

PATIENTS' PERCEPTION OF DIFFERENCES IN GENERAL PRACTITIONERS' ATTITUDES TOWARD IMMIGRANTS COMPARED TO THE GENERAL POPULATION: QUALICOPC SLOVENIA

POGLED PACIENTA NA RAZLIKE V ODNOSU ZDRAVNIKA SPECIALISTA DRUŽINSKE MEDICINE DO PRISELJENCEV V PRIMERJAVI S SPLOŠNO POPULACIJO: QUALICOPC SLOVENIJA

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ABSTRACT

Keywords:
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Introduction. Globally, the number of immigrants is rising every year, so that the number of immigrants worldwide is estimated at 200 million. In Slovenia, immigrants comprise 6.5% of the overall population. Immigrants bring along to a foreign country their cultural differences and these differences can affect immigrants' overall health status and lead to chronic health conditions. The aim of this study was to identify patients' perception of general practitioners' (GPs') attitudes toward immigrants in Slovenia.

Methods. This study was based on the Qualicopc questionnaire. We used the questions that targeted patients' experience with the appointment at their GP on the day that the study was carried out.

Results. There were no differences in GPs' accessibility based on groups included in our study ($p > 0.05$). Compared to the non-immigrant population, first-generation immigrants answered that their GPs were impolite ($p = 0.018$) and that they did not take enough time for them ($p = 0.038$). In addition, they also experienced more difficulties understanding their GP's instructions ($p < 0.001$). Second-generation immigrants experienced more negative behaviour from GPs, and first-generation immigrants had more difficulties understanding GPs' instructions.

Conclusion. There may be some differences in patients' perception of GPs' attitudes towards immigrants in comparison with the general Slovenian population. However, based on the perception of the immigrants that do benefit from the medical care it is not possible to judge the GPs' attitudes towards immigrants as worse compared to their attitude towards the non-immigrant population. Indeed, there may be other reasons why the patients answered the way they did.

IZVLEČEK

Ključne besede:
odnos
zdravnika
specialista
družinske
medicine,
priseljenci,
jezikovne
omejitve

Uvod. Število priseljencev v svetovnem merilu vsako leto narašča. Ocenjeno število priseljencev tako znaša že kar 200 milijonov ljudi. V Sloveniji priseljenci predstavljajo 6,5-odstotni delež vseh prebivalcev. Priseljenci ob selitvi v novo državo s seboj prinesejo tudi pomembne kulturne razlike v odnosu do zdravja in zdravstva v primerjavi s splošno populacijo. Vse te razlike imajo lahko pomemben vpliv na splošni zdravstveni status priseljenca in lahko vodijo v razvoj različnih kroničnih bolezni. Vedno več držav se v zadnjem času zaveda težav, s katerimi se priseljenci srečujejo v zdravstvenih ustanovah, ter se z različnimi programi skušajo priseljenecem približati ter jim olajšati in omogočiti enakovreden dostop do zdravstvenih storitev. Namen naše študije je bil ugotoviti, ali imajo zdravniki specialisti družinske medicine po mnenju pacientov resnično drugačen odnos do priseljencev v Sloveniji, kakšni so razlogi za to in s kakšnimi težavami na področju zdravstva se priseljenci v Sloveniji srečujejo.

Metode. Študija temelji na rezultatih, pridobljenih s pomočjo Qualicopcevega vprašalnika, izvedenega leta 2011 v Sloveniji. Pacientom so po posvetu z izbranim zdravnikom študenti medicine v izpolnjevanje ponudili vprašalnik, ki se je nanašal na njihovo predhodno obravnavo pri zdravniku. Iz Qualicopcevega vprašalnika smo izluščili tista vprašanja, ki zadevajo problematiko, obravnavano v naši študiji. Uporabili smo bazo PQE 4. 1. junij 2014.

Rezultati. Pri odgovoru na vprašanje o dostopnosti zdravnika specialista družinske medicine za priseljence glede na splošno populacijo ni bilo statistično pomembnih razlik ($p > 0,05$). V primerjavi s splošno populacijo je prva generacija priseljencev statistično pomembno večkrat podala odgovor, da je bil zdravnik specialist družinske medicine do njih neprijazen ($p = 0,018$), prav tako pa jih več misli, da si zdravnik ni vzel dovolj časa zanje ($p = 0,038$). Predstavniki prve generacije priseljencev imajo tudi več težav z razumevanjem navodil zdravnika ($p < 0,001$). Predstavniki druge generacije priseljencev so večkrat odgovorili, da je zdravnik do njih pokazal slabši odnos, predstavniki prve generacije priseljencev pa so večkrat odgovorili, da imajo težave z razumevanjem zdravnikovih navodil.

