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Learning to navigate the healthcare system in a new country: a qualitative study

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ABSTRACT

Objective: Learning to navigate a healthcare system in a new country is a barrier to health care. Understanding more about the specific navigation challenges immigrants experience may be the first step towards improving health information and thus access to care. This study considers the challenges that Thai and Filipino immigrant women encounter when learning to navigate the Norwegian primary healthcare system and the strategies they use.

Design: A qualitative interview study using thematic analysis.

Setting: Norway.

Participants: Fifteen Thai and 15 Filipino immigrant women over the age of 18 who had been living in Norway at least one year.

Results: The women took time to understand the role of the general practitioner and some were unaware of their right to an interpreter during consultations. In addition to reliance on family members and friends in their social networks, voluntary and cultural organisations provided valuable tips and advice on how to navigate the Norwegian health system. While some women actively engaged in learning more about the system, they noted a lack of information available in multiple languages.

Conclusions: Informal sources play an important role in learning about the health care system. Formal information should be available in different languages in order to better empower immigrant women.

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Primary health care;
immigrant women; barriers
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Introduction

Immigrant women face significant barriers to adequate health care [1,2]. Learning to navigate a healthcare system in the new country is one such obstacle [3]. With the exception of some specialised services, there is little focus on addressing this barrier. Yet, low-cost, universal interventions at a public health level could improve immigrants' knowledge of the healthcare system in the receiving country and ability to access services. The current study considers the challenges that Thai and Filipino immigrant women living in Norway face and how they learn to navigate the healthcare system.

Immigrant women from Thailand and the Philippines comprise the two largest groups of immigrant women in Norway from outside of the European Union (EU) [4]. There are almost five times as many women as men. Marriage is often the reason for coming to Norway, while others come as skilled workers

(often in the health sector) or students (often au-pairs) [5–7]. Many are married to Norwegian men and those who come to Norway as au-pairs live with Norwegian families. Thus, these women, having support from Norwegian residents or gaining knowledge through their workplace, may be well-placed for accessing health. Nonetheless, we know that Thai and Filipino women are underrepresented in using primary healthcare services for mental health problems, which may indicate they still experience barriers to care [8]. Understanding more about the specific navigation challenges these women experience may be the first step towards improving the accessibility and utilisation of information and healthcare services.

The Norwegian healthcare system

In Norway, the healthcare system is publically funded. All citizens, residents staying a minimum of 6 months,

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and registered asylum seekers are covered in the healthcare insurance system. Undocumented immigrants and asylum-seekers who have had a final rejection on their applications fall outside of this system. Healthcare is semidecentralised; municipalities are responsible for primary care and the state for secondary care [9]. Primary health care includes long-term care services, general practitioners (GPs) and emergency care. Secondary services include both specialists and hospitals. Residents are assigned a GP who acts as a gatekeeper to secondary services. Residents have the right to choose healthcare providers and can change their GP up to twice a year [9].

Patients, except children and pregnant women, pay a subsidised consultation fee when visiting their GP. Most GPs are self-employed and in addition to the patient co-payment, are paid by the state and the municipality. Most medical specialists outside hospitals, as well as ambulatory hospital services also require co-payments. Costs in excess of 2205 Norwegian kroner (260 USD) per year (around 10 GP consultations) are covered under the national insurance scheme [10]. Hospital services are free to the patient. There is also a private system in Norway where one can access specialists directly but out-of-pocket fees are typically four times higher. Private care is relatively uncommon and mostly only available in urban areas [11].

Health literacy and system navigation

Poor health literacy is a barrier to adequate and appropriate use of healthcare services among immigrants, as well as the general population [12]. Health literacy is defined as a person's 'knowledge, motivation and competences to access, understand, appraise and apply health information in order to make judgements and take decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life-course' [13, p3]. This means that health literacy not only varies by the health context (health promotion, disease prevention or treatment) but also by the social context in which healthcare decisions are made [13,14]. Healthcare interactions and the way in which services are organised can impede or improve literacy. Understanding how the healthcare system works, and how to use it, is a crucial component of health literacy that has, to date, received very little attention [15].

