論文の内容の要旨

論文題目　**Perceived access and unrealized access to health care among Nepalese migrants in Japan**

（来日ネパール人の認識する医療ケアへのアクセスと医療ケアアクセスの未実現）

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Background

Migrants' access to health care is an important area of concern in global health. It is generally defined as the timely use of personal health services to achieve the best possible health outcome. For the studies of access to health care among migrants, most of them are conducted for migrants in Europe and North America. Majority of them have poor access to health care. The factors affecting their access to health care occur in three different levels: system, provider and patient levels.

Migrants' health is an understudied area in Asia, despite hosting 75 million migrants. Evidence is limited on the factors contributing to access to health care among migrants in Asia. The socio-cultural environment of Asia is different from that of the Western world, which may reveal different dynamics of these issues among its migrants. Moreover, it is not known globally what kinds of associations exist with access to health care among migrants, when such factors are combined.

Evidence is even more limited on access to health care among migrants in Japan. Japanese immigration policy favors migrant control over migrant rights, which has negative consequences on their access to health care. Their health outcomes are worse in comparison with general population because of untimely access to health care. In Japan, about 60,000 Nepalese were residing in 2016. About 20,000 of them are students, most of whom are studying in Japanese language schools and professional training colleges. Most of the students are also engaged in part-time jobs in convenience stores, restaurants, delivery services and housekeeping jobs. A majority of the Nepalese male migrants are also working as cooks in Indo-Nepali restaurants under the legal status of skilled labors. Another majority are the wives of those cooks, who are engaged in part-time jobs under the legal status of dependents. Economic benefit is the main motivation for these migrants to come to Japan. Furthermore, unstable political situation and lack of employment opportunities in Nepal are the pushing factors for them. Most of these Nepalese migrants may be in vulnerable health conditions. They may have limited access to health care due to socio-cultural factors, language barriers and poor social support. However, little is known about access to health care and its associated factors among this vulnerable population in Japan.

Access to health care is a function of individual's predisposing, enabling and need factors.

Predisposing factors are characteristics that affect a person's tendency to seek health care services such as demographic and social characteristics. Enabling factors are characteristics that facilitate or impede access to health care such as employment status, income, health insurance and language proficiency. Need factors are individual's perceived or evaluated health conditions for which a person is likely to require health care such as self-rated general and mental health status.

Access to health care concerns both potential and realized entry of an individual into the health care system. Potential access to health care is reflected by the individual's perception on his current access to health professionals or health services. An individual's inability to actually use the health services when needed reflects his unrealized access. Measuring unrealized access helps to identify access barriers among non-users of health services.

In this study, first I examined the predisposing, enabling and need factors associated with perceived access and unrealized access to health care among Nepalese migrants in Japan. Second I examined the association of those factors with their perceived access and unrealized access to health care, when several key factors are combined with each other.

Methods

I conducted this cross-sectional study in the following 10 prefectures of Japan; Tokyo, Fukuoka, Osaka, Gunma, Tochigi, Hyogo, Kanagawa, Chiba, Aichi and Saitama. Most of the Nepalese migrants are residing in these prefectures.

I recruited the migrants based on convenience sampling method, in each study prefecture. I along with the research assistants visited language schools, professional training colleges, Indo-Nepali restaurants and other work stations in the study area to recruit the migrants. I collected the data using the self-administered questionnaire in the Nepali language.

I measured migrants' perceived access and unrealized access to health care two binary variables. I measured perceived access to health care among the migrants by asking if they currently have proper access to a doctor/health worker. I measured unrealized access to health care by asking if in the past year, they needed to see a doctor/health worker for an illness but did not.

For predisposing factors, I asked questions on socio-demographic characteristics such as sex, age, marital status, ethnicity, and educational level obtained in Nepal before migration. I also asked them questions on their visa/legal status and length of stay in Japan. I assessed the enabling factors by asking questions about their employment status in Japan, payment of the health insurance premium and their need of a Japanese language interpreter during the visit to health facility. I measured perceived social support using the Multi-dimensional Scale of Perceived Social Support (MSPSS). I measured the need factors by asking questions on self-rated health status and common mental health problems. I measured self-rated health status using a 5-point Likert scale (excellent, very good, good, fair, or poor). I measured common mental health problems by assessing stress, depressive symptoms and anxiety among

the migrants.

I included a total 659 migrants in the data analysis. I used logistic regression models to conduct two separate multivariable analyses. First, I used Model 1 to examine the factors associated with perceived access and unrealized access to health care among the migrants. Then, I selected the predisposing, enabling, and need factors significantly associated with perceived access or unrealized access to health care (key factors). I conducted the descriptive statistics by combining these three key factors. The combinations were based on the presence or absence of the factors which were positively associated with better perceived access or less unrealized access to health care in Model 1. Lastly, I used Model 2 to examine the association of factors when these three key factors are combined in such way.

Results

The key factors associated with migrants' better access to health care were longer length of stay (predisposing factor), not needing a Japanese language interpreter during visit to health facility and paying the health insurance premium regularly (enabling factors), and self-rated health status as good or very good or excellent (need factor). The migrants were more likely to perceive better access to doctor/health worker (AOR=8.32, 95% CI 3.48-20.51) when they had all the three key factors, compared to those who had none of them. They were also less likely not to see doctor/health worker when needed (AOR=0.12, 95% CI 0.03-0.55). They were more likely to perceive better access to doctor/health worker (AOR=4.25, 95% CI 1.67-11.31) when they had key predisposing and enabling factors, compared to those who had none of them. They were also less likely not to see doctor/health worker when needed (AOR=0.17, 95% CI 0.04-0.81). Furthermore, they were more likely to perceive better access to doctor/health worker (AOR=3.23, 95% CI 1.57-6.63) when they had key enabling and need factors, compared to those who had none of them.

Conclusions

Nepalese migrants in Japan were more likely to have better perceived access and less unrealized access to health care when they had all the three key predisposing, enabling and need factors, compared to those who had none or either two of them. Moreover, the key enabling factors had more important roles than key predisposing or need factors when combined with either of them. Such key enabling factors were language skill and health insurance.

Interventions should focus more on key enabling factors. It may include reducing the language barrier between the migrants and health workers, possibly by providing the professional interpreter service in health facility. Moreover, awareness and educational programs should be implemented to encourage the migrants to pay the health insurance premium regularly. The target population may be the newcomer migrants.