Zaključki. Rezultati študije so prikazali, da obstaja kar nekaj razlik med predstavniki prve/druge generacije priseljencev in splošno populacijo v povezavi z njihovim doživljanjem odnosa z zdravnikom specialistom družinske medicine. Kljub temu pa ne moremo le na podlagi nekaj izvzetih vprašanj dokončno zaključiti, da je odnos zdravnikov specialistov družinske medicine do priseljencev slabši kot do splošne populacije, saj za dane odgovore obstaja več različnih vzrokov, za katere pa ni nujno odgovoren le zdravnik.

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1 INTRODUCTION

People leave their home countries for various reasons: either because of war and poor living conditions in their homeland, or due to better job opportunities and social-economic status in a new country (1-3). This is why people mostly emigrate from countries with poor medical care to the countries where medical care is considerably better (1). Globally, the number of immigrants is rising every year; between 1990 and 2005, this number increased by 33 million each year. The number of immigrants worldwide is estimated at 200 million (4).

The important issue for this study is that immigrants bring along their cultural differences in relation to health and also their own perspective on the healthcare they need (1). They tend to have a different health behaviour compared to the non-immigrant population: regarding alcohol consumption, smoking, physical activity, among other behaviours. These differences may affect immigrants' overall health status and lead to chronic health conditions (5, 6). Immigrants are less responsive to various systematic prevention programs, and they have a lower vaccination rate (1, 7). It is also significant that they often do not know the healthcare regulations in their host country, which may lead to difficulties when arranging appointments and following registration procedures (1). In order to ameliorate the situation, general practitioners (henceforth GPs) dealing with recently arrived immigrants are provided with certain guidelines. These guidelines advise caution in the first contact with immigrants and recommend treating high-priority conditions immediately. GPs should pay special attention to abuse or domestic violence, mental illnesses, diabetes mellitus, dental care, infectious diseases (HIV, hepatitis), and other conditions (4, 8-10). When doctors and their patients come from different cultural environments, their communication is somehow difficult. If patients have to express themselves in a foreign language, problems may arise already at the linguistic level. For example, immigrants may not understand their GPs, but are too embarrassed to admit it. They may also misunderstand the doctor's instructions. Studies have shown that the greatest difficulties occur with the patients that have limited language proficiency: even if they can articulate their problems and they do understand the doctor's instructions, they might not be able to talk about their emotions. Too often, the language issues prevent these patients from being treated the same way as the non-immigrant population. Many studies have recommended that doctors should suggest an interpreting service for their patients in such cases (11, 12).

Many studies have highlighted adjustment challenges that immigrants might experience, including (as mentioned above) language differences, as well as homesickness, unfamiliarity with the social-cultural

system, unemployment, educational difficulties, and social exclusion. They may also experience difficulties with respect to their religion, family traditions, and values (13-15). All of these differences and difficulties may contribute to immigrants' social and emotional instability. This is an additional challenge that GPs face when consulting immigrants (13).

1.1 Immigrants in Slovenia

Immigrants have left a significant mark on the population and social development of Slovenia over the last fifty years. The migration flow between Slovenia and foreign countries beyond the former Yugoslavia did not change significantly after Slovenia's independence. Migration remains closely associated with immigrants from other countries of the former Yugoslavia. Slovenia has been and also remains a target destination for many residents from these areas. It has also been observed that the number of immigrants in Slovenia has increased in the last decade, mainly due to two reasons. First, there are favourable economic conditions and increased demand for labour in certain sectors (e. g., construction) that cannot be satisfied by Slovenian labour market. Second, Slovenia's admission to the European Union (EU) has encouraged migration of EU citizens and family reunification (secondary migration of family members to Slovenia) (16).

On January 1st, 2014 there were 96,608 immigrants registered in Slovenia which, according to the data provided by the Statistical Office of the Republic of Slovenia, comprised 4.7% of all Slovenian residents. In this share, men predominate (67.2%). However, the proportion of female immigrants is growing every year. In 2013, their share increased by 6.5% compared to the previous year (17). Regarding the distribution of immigrants in Slovenia, more immigrants settle in urban areas than in rural areas, but there are also significant variations between different cities (18).