Gaining system knowledge can be challenging for immigrants, as formal language is often used in official information, making it difficult to understand [15]. Immigrants also have less experience with the healthcare system in the new country than non-immigrants,

so we can also assume they are at greater disadvantage in terms of gaining knowledge through experience. Further, because healthcare takes place in a social arena with power relations (between the patient and health care provider), a person's capacity to apply their knowledge of the system may also be influenced by his or her status [16]. Immigrants, with their lesser experience of the health system, may experience a greater power differential than non-immigrants.

Internationally, there is an increasing number of researchers evaluating interventions aimed at increasing knowledge and uptake of health services for both immigrants and other groups [17–19]. Findings appear to be positive with regard to improving understanding of illnesses, uptake and navigation of services, and thus, the increasing equity of care [17,19]. These studies, however, often target specialised services such as screening or cancer care and are tailored towards the needs of individuals or specific groups. Such interventions are costly and not transferrable to other services. *General* navigation of the healthcare system could potentially be improved for immigrants at low cost, through more accessible information [20]. In order to do this, it is important to understand how immigrants learn to navigate the healthcare system and what difficulties they encounter. Except for emergency situations, the first point of contact with healthcare services in Norway is with an assigned GP. Thus, understanding the healthcare system should begin at the primary care level. In this study, we ask: What challenges do Thai and Filipino immigrant women experience when learning to navigate the primary healthcare system in Norway and what strategies do they use?

Materials and methods

Informants

The sample consisted of 30 immigrant women; 15 from the Philippines and 15 from Thailand. The women were aged between 24 and 65 years (mean = 38.3 years). With the exception of two who had been in Norway more than 30 years, the women had lived on average 5.6 years in Norway (1–15 years). Ten women lived in Oslo and 10 in other major cities, four women lived in suburban areas (<40 km from major cities), while six lived more than 100 km from major cities. At the time of the interview, 14 were married and 16 were mothers. Fifteen had higher education and 25 were employed and/or studying. Sixteen women had initially moved to Norway due to a Norwegian partner/spouse, six through the au pair scheme (a cultural exchange with a host family in

return for domestic work and childcare [21]), four to find skilled work and four for other reasons. Nine women worked in or were studying health care in Norway.

Interview procedure

Starting from several sources including key contacts in immigrant organisations, interpreters and personal contacts to identify a range of potential informants, we then used purposive and snowballing sampling techniques to recruit others [22]. Having multiple key contacts helped us to reach women with different characteristics, resources and experiences. Selection criteria included individuals over the age of 18 that had lived in Norway for at least one year. Women were contacted via telephone or e-mail through key contacts and organisations and asked to participate. They received written information about the goals of the study, the interview procedure, their rights and ethical considerations. A suitable time and place for the interview was arranged for those who wished to participate. Informants were asked to tell their contacts about the study and those who wished to participate contacted the first author. All interviews took place over a 6-month period in 2013/2014.

Informants completed a short questionnaire with background information prior to interview. The main aim of the interview was to investigate immigrant women's emotional health and their experiences in consulting with GPs in Norway. We used a semistructured interview guide with open-ended questions on topics such as living in Norway, emotional difficulties, perceptions of health and mental health and experiences in using healthcare services in Norway. The first author, a native English speaker, fluent in Norwegian, interviewed all the informants. An interpreter was present in two interviews. All interviews were audiorecorded and transcribed. They lasted on average 64 minutes (range 25–116 min).

Analysis

We used thematic analysis to analyse the data, applying a contextualist approach [23]. This allowed us to consider how the broader sociocultural context (including the structure of health services and an immigrant's previous knowledge and experiences from their home country) influenced informants' understanding, experiences and navigation of the healthcare system. Informants were not specifically asked what they understood about different aspects of the healthcare system but navigation issues came to light during

the discussions. As such, informants' comments about navigating the healthcare system were either spontaneously and explicitly produced or implicit in their narratives about their health and healthcare experiences.

The first author read the transcripts to become familiar with the data. She then reread them to identify the units of text referring to health or the healthcare system in Norway and the home country. Working case by case, the first author coded units into analytic categories. Each unit of text could be assigned to more than one category. Each category was then reviewed for cohesion and data sufficiency. By comparing and contrasting categories across the cases and referring back to the full interviews, the first author grouped the categories into higher order themes by merging sub-categories. Resultant themes were then reviewed again and discussed with the second author. NVivo was used to assist in coding and categorising the transcripts.

