

Expert Opinions on Healthcare for Immigrants in Norway

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Background: Documented immigrants eligible to stay in Norway for more than 6 months can enroll in the universal healthcare system for full healthcare services, such as acute, chronic, and preventative care.¹ All other non-citizens only have access to emergency services. With an increasing influx of immigrants to Norway, it is advantageous to evaluate the Norwegian healthcare system, how documented and undocumented immigrants utilize the system, and any barriers they may face when doing so. The aim of this study is to identify barriers to healthcare for immigrants in Norway in order to better address them in the future.

Methods: Sixteen subjects with knowledge of immigrant healthcare in Norway were interviewed. Participants were asked the same standardized four questions; answers were audio-recorded, transcribed, and analyzed.

Results: Major themes that emerged included the following: (1) universal access is a benefit once accepted into the system, (2) timeliness is an issue, (3) chronic disease and mental health are common immigrant-specific health issues, and (4) language and lack of cultural competency are major barriers to care.

Conclusion: There is a need for improved translation services and cultural competency as the immigrant population in Norway increases.

Keywords: Norway; healthcare; immigrant; barriers to care; language

INTRODUCTION

The World Health Organization's (WHO) constitution states that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic, or social condition.'² A 1992 comparative study on immigrant health found only three of seven advanced industrial countries (Canada, the United Kingdom, and Sweden) had taken steps to promote equity of access and quality for immigrants in their health services.³ These steps include the creation of comprehensive and universal health systems that target the needs of immigrant populations, such as seeking to remove economic and administrative barriers for immigrant populations seeking both specialized and general healthcare.³ More than 25 years later, the focus on health equity for immigrants has increased globally. However, according to the 2016 Migrant Integration Policy Index (MIPEX) Health Strand, many countries still take a passive approach to the issue.⁴

Norway has historically been a homogenous society, with the large majority of the national population consisting of native Norwegians. In 1988, the country passed the Immigration Act and immigration to Norway increased.⁵ In recent years, the inflow of immigrants to

Norway has reached record levels, leading to a change in the demographic landscape of the country.¹ Research shows that 'the ethnic and cultural diversity in Norway is greater now than ever before.'⁶

Immigrants are defined as 'being born abroad by two foreign-born parents and registered as residents in Norway.'⁷ Registration as a Norwegian resident offers healthcare entitlements such as assignment to a general practitioner and healthcare cost coverage. Undocumented immigrants, otherwise known as illegal or irregular immigrants, are 'third-country nationals without a valid residence permit or visa allowing them to reside in the country of destination and who, if detected, may be liable to deportation.'⁸ Undocumented immigrants only have access to emergency services. This limits their ability to obtain specialist services and engage in preventative care. In Norway, the correlation between people's socioeconomic status and their state of health is significant and well established.

In 2016, at the time of data collection for this project, there were '848,200 immigrants and Norwegians born to immigrant parents in Norway, representing 16% of the entire population.'⁹ The current Norwegian immigration policy states that 'all immigrants who are admitted to Norway should have equal legal and practical

opportunities in society.⁵ This research explores the Norwegian healthcare system and immigrant healthcare access by interviewing those who are working in the field. The study aims to identify barriers to immigrant healthcare access so that they may be better addressed in the future. Access issues for both documented and undocumented immigrants are included in this study.

METHODS

Sampling and Recruitment

For this study, an expert is defined as an individual with 5 or more years of experience who is currently working with immigrants in a clinical or research-based healthcare setting. Participants were found using a convenience sample. Initial interviews took place with healthcare professionals at the Norwegian Centre for Migration and Minority Health (NAKMI). Additional participants were found through contacts given by NAKMI employees. Job experience ranged from 6 to 49 years. Job titles included the following: physician, researcher, public health worker, consultant, hospital advisor, and director of specific hospital affairs. The study design was reviewed and approved by the Michigan State University College of Human Medicine IRB.

Interviews

All interviews were conducted in person in August 2016. Sixteen individuals were interviewed via eight individual interviews and three focus groups. A total of 24 professionals were employed at this time by NAKMI. Participants signed a consent form for participation and audio recording of their responses. No compensation was given for participating in the study.

The participants were asked the following four questions:

1. From your experiences, what are the positives and negatives of the Norwegian healthcare system?
2. What experiences have you had regarding immigrants seeking healthcare services?
3. What health issues are specific to immigrant populations?
4. What are the barriers to care for immigrants in Norway?

The researchers did not prompt any discussions other than posing the initial question. Interpretation of each question was at the discretion of the participant.