In order to help immigrants to integrate into Slovenian society, they are provided with an educational program. In the course of initial integration, immigrants are familiarized with Slovenian language and culture, the education system, and their options for finding employment. This allows them to integrate more rapidly and find a job more easily, which makes them financially independent (19).

1.2 Immigrants and the Healthcare System in Slovenia

Slovenia has a Bismarckian type of social insurance system based on a single insurer for statutory health insurance, which is fully regulated by national legislation and has been administered by the Health Insurance Institute of Slovenia (HIIS) since 1992. This insurance is universal and is based on either clear employment status or a

legally defined dependency status (such as: for minors, unemployed spouses, registered unemployed people and individuals without a source of income) (20). In Slovenia, the access to GPs and to other doctors in primary care (e. g., paediatricians, gynaecologists) is almost universal. Since all insured residents of Slovenia have the right to choose a GP, paediatrician, and/or gynaecologist for free (21).

Healthcare for asylum seekers is organized within the framework of the public health network. In the event of sickness, the asylum seeker may receive treatment at the nearest healthcare centre upon presenting a valid asylum-seeker identity card. There is no specific legislation regarding healthcare for undocumented migrants. However, according to the Health Care and Health Insurance Act of 1992 (Official Gazette of the Republic of Slovenia no. 9/92), the Asylum Act (Official Gazette of the Republic of Slovenia no. 61/99), and the Aliens Act (Official Gazette of the Republic of Slovenia no. 14/99) the funding of urgent healthcare for individuals of unknown residence should also be provided (22). Since this entitles anybody to urgent medical care, it applies to undocumented migrants, too (23).

According to current international law (the General Administrative Procedure Act, Patient Rights Act, and International Protection Act), patients have the right to an interpreter if they cannot understand or speak the official language of the country in which they are treated. In Slovenia, however, legislation in this area is insufficient and, as a consequence, the communication between patients and medical staff is often improvised (24).

1.3 Healthcare Providers' Attitude toward Immigrants

Today, most countries are more aware of the problems that immigrants encounter when entering foreign healthcare systems. Governments are preparing documents that would establish equally accessible healthcare for all. These new practices represent a complex challenge for healthcare employees, social workers, and the Governments themselves (25, 26). Given high percentages of immigrants, the question arises whether GPs' attitude towards immigrants differs from the one they develop towards the non-immigrant population. The aim of this study was to explore whether GPs show a different attitude toward immigrants in Slovenia and, if so, what are the reasons for this, and whether this attitude causes any difficulties for immigrants in Slovenia when accessing medical care. We were interested in the greatest obstacles that immigrants face when consulting GPs and we tried to find out what can be done to minimize or at least reduce these inequalities.

2 METHODS

2.1 The Qualicopc Questionnaire

The research questions of this study were based on the Qualicopc questionnaire. The questionnaire and the introductory page were translated into national languages in two steps. As the first step, the national coordinator organized the translation of the questionnaire by a small local team of people that were familiar with primary care practice and terminology in their country, and had a thorough knowledge of the English language. The national coordinator subsequently forwarded this translation to Netherlands institute for health services research (NIVEL), which had the text translated again, this time by a professional translator. The differences between both translations were examined by a professional translator. Passages inappropriately translated according to the professional translator were corrected and sent back to the national coordinator. The national coordinator and professional translator harmonized the discrepancies and jointly decided on the best version of translation (27-29). At the coordinators' meeting, we decided that the number of GPs sampled should be large enough to obtain a response from at least 220 GPs in each country (one GP per practice). Thus, the size of the sample depended on the expected participation of GPs. For example, if the national coordinator expected 25% of the GPs contacted to participate, the original sample size had to include at least 880 GPs. In countries with a very small population, the desired number of GPs surveyed was smaller (80 to 100). GPs were invited to participate using various methods: e-mail, letters, telephone calls, personal contacts, and advertisements. We aimed for a nationally representative sample of GPs. If national registers of GPs were available, we used random sampling to select GPs. In countries with only regional registers, random samples were drawn from regions that represented the national setting. If no registers existed, but only the lists of facilities in a country, a random selection was made from such lists (27-29).