Results

Informants mentioned encountering several challenges when learning about the Norwegian healthcare system: 'Understanding the GP system', 'where to seek help', 'lack of formal information in an understandable language and using an interpreter'.

Understanding the GP system

The women generally had some understanding of primary healthcare services in Norway; they knew that they had a GP, how to contact him or her and that they needed to set up an appointment. Two women were not (yet) part of the National insurance system in Norway, but were aware of this system. However, informants noted that they were still learning. It had taken time to familiarise themselves with the GP system in Norway. In their home countries, they attended clinics where they could see a doctor within a few hours; setting up an advance appointment was new. Additionally, the gatekeeping role of the GP was unfamiliar:

In the Philippines you don't have a GP. So if we feel like we're having... a simple cough or a bit of flem, we go to a respiratory doctor. To the specialist right away, if we have problem with our eyesight, we go to the eye doctor. In [Norway] you have to go to the GP and... wait for a... [referral]... So it's a more aggressive approach in my [country] (participant 27).

The referral system led to frustration for many of the informants who felt the process was slow, especially when serious health problems arose. Some also

felt confusion about the communication between the GP, the specialist and the patient. The informants were unsure if, and when, to contact the specialist following referral.

Most of the women were aware that they could change their GP, and several had done so due to dissatisfaction. Others had changed due to moving to another municipality. However, there was some indication that knowledge about the right to choose a healthcare provider was acquired after several years of living in Norway.

Where to seek help

The women quickly learned how to seek routine care from the GP. However, when the need for care was more urgent, they were unsure where to seek healthcare:

At the time I didn't know that we could go to the GP right away if we feel really ill... Yes, so I went to [the accident and emergency department]... I didn't know that I could get an appointment right away if I felt really ill, I [didn't want] to wait two weeks (participant 20).

Beyond using the GP, the women were aware of some different services but found the operational structure of the healthcare system confusing: *'the GP system, the municipal health services - what's that? The hospital - why is it so different? What's the nursing home? How do they get there?'* (participant 28).

The informants often learned about different services such as health clinics for mother and child, specialists and hospital care when the need arose, although not everyone knew where or how to get the help they needed: 'A friend of mine told me that you can go somewhere... a psychiatric thing that is for free... but... I mean in Norway I haven't gathered so much information about mental health and health' (participant 16). Finally, although a couple of informants had used private health care in Norway, several women were unaware that private health care was available.

Lack of formal information in an understandable language

Norwegian residents are assigned a GP and informed by letter in the mail. The letter is in Norwegian, so the women had to rely on help from others to understand it. When asked what might help immigrants understand the healthcare system better, one woman responded with *'explaining to them in their own language. Yes, and not getting a letter in Norwegian, that*

you don't understand...' (participant 26). Additionally, the women felt accessible online information available was lacking:

if someone can't speak the language, it is difficult for them... Maybe they should make [the information available] in Thai you know... there are so many people who can translate. Not just in Thai but in other languages too. Yes, there is a lack of information. (participant 3)

Using an interpreter

Although the Filipino women felt that they could communicate sufficiently with their doctor in Norwegian or English for their current needs, some did express that language would be a problem if they had a more serious health condition. Yet, several indicated that they were unaware of their right to an interpreter. Many of the Thai informants were aware of the interpreting service but knew other Thai women who lacked information about their right to an interpreter or the knowledge of how to use this right:

I think that us Thai women, we don't find out that we can request an interpreter through the health service... because they haven't said that if you can't speak Norwegian, then you can get [an interpreter], or that you have the right... that [the health service] will book someone for you... This isn't made clear. Someone I know, they were going to the doctors and asked if I could go with them. So I said 'you have the right to [an interpreter]... but you must give them notice to request one. And they are obligated to help you' (participant 3)

Lack of knowledge about the right to an interpreter suggests that some women avoid seeking healthcare due to effective communication concerns: 'Many of the women have never been to the doctor before. They say "I can't speak the language, how can I tell the doctor?"... because they don't know [their rights]' (participant 5).

