of the data which helped interpreting and dividing the data. The codes were compact enough and yet vast enough, which gave room to the researcher to interpret. The analysis would have been easier if the second, third and fourth sub-questions would be more specifically linked to codes, which now was not the case. This gave room to the researcher to interpret, but at the same time, made the analysis less structured.

5.2.2 Implications of this thesis

This thesis dives into the world of CSHCOs which is a field fairly unknown. This explorative research made it possible to take a look into the position of CSHCOs in the Dutch health care sector. The outcome of this thesis sheds light on possible exclusionary processes caused by the Dutch national health care policy for CSHCOs and culture specific health care. This thesis tries to show how migration in the Netherlands shapes the landscape of the Dutch health care sector and shows how the system level of a country can influence the inclusivity of minorities on the micro level, even in health care. The results can be used to critically look at the current national health policy and its implementation to make it more inclusive, as an inclusive society is the goal of the Dutch government.

5.2.3 Further research

This thesis was a first step into the world of CSHCOs in the Dutch health care sector. Due to the fact that the thesis was an explorative research, the conclusion that resulted from the

findings should be further researched in order to be able to make generalizations. Further research should focus more on regular health care organizations and their view on culture specific health care and CSHCOs, as this thesis mainly focused on CSHCOs, as was previously mentioned. Also, future research should entail the viewpoint and attitude of big actors in the Dutch health care sector towards CSHCOs, the insurers and municipalities, who lacked in this thesis, as they hold considerate power in shaping the health care sector.

Additionally, it would be interesting to look at this question not only from an institutionalist viewpoint, but also from the viewpoint of the patients themselves. It would be interesting to further research why patients with a migration background choose for culture specific health care. This could help make the Dutch regular health care more inclusive. Thereby, the OECD mentioned that there is an increase of out-of-network payments. This shows that patients are choosing health care providers that are not contracted by health insurers, which could possibly indicate that there is a discrepancy between the demand of patients and supply from the insurers. Further research should be needed to find out to which kind out-of-network health care providers the patients turn to and why. The results can provide insight into the functioning of the market system of the Dutch health care sector.

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Appendix 1 Respondents

Short description of the respondents.

Organization	Respondent	Function(s)
1	Respondent 1	Medical director
2	Respondent 2	Psychiatrist/departement manager
3	Respondent 3	Founder/director
4	Respondent 4 and Respondent 5	Both psychiatrists
5	Respondent 6	Caregiver
6	Respondent 6	Caregiver
7	Respondent 7	Founder/ director
8	Respondent 8	Director

Appendix 2 Interview guides

Regular health care interview guide

Definition of culture specific health care

Different terms are used in literature and practice to speak about care that takes into account culture, language and migration background. In this research, we focus on culture specific health care organizations. By this we mean a healthcare facility (organization, department) that is explicitly aimed at clients with a migration background. The provision is in all facets (accessibility, methodology, working method, competencies and composition of staff) focused on customization, taking into account lifestyle, cultural background, migration background, language and identity of the client and their context.

General questions

1. Are you familiar culture specific health care organizations (see definition above)?
2. What does the group of clients look like in your organization? (Ethnic background (are there also clients without a migration background?), Religious background, Age (especially at GGZ))
3. Is your organization easily accessible for clients with a migrant background? How do you know?
4. To what extent is the work in your organization sensitive to the culture of your patients? Do your working methods and the competencies of your employees fit well into the expectations and living environment of clients with a migrant background?
5. Do you identify certain needs (with regard to, among other things, accessibility, diagnosis, treatment) for clients with a migration background that you are unable (or are difficult) to meet?
6. To what extent has your organization been engaged in interculturalization of health care over the past 10 years?

Regular health care and/ or culture specific health care

1. Do you refer clients to culture specific health care services? Why?
2. What is your view on culture specific health care? Does it have an added value? Which?
3. Do you collaborate with culture specific health care organizations on intercultural quality development?
4. Is it desirable to collaborate more intensively with culture specific health care organizations to further develop the care as whole? Why yes/ no?
5. Do you see opportunities to collaborate more with regular healthcare facilities? Under what conditions can that be successful?
6. In which way could culture specific health care organizations learn from you? And vice versa?
7. In what way could regular care learn from you? And vice versa? Do you see opportunities to collaborate more with regular healthcare facilities? Under what conditions can that be successful?
8. What are the advantages and disadvantages of the existence of culture specific care services in addition to regular care facilities? Is this a reason for regular care not to improve? Is there no continuum in approach, directing towards segregation in health care?

9. Do you see culture specific care as an addition to regular care, as long as in regular health care there is still an insufficient integral cultural sensitive way of working? Or is culture specific health care something that will always remain a specialty?
10. What do you see as a perspective for the future? Do you see culture-specific and regular care gradually merging into one another, or not?

Culture specific interview guide

Definition of culture specific health care

Different terms are used in literature and practice to speak about care that takes into account culture, language and migration background. In this research, we focus on culture specific health care organizations. By this we mean a healthcare facility (organization, department) that is explicitly aimed at clients with a migration background. The provision is in all facets (accessibility, methodology, working method, competencies and composition of staff) focused on customization, taking into account lifestyle, cultural background, migration background, language and identity of the client and their context.

General questions

1. Are you familiar with both regular health care and culture specific health care?
2. What does the group of clients look like in your organization? (Ethnic background (are there also clients without a migration background?), Religious background, Age (especially at GGZ))
3. Why did your culture specific health care service arise? (Are regular health care services insufficiently accessible? Or, because regular health care does not fit the needs of migrants or are there other reasons?)
4. Does your culture specific health care organization fit the health care system? Or are there any challenges?

Collaboration

1. How do clients end up with you?
   a. (Are they coming directly to you? Are you more accessible than regular healthcare facilities?
   b. Are they referred? Why? Because you have an offer that regular care does not have? Because you can offer specialist intercultural care (for problems for which regular care has no solution))?
2. Do you work together with regular health care organizations on "intercultural quality improvement"? (If so, how? If not, why not?)

Regular or culture specific health care

1. Is it desirable to collaborate more intensively with regular healthcare organizations to further develop healthcare as a whole? Why yes / no?
2. In what way could regular care learn from you? And vice versa? Do you see opportunities to collaborate more with regular healthcare organizations? Under what conditions can that be successful?
3. What are the advantages and disadvantages of the existence of culture specific care services in addition to regular care facilities? Is this a reason for regular care not to

improve? Is there no continuum in approach, directing towards segregation in health care?

4. Do you see culture specific care as an addition to regular care, as long as in regular health care there is still an insufficient integral cultural sensitive way of working? Or is culture specific health care something that will always remain a specialty?
5. What do you see as a perspective for the future? Do you see culture-specific and regular care gradually merging into one another, or not?

3 Annual reports

Organization	Year of annual report
1	2018
2	2017
3	X
4	2018
5	X
6	2018
7	X
8	2018