The questionnaires were filled in by patients in GPs' waiting rooms in 34 different countries. Thirty-one European countries participated, among them 27 countries from the European Union, plus Iceland, Norway, Switzerland, and Turkey. Australia, Israel, and New Zealand also participated in the study. The Qualicopc study was funded by the European Commission under the Seventh Framework Program to access the quality, equity, and costs of primary care in Europe. The study started in 2010 and lasted until 2013. Three level approaches to data collection were used in this study: the system, practice, and patient levels (27). The Qualicopc study consisted of four questionnaires: patients completed two questionnaires, one based on their experiences

with physicians, other healthcare professionals, and the healthcare system, and the other based on their judgments regarding what is important for them in primary care (their values). Another questionnaire was completed by GPs, and the fourth questionnaire was completed by fieldworkers. The questionnaire for GPs mostly focused on the type of work they have and the structural organization of their practices, clinical tasks, and workloads, but not on their attitude toward immigrants (28).

In Slovenia, the Qualicopc survey was conducted in 2011. All GPs in Slovenia received the invitation letter to participate in the survey. From all GPs in Slovenia we made a random sample. GPs in the sample received a phone call from a researcher with invitation to participate in the survey. None of the sampled GPs refused to participate in the survey. GPs were asked to answer the questionnaire for physicians. The second part of the study consisted of a visit by the fieldworker (a medical student) in the chosen GP's waiting room. This was done with the intention of avoiding any impact of GPs or nurses on patients when completing the questionnaires. Patients were interviewed in September and October 2011, at any work day in the morning or in the afternoon, depending on GP's working hours. The fieldworker collected 9 completed questionnaires about today's experience in GP's office and 1 completed questionnaire about values in each GP's waiting room. Patients filled in the questionnaire in complete anonymity. Patients older than 18 years were invited to participate in the survey, and each patient had the option to refuse to participate. Fieldworkers, if it was necessary, helped patients complete the questionnaire. They also helped to fill in the questionnaire if patients had poor eyesight, reading difficulties and/or poor hearing. They excluded only patients who were not able to answer the questions in spite of fieldworker's help.

The results of the questionnaire for the Slovenian population are available at the Statistical Office of the Republic of Slovenia.

For the purposes of this study, we used the data obtained in Slovenia. We used questionnaires completed by patients referring to the patients' experience with their GPs. For our analysis, we used base P QE 4.1. June 2014 (this database was the most recent at the time of writing and it is available at the Statistical Office of the Republic of Slovenia).

We focused only on some of the issues from this questionnaire that we found crucial for our study. Some basic data about our participants were used in the research, such as patients' gender, age, education, and country of birth for them and their mothers. We focused on the following questions in the Qualicopc questionnaire. First, we were interested in GPs' availability, and so we focused on whether patients have their own GP whom they

consult first and whether it was easy to fix an appointment with their GP. Possible answers were "yes" and "no". The next selected question was related to the consultation that day. Patients were able to choose among several possible answers, which are listed in Table 2. We were also interested in whether the patient would recommend the GP to a friend or a relative. The only possible answers were "yes" and "no". We also focused on questions that concerned negative experiences with the GP during the previous 12 months. These questions are listed in Table 3. Patients were able to choose among multiple answers. Finally, we focused on interpreters' availability. The possible answers were that an interpreter is always available, usually available, not available or insufficiently available at GP's practice.

For the purpose of our study, we defined three groups of participants. Group 1 (G1) included patients that were born abroad (first-generation immigrants) according to the Qualicopc questionnaire. Group 2 (G2) included patients that were born in Slovenia, but whose mothers were born abroad (second-generation immigrants). We did not focus on the father's birthplace because this information is not included in the Qualicopc study. Group 3 (G3) included the Slovenian non-immigrant population.

2.2 Statistical Analysis

Statistical analysis was performed using SPSS Stat. Software. A binominal test was used to determine gender distribution and Student's t-test was used to determine age distribution. To compare the differences between groups, we used Student's t-test and a chi-square test. The data were compared by average, summation, and standard deviation.

3 RESULTS

3.1 Patients' Characteristics

Questionnaires were completed by 1,941 patients between the ages of 18 and 95 years. The average age of respondents was 49.74 (± 16.98) years. Among these, 793 (40.9%) were male and 1,146 (59.1%) female; for two patients these data were not available.