For most informants, the navigation difficulties became less challenging through a combination of time and acquiring experience using the healthcare system. The informants also mentioned numerous strategies for augmenting their knowledge about the healthcare system including *educational resources* and *informal social networks*.

Educational sources

Non-labour immigrants from non-EU countries are obliged to take a language and social studies course in Norway [24]. The women mentioned that this

course contains important information about the healthcare system and how to use it. However, this is not always offered in one's mother tongue. Thus, those with low Norwegian proficiency may misunderstand or miss important information.

Some informants were working in healthcare or studying healthcare. Those who had health qualification from their home country were required to take a formal education course in order to work in the health sector. This improved their knowledge of the system: 'I understood the health system through our course [for health personnel from non-EU countries] when it was required. But before that, it was quite difficult ...' (participant 28).

Several women also indicated that they had consulted additional sources when, for example, choosing a new GP:

I saw her name on the internet and I chose myself. There is a little [information], she has worked as such and such, she has specialised in this and so I could request her on the internet... We can read the name and her CV is there too, so we read a little about her and selected her. (participant 10)

A few highlighted that one mostly does research when the need arises; when they are dissatisfied with care or when they have a specific or new health care need. Some felt it was important to take initiative to learn more about the system: 'If they are really interested in how the system works, they have to research, read... Because [in Norway]... you're not being spoon fed information. You have to... make the effort' (participant 27).

Informal social networks

Many of the informants had partners/spouses, family members or host family members (for those who came as au pairs) who had assisted them with basic information and practical issues about the healthcare system. They often obtained more in-depth information from their Filipina/Thai friends about the system, exchanged experiences and tips: 'it's my friend actually who told me that you can read about the reviews of the doctor' (participant 26). Married women, with lower proficiency in Norwegian, were especially reliant on their husbands when it came to health information:

Before, I lived with my [Norwegian] husband. When I got a letter from the doctor, he read it and explained what it said... I don't speak good Norwegian but he understood me, because he heard me talking every day. So he helped me. (participant 14)

This further highlights the importance of the role of language; without accessible information in an

understandable language, immigrant women may have less autonomy and control over their healthcare decisions.

Thai/Filipino associations were another important source of information exchange: 'they give you a lot of tips, because of course some of them ... have been here long time, so [they] know more ... here than us' (participant 29). A few informants also devoted their own time and resources to such associations to help others learn about the healthcare system, among other things. Although on occasion they accompanied women to appointments, they explained that they also tried to inform women so that they could use the healthcare system independently.

Discussion

This study highlights some of the challenges Thai and Filipino immigrant women encounter when navigating the healthcare system and the sources they use to help do so. Coming from countries with different healthcare systems, our informants indicate that it took time to become familiar with the role of the GP. System knowledge is acquired throughout the life course [13] and so immigrants' expectations about the new healthcare system are somewhat based upon their experiences and knowledge of the healthcare system in their home country. Yet, formal information sources on the Norwegian healthcare system such as www.helsenorge.no and www.helsetilsynet.no often assume this foundational life-course knowledge and therefore do not provide details about the operational structure of the system.

A common perception of immigrants is that they overuse emergency departments for routine problems that could be resolved by a GP [25]. This may be somewhat due to a higher perceived need of urgency among some immigrant groups [26]. However, our findings indicate that this may be due to lack of information about the possibility of emergency appointments with a GP. Over time, as immigrants become more familiar with the healthcare system and improve their health literacy, they are likely to use it more appropriately. However, more accessible information could expedite this process.

The information letter immigrants receive as newcomers is in Norwegian. While some informants actively engage in learning more about the system, information may not be readily available to those most in need; immigrants with low language proficiency and poor literacy skills. Indeed, up to 60% of immigrants from countries outside the EU, North America and Oceania have low Norwegian literacy

levels [27]. This lack of accessible standardised health-care information has important implications. Without the ability to navigate the system, one may be less inclined to use preventive healthcare services, delay help-seeking and seek healthcare only in acute situations. As well as resulting in poorer health, this can also lead to greater healthcare costs at the societal level when health care is eventually sought.