Data Analysis

The researchers divided the audio recordings, and one researcher was assigned to transcribe each interview verbatim onto a word document. A second researcher read through the transcription while listening to the audio recording to check the transcription for accuracy. All transcriptions were uploaded to Dedoose, a qualitative software program. Each researcher read through every transcription individually and identified themes and subthemes. The researchers met after every three transcriptions were read to discuss themes. If three of the five researchers agreed on a theme or subtheme, it was added to a running list of themes, and the passage was coded under this theme using the Dedoose software program. After all transcriptions were coded, the number of times each theme or subtheme was mentioned was totaled. The percentage that each theme was mentioned compared to the total number of coded passages was determined.

RESULTS

The researchers coded a total of 276 passages. The most frequently coded theme was 'barriers to care' (89/276 or 32.2%). Other frequently mentioned themes included healthcare system negatives (19.5%), immigrant-specific health issues (13.4%), and healthcare system positives (11.2%). The most prominent themes are displayed in Figure 1.

The results are categorized under four most frequently mentioned themes: barriers to care, negatives, immigrant-specific health issues and positives. Subthemes pertaining to each main theme are discussed below. Interjections and conversational elements unrelated to the discussion were removed from the included quotations.

Barriers to Care

Language was the most frequently discussed barrier to care. Participants discussed how language barriers affected immigrants' abilities to both communicate with their provider and navigate the healthcare system. One participant stated:

The language is the key, the key here in Norway. If you can [speak] Norwegian then you can get anything, but if you cannot speak Norwegian, then you need a translator but [...] sometimes... we don't know what he or she is translating to the patient. And of course, immigrants sometimes they won't have a translator... if an immigrant comes to

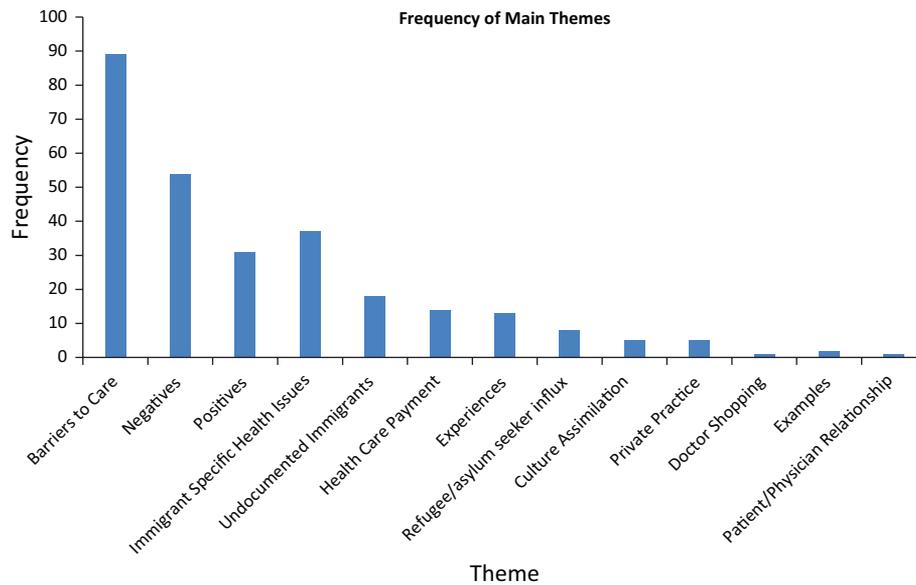


Figure 1.

me and she or he can speak Norwegian fluently, then we don't have a problem and they get the help they need....

'Translation services' was the most frequent subtheme of language barriers. This service is a right for those seeking healthcare in Norway; however, participant stated that immigrants are frequently unaware of this right. One participant said, '[If] I'm new in Norway, I don't know that I have the right to a translator and my GP (general practitioner) doesn't tell me that you have a right'.

Inadequate health literacy was another common barrier to care. One participant stated, '[We have a] lack of what we call as health literacy. Lack of information not only for the user but for the healthcare provider as well'. Immigrants' misinformation, lack of information, and lack of awareness of their rights with regard to healthcare were frequently reported. One participant stated: 'everyone doesn't know how to demand their rights and, in addition to that, in order to demand your rights, you also have to be aware of these rights, and even when you're aware of the rights, it's not always that you get what you need'. Another participant added:

I worked in a densely populated immigrant area and many of them wanted practical solutions for practical problems and they wanted it to happen right now.

They wanted medication to fix whatever and very often that was quite the wrong solution. So many people would call that lack of health literacy.

Lack of cultural competency in the medical field was another main barrier to care. One participant stated, '... many doctors and nurses, they have very little experience working with people from different cultures'. Study responses suggested a lack of understanding and/or education on the cultural norms of various ethnic groups. Participant explained the importance of increasing cultural competency as Norway becomes more diverse. One ethnically Norwegian participant mentioned creating and attending a monthly cooking class for a specific immigrant population with the goal of improving cultural competency and establishing patient trust.