G1 included 225 (11.6%) individuals: 41 (18.2%) patients were born in a foreign EU country, 138 (61.3%) in a European country outside the EU, one (0.4%) in North America, Australia, or New Zealand, and 42 (18.7%) in other countries. For three (1.3%) patients we do not have this information. G2 included 128 (6.6%) individuals whose mother was born abroad: 25 (19.5%) in an EU country, 71 (55.5%) in a European country outside the EU, one (0.8%) in North America, Australia, or New Zealand, and 31 (24.2%) in other countries. G3 included 1,588 (81.8%) patients, representing the non-immigrant population of Slovenia.

G1 included 104 (46.2%) men and 121 (53.8%) women, G2 included 57 (44.5%) men and 71 (55.5%) women, and G3 included 632 (39.8%) men and 954 (60.2%) women; for two patients these data were not available. It is important to emphasize that the G3 is significantly greater than the other two groups (G1 and G2) due to specific distribution of our patients. Patients' gender had a normal distribution based on a binominal test ($p < 0.001$), and age also had a normal distribution according to Student's t-test ($p < 0.001$). The comparison between the study groups according to the age and education level of the patients is presented in Table 1.

Table 1. General characteristics of the study groups. A chi-square test was used to compare different groups.

| | G1 n=225 | G2 n=128 | G3 n=1,588 | P (G1+G2) | P (G2+G3) | P (G1+G3) |
|---|-------------------|-------------------|-------------------|--------------|--------------|--------------|
| Average age (in years) | 51.50 (±13.76) | 39.76 (±15.02) | 50.31 (±17.28) | <0.001 | <0.001 | 0.1 |
| Education (the number of patients) | | | | <0.001 | 0.025 | 0.025 |
| • None or (pre)primary | 108 (48.0%) | 24 (18.8%) | 470 (29.6%) | | | |
| • Upper secondary | 78 (34.7%) | 72 (56.3%) | 709 (44.6%) | | | |
| • Post-secondary, non-tertiary, or higher | 38 (19.9%) | 32 (25.0%) | 399 (25.1%) | | | |
| • No information | 1 (0.4%) | 0 (0.0%) | 10 (0.6%) | | | |

Legend: G1=first-generation immigrants; G2=second-generation immigrants; G3=non-immigrants; n=the number of patients.

3.2 Access to GPs

We wanted to know whether the accessibility to GPs is different for immigrants compared to the non-immigrant population. For this purpose, we selected questions from the Qualicopc questionnaire in which patients were asked to specify whether they have their own GP that they normally consult first. In G1, two (0.9%) patients answered negatively, in G2 there was one (0.8%) such patient, and in G3 there were 12 (0.8%) such patients. There was no significant difference between the three groups ($p > 0.05$). Patients were also asked whether it was easy for them to make an appointment at the GP's office. A negative response was obtained from six (2.7%) patients in G1, from two (1.6%) in G2, and from 63 (4.0%) in G3. There was no significant difference between the three groups ($p > 0.05$).

3.3 Patients' Reflection on their Consultation

All three groups of patients were asked how they felt after their consultation at the doctor's office on the day they filled in the questionnaire. Their answers are presented in Table 2, which also shows some statistically important differences between the groups.

Table 2. Patients' impressions of their consultations with their GPs on the days they filled-in the questionnaire. A chi-square test was used to compare different groups.

| | G1 n=225 | G2 n=128 | G3 n=1,588 | p (G1+G2) | p (G2+G3) | p (G1+G3) |
|---|----------------|----------------|------------------|--------------|--------------|--------------|
| The GP was not polite | 7 (3.1%) | 1 (0.8%) | 20 (1.3%) | 0.270 | 0.876 | 0.018 |
| The GP hardly looked at me | 19 (8.4%) | 4 (3.1%) | 108 (6.8%) | 0.107 | 0.265 | 0.117 |
| The GP did not ask about my health problems | 17 (7.6%) | 17 (13.3%) | 138 (8.7%) | 0.169 | 0.212 | 0.160 |
| I could not really understand what the GP was trying to explain to me | 39 (17.3%) | 11 (8.6%) | 156 (9.8%) | 0.053 | 0.886 | <0.001 |
| The GP did not take sufficient time for the appointment | 21 (9.3%) | 8 (6.3%) | 99 (6.2%) | 0.435 | 0.979 | 0.037 |
| The GP did not involve me in decisions about treatment | 41 (18.2%) | 31 (24.2%) | 362 (22.8%) | 0.321 | 0.911 | 0.063 |
| The GP is not familiar with my living situation | 47 (20.9%) | 37 (28.9%) | 360 (22.7%) | 0.021 | 0.028 | 0.506 |
| The GP did not help me with my personal problems | 47 (20.9%) | 38 (29.7%) | 446 (28.1%) | 0.001 | 0.002 | 0.047 |
| I would recommend this GP to a friend or a relative | 206 (91.9%) | 117 (91.4%) | 1,452 (91.4%) | 0.176 | 0.285 | 0.071 |