All patients have the right to tailored healthcare information in a language they understand and regional healthcare trusts are responsible for providing interpretation services in their area [3]. Yet, this service is thought to be underused [3]. Our study indicates that this may partly be due to a lack of awareness regarding the right to an interpreter. This echoes an earlier Norwegian study that found that not only were some immigrants unaware of this right but neither were some health personnel [28]. Further, information about the need for an interpreter was not conveyed by a GP upon referral to a hospital and there was no mention of the right to an interpreter when the patient was called into a hospital appointment [28]. Lack of awareness of this right may again mean that some immigrants delay seeking healthcare. Many of the informants were married to Norwegians and received help from their spouses, not only when it came to system navigation, but also for interpretation assistance. This is problematic as the quality of the interpretation is questionable, especially as spouses were not fluent in the wives' mother tongue. This may also limit the information women provide to the doctor and has implications regarding privacy and confidentiality. Furthermore, relying on a spouse gives women less control over their own health. It is imperative that information about the right to an interpreter is improved in order to empower immigrant women and improve patient-provider communication.

Limitations

There are some study limitations to highlight. First, we did not specifically ask if the women understood various aspects of the healthcare system. Rather, the information emerged spontaneously during the interviews. There are likely to be more navigation difficulties for the treatment of complex medical problems for instance. However, given that the GP is, in most cases, the first point of contact with the health system, our focus is relevant for gaining access to secondary services. Second, half of our informants had higher education and a third of the informants worked, or were studying to work in health care and therefore had a good understanding of the healthcare system and

high health literacy. Third, a relatively high proportion of Thai and Filipino women have Norwegian spouses compared with immigrant men (and other immigrant women from Asia) (7) so Thai and Filipino women may have more assistance from Norwegians than other immigrants. Not all immigrants have such resources for learning to navigate the healthcare system; we might expect greater challenges among other groups. As such, our findings are unlikely to reflect the full extent of navigation difficulties other immigrant groups encounter.

Another consideration is the role of the researcher in both data collection and analysis. The first author, a British immigrant living in Norway, conducted the interviews. She therefore shares some experience with the informants in terms of being an immigrant woman which may have made informants more comfortable in discussing some topics raised in the interview. However, coming from a different cultural background and having the role of the researcher may have introduced some distance during the interviews. Her experiences with the healthcare system in the United Kingdom will also have influenced data analysis.

Implications and conclusions

Nonetheless, although our findings may not reflect all the difficulties that other immigrants experience, some of the implications may benefit other groups. For instance, our study suggests that formal healthcare system information, including letters, information leaflets and websites, should be available in multiple languages so that immigrants can access information in a language they understand. Healthcare system information should not be written with the assumption that the reader is familiar with a GP gatekeeping model or interpreter services. This study also suggests that those who are actively engaged in seeking healthcare information tend to have more education; thus there needs to be different channels of information available in order to reach less educated or resourceful immigrants. The women indicated that one useful way was through the social studies course that non-EU and non-labour immigrants are obliged to attend. Yet, this is not always offered in one's mother tongue. Offering this course in multiple languages is an important measure to ensure that information about rights and responsibilities of residents reaches a larger number of immigrants.

In addition, the study highlights the importance of informal networks and voluntary associations for immigrant communities. Thai or Filipino organisations were also important arenas for information dissemination and exchange. Providing resources or training for key actors in such organisations could be a useful strategy

to ensure that the information they give to their fellow immigrants is timely and correct. Further, this type of training should specifically target immigrant communities from low-middle income countries, as these countries tend to have more dissimilar healthcare systems (for instance, specialist-oriented care models).

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Ethical approval

Ethical approval was obtained from the Regional Committee for Medical and Health Research Ethics, West Norway (2013/542/REK Vest). All informants gave written consent to participate. Information about the study was offered to informants in English, Norwegian, Thai or Tagalog.

Disclosure statement

The authors report no conflicts of interest.

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Notes on Contributors

Melanie L. Straiton, is a researcher at the Norwegian Institute of Public Health. She has a PhD in psychology and an interest in immigrant mental health and use of health care services.

Sonja Myhre, is a senior advisor at the Norwegian Institute of Public Health. She has a PhD in public health and her research interests include health communication, migrant health and cultural competence in health care.

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