Some participants discussed the importance of having healthcare providers of the same cultural background to facilitate communication. They expressed that a shared cultural background makes patients feel as if their beliefs and customs are understood, especially when discussing sensitive topics. The subthemes of barriers to care are depicted in Figure 2.

Negatives

Timeliness was the most often identified negative factor of the Norwegian healthcare system. Many participants

discussed significant wait times for appointments with healthcare providers, particularly specialists, and how this negatively affected care and experience. One participant stated, 'But many people [...] complain about [...] the waiting system [...] when a GP refers to a specialist sometimes they have to wait for 6–7 months [...] so it's a long time.'

Lack of resources was another negative factor described by many participant. Some participants felt that there are not enough specialists available in Norway. Rural areas with smaller populations were described as having limited access to specialist services, thereby necessitating travel to major cities to see these specialists. Others described a lack of resources for specific immigrant populations. One participant stated, '[...] some of our therapists must be in some way dedicated to work towards migrants. We need a bit more specialization [for these] patient groups.'

Difficulty navigating the system was frequently mentioned. One participant stated, 'You will find some information about the healthcare system on the Internet, but it is not enough to navigate comfortably within the system'. The many regulations of the Norwegian system were described as a cause of this difficulty. One participant said, 'And then the Norwegian system is very regulated. There are a lot of rules about how to behave within the healthcare system. When you are new in Norway, it is very difficult to find out all the rules and all of them are not written down'.

Lack of patient-centered care was also mentioned. This was discussed as especially problematic for immigrants who come from countries with different healthcare systems. One participant gave the example of an immigrant patient who expects to have all of his or her issues addressed in a 15-min visit, and the issue of computers interfering with the patient–physician interaction. They stated, '[the physician is] typing in whatever you are telling them. So many patients are not satisfied. They think that the doctor is not having any eye contact [...] He or she is not listening to us. They are more concerned about writing whatever we are saying...'

Immigrant-Specific Health Issues

Participants were asked to identify specific health issues among immigrant populations. Chronic disease was mentioned most frequently, especially diabetes. One participant said, 'Diabetes is a problem [...] there's been a focus on diabetes and the increase of diabetes within

certain groups, ethnic groups or immigrant groups [...] We know that Africa, and Asia to a certain extent, is over-represented when it concerns diabetes [...]'. This participant stressed the importance of reaching out to these groups to 'provide the necessary information when it concerns diets, exercise, etc.'

Mental health was also frequently mentioned. Many participants felt that previous trauma or hardship predisposes individuals to develop post-traumatic stress disorder, depression, or addiction. One participant stated, 'Almost 80% of patients with PTSD also have a depression, so, it's important to actually be able to handle both things at the same time. And 60% of them often have an addiction problem, so these comorbidities are very important'.

Positives

Many participants identified universal coverage as the best part of the Norwegian healthcare system. One participant stated, 'everyone gets free medical care, I would say that's the biggest pro. You don't need money, you don't need insurance, you don't need anything. You just need to be human'. Another participant stated, 'Our view on the patients and the people we treat [is that] they are all equal. They deserve good treatment and I think that's the main [thing] underlying the whole healthcare system'. Some participants discussed how this sentiment is true on paper but does not always hold true in reality. One participant stated, 'I think the positive is the universal access healthcare system compared to the United States, and many other countries. That in principle as long you have permission to stay, everybody has the same rights for healthcare, but that's in principle'. Participants discussed how legal status affected the implementation of universal coverage. They stated that legal immigrants receive full healthcare access after being in Norway for 6 months, but undocumented immigrants have no coverage at all except for emergency services. One participant said, 'We have universal access, but not for those who don't have staying permits. This is an issue'. Some providers discussed seeing undocumented immigrants in their clinics for little or no cost.

DISCUSSION

Based on the results discussed above, three areas that should be looked upon to increase immigrant healthcare access are universal coverage, language, and cultural competency of providers.



Figure 2. Word cloud representing subthemes of the main theme “Barriers.” Language was the most frequent; this is depicted by the word “language” being the largest in size.