Legend: G1=first-generation immigrants; G2=second-generation immigrants; G3=non-immigrants; n=the number of patients.

3.4 Patients' Negative Experiences with their GPs in the Past 12 Months

Patients were asked whether they had any negative experiences in the past 12 months with their GPs or with their staff. They were also asked whether they felt being treated badly by their GPs or by the staff based on their ethnic background or gender. Their responses

are summarized in Table 3. There were no statistically important differences found between the groups, as shown in Table 3, except regarding the statement "The GP or staff acted negatively toward me in the past 12 months" between G2 and G3 and regarding the statement "Other patients are treated better" between the groups G1 and G3.

Table 3. Patients' negative experiences with their general practitioners during the previous year. A chi-square test was used to compare different groups.

| | G1 n=225 | G2 n=128 | G3 n=1,588 | p (G1+G2) | p (G2+G3) | p (G1+G3) |
|--|--------------|--------------|---------------|--------------|--------------|--------------|
| The GP or staff acted negatively toward me in the past 12 months | 11 (4.9%) | 10 (7.8%) | 53 (3.3%) | 0.341 | 0.031 | 0.469 |
| Other patients are treated better | 9 (4.0%) | 7 (5.5%) | 35 (2.2%) | 0.379 | 0.084 | 0.047 |
| The GP disrespects me due to my ethnic background | 1 (0.4%) | 2 (1.6%) | 11 (0.7%) | 0.563 | 0.669 | 0.184 |
| The GP disrespects me due to my gender | 2 (0.9%) | 0 (0.0%) | 6 (0.4%) | 0.324 | 0.813 | 0.191 |

Legend: G1=first-generation immigrants; G2=second-generation immigrants; G3=non-immigrants; n=the number of patients.

3.5 Language Barriers and the Possibility of an Interpreter

Because we studied the perception of GPs' attitudes toward immigrants, we also examined what patients' options are if they cannot understand what the GP is saying. Patients were asked if they were provided with interpreting service when they needed one to help them communicate with their GPs. Of all the patients, 53 (2.7%) answered that an interpreter was always available in their GP's practice, 19 (1.0%) patients answered that an interpreter was usually available, and 36 (1.9%) patients answered that an interpreter was not available or was insufficiently available. A total of 360 (18.5%) patients were unable to provide any information ("don't know"), and 1,473 (75.9%) patients did not answer the question.

4 DISCUSSION

The data obtained through the Qualicopc questionnaire provided valuable information regarding patients' perceptions of GPs' attitude toward immigrants in Slovenia.

According to the data available from the Statistical Office of the Republic of Slovenia, immigrants represent 4.7% of the population (17). This is a much smaller percentage than in our study, with patients that identified themselves as first-generation immigrants (11.6%). Such a difference is due to different methodologies. The statistical office included only individuals with foreign citizenship in this number. On the other hand, our study did not ask about the citizenship but only about the birth country.

Comparing the groups with respect to the education level showed statistically significant differences between the groups. Immigrants have lower education than the non-immigrant population. This is a possible reason why immigrants appear to be more susceptible to their environment and why they tend to think that they are treated worse than others. It was repeatedly shown that immigrants in general have lower education levels, but studies have also shown that those with lower education levels integrate more easily in their host countries (30, 31). On the other hand, for immigrants with a higher education it is more difficult to get a job, mostly due to the low rate of recognition of their credentials (32).