Universal Coverage

Universal access was cited as the most important positive factor of healthcare system in Norway; however, many participants stated that this universality was only true on paper. As stated above, undocumented immigrants are left out of this universal coverage as are immigrants who have not been in the country for more than 6 months. The next step will involve discussing ways to increase healthcare access to those who are currently left out of the system. As mentioned in the ‘Results’ section, some providers attended undocumented immigrants in their clinics for little or no cost. Although this may be helpful to select individuals in the short term, this is not a long-term solution, is provider-dependent, and does nothing to further the accessibility to healthcare for those without legal status. Free healthcare clinics may be another way to improve healthcare access for immigrants in a way that is less secretive than providers in clinics. These clinics would depend on volunteer physicians and would require that immigrants are comfortable seeking out these clinics without fear of being reported. Immigrants would require education on how and where to access these services. For a more permanent solution, it will be required that the Norwegian government decides how it will view undocumented immigrants and their healthcare access when moving forward. Ethical questions of access balanced with the cost to the system must be considered. Even for immigrants with legal status, it is apparent that increased education needs to be provided to inform them of their

rights (to translation, etc.) and explain how to better access the healthcare system. Organizations carrying this out may find it advantageous to utilize members of these communities to better access specific immigrant populations.

Language

Addressing the language barrier is essential for improving healthcare for immigrant populations. A Norwegian study found that language barriers amplify the difficulty immigrants face when understanding the healthcare system, resulting in lack of confidence in general practitioners and increased emergency room visits.¹⁰ Previous studies have found that communication between doctors and immigrant patients is problematic.^{10,11} One study found that translation services are often difficult to access. A study on immigrant access to healthcare in Denmark found that ‘access to interpreters’ was the most important factor in best practice.¹² An important solution in increasing immigrant healthcare access will be increasing the number and accessibility of translators in Norway.

Furthermore, immigrants must be educated about their rights to a translator and how to request one when necessary. A language barrier in itself may decrease the ability of a non-Norwegian-speaking immigrant to advocate for his or her right to a translator. Thus, it must also be the responsibility of healthcare professionals to provide these services as the need arises. In-person, well-trained healthcare translators would also be a beneficial addition to healthcare systems.

Cultural Competency of Providers

Healthcare providers in Norway lack experience with a diverse patient population, leading to suboptimal care for these groups. A study on immigrant health in the European Union found that differences in cultural expectations greatly impeded the access to and delivery of healthcare for immigrants.¹³ Another study found that general practitioners do not consider cultural differences when working with patients of different cultural backgrounds and suggests that improved cultural competency could improve understanding and communication.¹⁴ Providers should be encouraged to gain an understanding of the cultural norms of immigrant populations whom they frequently interact with. Formal education may also be provided by employers to increase provider knowledge of diverse cultural norms. As one participant discussed, taking time to get to know diverse populations in a relaxed, social setting (i.e., cooking) may improve cultural competency and increase trust.

Study Limitations

This study had a small sample size (16), with the majority of participants being from Oslo, a large city and the capital of Norway. This small sample size is a limitation of the study in terms of generalizability. In addition, it is not known how participants in this convenience sample differ from those who did not participate in the study.

A minor language barrier was present throughout the interviews as English was a second language for most participants. Meanings could be interpreted differently due to this second language component as well as colloquial differences in English. This study relied on self-reporting, and some details may suffer from recall bias. Participant opinions are subjective which may not represent current legislation and policy at large.

This study was qualitative in nature, resulting in subjective interpretation by the researchers when analyzing and coding the interview data. This was minimized by individually coding the interviews but then basing final codes on a group consensus.

CONCLUSION

This study is important because there are no published studies examining access to healthcare for immigrants in Norway based on the experiences of experts in the field. The study suggests that there are a few main topics that can be addressed to provide better care for both documented and undocumented immigrants in Norway

in order to come closer to achieving the WHO goal of equitable healthcare for all.²

The main topics to address include universal coverage for immigrants, language barriers affecting healthcare, and the cultural competency of providers. Most of the participants agreed that Norway has better healthcare policies for immigrants than other countries, as undocumented immigrants have access to emergency services and documented immigrants have access to primary care services after a waiting period. Unlike documented immigrants, undocumented immigrants never obtain access to primary care services. This presents an issue for the Norwegian healthcare system. In addition, language is a major barrier for many immigrants seeking healthcare services. Translation services is a practical area that needs improvement. One solution is to have well-trained, in-person medical translators available in healthcare settings. Finally, cultural competency is an issue in the Norwegian healthcare system as healthcare providers may not have a comprehensive understanding of certain patient's cultures. Healthcare systems could focus on providing additional cultural competency training to healthcare providers, especially regarding immigrant populations that are more commonly encountered.

This study is applicable to Norway and the Norwegian healthcare system but may also provide information about other developed countries with similar challenges in providing equitable care to increasingly diverse populations.

FUTURE RESEARCH

This study did not focus on meaningful and practical solutions for healthcare issues immigrants face in the short or long term. Further studies should include solution development. It would be beneficial to conduct this study in other countries with both similar and diverse healthcare systems and immigration policies to assess how various countries are handling these issues. Research is also needed to investigate the perceptions of the healthcare system from the viewpoint of the immigrant populations themselves.

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