When comparing our three groups (first-generation immigrants, second-generation immigrants, and non-immigrants), we found no significant differences among them regardless of whether they have a personal GP selected or not. In general, only a very small percentage of the patients answered that they do not have a personal GP or that they had difficulties in making an appointment at their GP's office. All together could indicate that immigrants in Slovenia do not experience major difficulties

accessing GPs and that they do not have to wait longer for an appointment than the general population. It is important to emphasize that these questionnaires were completed by patients in GPs' waiting rooms. Therefore, this data may only be accurate for our group of patients and cannot be understood in the sense that all immigrants in Slovenia have equal opportunities to get an appointment at a GP's office. The available data from the literature show that the choice of GP is influenced by several different factors, such as care quality, availability, and practice characteristics (33). Comparable data have been obtained in Canada with respect to the availability of GPs and other specialists for immigrants and for the rest of the population. However, according to the Canadian studies, fewer immigrants benefit from medical treatment. The reasons for such results may lie in better health status of immigrants and cultural differences in attitudes toward medical admission (7, 34). On the other hand, in Norway there is lower utilization of primary healthcare among elderly immigrants compared to the general population. The reasons for this may be the same as above, relying on cultural differences (34, 35). Better health status of immigrants in Europe compared to the non-immigrant population is a bit controversial; it shows a north-south gradient, since immigrants' health is better in Italy and poorer in France and Belgium (36, 37). Analysing the questions related to the appointment at the GP's office, we encountered some significant differences between the groups (Table 2). A comparison between the first-generation immigrants and the non-immigrant population shows that GPs are more impolite with immigrants. Several studies have shown that immigrants have a more negative experience with GPs compared to the non-immigrant population due to the language barriers, cultural differences, and the lack of familiarity with the healthcare system in the host country (1, 4, 5, 38, 39). An important cause of GPs' attitude toward immigrants in Slovenia may also be the additional burden they represent for the GPs' workload (40). There were 237 GPs per 100,000 people in Slovenia in 2006, which was well below the European average (332 to 338 per 100,000 in 2007) (41). GPs in Slovenia have between 862 and 3,186 registered patients, or an average of $1,771.37 \pm 68.8$ (42), and immigrant's unfamiliarity with the country's healthcare system (e. g., to call for an appointment) may present an additional workload, causing GPs to develop an unfriendly attitude toward the patient. A Canadian study showed that the immigrants' experiences with GPs significantly improved when these barriers and limitations disappeared (38). Several studies showed that the attitude of GPs is worse toward the people with mental illnesses compared to the healthy population (43, 44). This can lead to the conclusion that, as anybody else, GPs also have their stereotypes, and that these stereotypes influence their attitude toward their patients (45). At this

point it is also worth mentioning that, according to some studies, immigrants are more vulnerable to developing a mental illness (46-48), and that they are also less likely to seek professional help in such case (49). Many factors are known to influence immigrants' mental health. Kirmayer et al. divided these factors into three groups, according to the stage of migration the individuals are in: premigration (e. g., trauma, political involvement, disruption of social norms), migration (e. g., trajectory, exposure to violence, disruption of family or community network), and postmigration (e. g., uncertainty about immigration or refugee status, unemployment, difficulties in language learning). They also presented factors affecting mental health distributed by age (children, adults, and the elderly) and by gender, arising from their different social roles and responsibilities. Immigrant women have a two- to three-times greater risk of developing depression compared to non-immigrant women (46). It is also interesting that different subgroups of an ethnic group vary according to incidence and type of mental illness. This shows the utmost importance of psychosocial and cultural factors related to migration and mental health (47). Therefore, in dealing with immigrants, GPs should pay special attention to evaluating risk factors for specific subgroups to develop a mental illness.

An important difference between the first-generation immigrants and the non-immigrant population is also that significantly more immigrants answered that their GP did not take enough time for their appointment. There may be multiple reasons for this: the GP may indeed have a slightly more negative attitude toward immigrants and wish to end the appointment as soon as possible, or immigrants may need more time than the non-immigrant population. This may be due to cultural differences, language barriers, and so on (13, 14). As already mentioned, the GPs' large workload may also prevent them from taking as much time as a patient needs (40). On average, in Slovenia, GPs have 45.63 patient encounters per day, which allows them 6.93 minutes per person - and this may not be enough in certain cases (42). In all three groups, a fairly large percentage of patients (from 20 % to 28%) answered that their GP did not help them solve their personal problems. In our opinion, this shows general discontentment with the healthcare system, which can be connected to the economic crisis peaking in Slovenia in the year the Qualicopc questionnaire was administered. Another reason, as mentioned earlier, may be short consultation times (43).

The analysis of questions related to patients' negative experience in the past 12 months indicates a significant difference between the groups (Table 3). Second-generation immigrants had negative experiences with GPs or their staff more often than the non-immigrant population, but unfortunately we do not have information

about the type of these experiences. There are significantly more patients among first-generation immigrants that think that other patients receive better treatment than them. Indeed, several studies have shown that access to healthcare for immigrants may be more difficult because they do not understand the system very well, have trouble understanding the language, have difficulties adjusting to certain norms, and so on (13, 25, 50). All this may lead to poorer healthcare and therefore to more negative experiences with a GP or staff.

All of these differences in GPs' attitudes toward immigrants in comparison with the general population according to patients' perspectives could also be due to sociological factors. All individuals derive from their own cultural environment with different values, and thus have subjective expectations from their GPs (1, 4, 5, 39, 51, 52). As mentioned above, immigrants may also face different challenges in their host countries, such as language differences, homesickness for relatives still living in their countries of origin, unfamiliarity with the sociocultural system, unemployment, educational difficulties, and social exclusion, which may affect their view of their GPs' attitudes (13-15). This is why GPs must be aware of all these obstacles and difficulties that immigrants face and should try to remedy them (38, 53).

Among all of the patients, only 2.7% answered that an interpreter is always available at the GP's practice, and 1.0% answered that an interpreter is usually available. Based on the data available, we do not have clear information on how many practices abroad have an interpreter available if a patient requires one. However, many authors agree that the presence of an official interpreter (if needed) improves the quality of patients' care (54, 55). On the other hand, studies show that patients that need an interpreter but do not have access to one receive poorer medical care in comparison to the general population; their outcome seems to be worse, and their confidentiality is repeatedly violated (54, 55). An alternative has also been proposed in the literature: if a professional interpreter cannot be physically available at the practice, a telephone access to a professional interpreter should be offered (54). Another possibility is professionally trained volunteers to work as interpreters at GP practice (56). It has turned out that using family members as interpreters is not an optimal alternative, because they often fail to translate patients' words literally. They can also magnify patients' problems or minimize them, or even not attach importance to these problems (54, 57). Their mistakes in translation can also be life-threatening for patients (57). Today, GPs are increasingly aware of the importance of having access to interpreters for their patients if needed (58). Another interesting fact is that 18.5% of respondents are not familiar with the information about interpreter availability at their GP practice. These data should

encourage GPs to promote interpreter service where it is available and therefore make it easier for their patients to visit a doctor and to talk about their health issues. It is also important for GPs to encourage the presence of an interpreter at their practice. Another important fact is that there is a significant difference in understanding GP's directions between G1 and the non-immigrant population (Table 2). The reason for this may be that immigrants have problems fully understanding Slovenian (11, 12) and are therefore in need of an interpreter. Another reason may be that they are less educated (Table 1) (1) compared to the non-immigrant population, and experience difficulties understanding technical words used by GPs.

Disadvantages of our study were that the G3 significantly outnumbered the other two groups (G1 and G2). This was of course expected, since the opposite breakdown is normally found in the general population. An important weakness of this study is also that we have lower frequency of positive answers in some questions than in others, in spite of statistically significant difference between selected groups.

5 CONCLUSION

It has been shown that there may be some differences when comparing GPs' attitudes towards first- or second-generation immigrants to the general Slovenian population based on patients' opinions. The study showed that there are no statistically significant differences with regard to GPs' availability when comparing immigrants to the non-immigrant population of Slovenia. However, in their own perception, the second-generation immigrants experienced more negative behaviour from GPs or their staff than the non-immigrant population. First-generation immigrants have more difficulties in understanding GPs' instructions, and claim to be given insufficient appointment-time when compared to the non-immigrants. However, on the basis of the questionnaire that targeted the patients in GPs' waiting rooms, we cannot conclude that GPs' attitude towards the immigrants is indeed below the standards that is assured to the non-immigrant population.

CONFLICTS OF INTEREST

The authors declare that no conflicts of interest exist.

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ETHICAL APPROVAL

The data for this study was derived from Qualicopc study, Slovenia. The National Medical Ethics Committee of the Republic of Slovenia approved the study on July 12th, 2011 (no. 144/07/11).

The study was conducted in accordance with the code of Ethics of the World Medical Association (Declaration of Helsinki).

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