

Alternative ways for public health information to reach diverse communities.

Preliminary result from studies on primary health care in Norway.

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Introduction:

Health care in Norway is more than ever confronted with the consequences of the ethnic diversity after more than 50 years with increasing influx of immigrants(1).

Recently arrived migrants are particularly affected by situations that differ from those in their home country. After arrival in the new country, such essential features of life as family structure and social network may change.

As a consequence of being in a new environment, the incidence and prevalence of health problems may change. The majority of researchers assume that they rise. Even the ability to comprehend life and receive information is compromised (2,3).

The general complexity of a western health system like the GP Scheme (fastlegeordning), may be difficult to understand, even for the local population (4).

Problem Definition

In order to act in accordance with the public health care system, the individual needs to know “when to go where”. This requires that information from the health authorities is received and comprehended by all inhabitants.

In a not fully integrated community, often new ways have to be found in order to get information across to every resident.

Integrating different categories of immigrants in a new environment often creates the need for strategies which are flexible and adapted to the level of functioning of immigrant groups. The necessary information may be very different across immigrant groups. In addition, supplying information to illiterate people is a special challenge.

The situation in Norway today

The goal of the GP scheme, introduced in 2002, was to provide all inhabitants with an assigned GP. This GP also functions as a gatekeeper for other primary and secondary health facilities. Access to non-emergency treatment at the office of a medical specialist is channelled through general practitioners for all Norwegians. This may come as a surprise to many immigrants, also from Western countries.

Norway has experienced an increased use of health services among certain migrant populations (3). This might indicate that migrants require more medical attention, but also that the attention they are receiving might not be experienced as satisfactory, and hence lead to an increase in demand for services (or number of visits) (3).

To this date (Sept. 2009) we do not have available documentation of the usage of health services of all migrant populations. Up till now Norwegian migrant health studies did not include the country's largest migration populations, such as Poles, Swedes, Germans or Russians, but are limited to a range of "non western" migrant populations like Pakistanis, Vietnamese, Somalis and Chileans (2,3).

Additionally, most migrants included in local studies, have lived in Norway for more than five years. Some of the questionnaires used in Norway's comprehensive studies were in Norwegian, assuming that the respondents comprehend the language.

As indicated in previous publications, 77 % of all inquiries to emergency clinics and emergency clinic consultations in Norway are categorized as low urgency (6) and immigrants use the public health care services to a greater extent than the majority population (2,3).

Information about the regular GP scheme provided by the Norwegian Labour and Welfare organisation (NAV) is only available in the two Norwegian languages bokmål

and nynorsk, as well as in English. Emergency clinics on the other hand, have no obligation to inform patients about the Norwegian public health care system.

Demand for information – visible signs of inefficiency in the public health care system.

As M. Castells said: “One of the key features of the information-society is the networking logic of its basic structure, which explains the use of the concept of “network society” (5).

But the existence of different sets of networks implies that this logic may be of local or regional origin. Hence, immigrants cannot be assumed to fully understand an unfamiliar system without thorough explanations.

According to previous studies, the increased use of emergency clinics (emergency ward/legevakt) is one of the signs of inefficient use of the public health care system (6,7). Failing to understand the system may be a significant cause for patients to use the health care system inefficiently.

The aim

The aim of the study was to gain information about possible obstacles the immigrants may experience within the public health care service.

Methodological approach

Our study included twelve GPs located in Oslo or its suburbs as well as thirteen key informants from the thirteen largest immigrant populations in Norway. They served as informants for the study aim from two different angles. The key informants, leaders of migrant organisations, were interviewed about their opinions concerning compatriots’ experiences with the health care services in Norway. The GPs were interviewed about their experiences with immigrant patients. We asked about the interaction patterns between doctors and patients, complicating factors like limited language proficiency, as well as the expectations of both migrant and physician. Interviews were conducted in Norwegian using a semi-structured interview guide. The results were analyzed, validated and summarized by two researchers.

Overview of the project

Currently, we are analyzing data from several public sources about the registered and factual use of primary health care services by immigrant patients versus patients born in Norway. The material is gathered from several public data sources not combined to date.

Preliminary results

Preliminary results of the interviews with the GP's indicate that assigned GPs experience reactions of helplessness among newly arrived immigrant patients. The patients' lack of information about the public health care system in Norway may be seen as an explaining factor.

The preliminary results from the interviews with the migrant key informants indicate that correct information about the Norwegian health care system did not reach certain populations of immigrants. This resulted in obstructed interaction with and adaption to the health care system.

The preliminary results of the interviews with the GP's show that information about the individually assigned GP and the GP system is distributed only in Norwegian to newly arrived migrants. Regarding refugees and asylum seekers, the results showed that they often receive information about the Norwegian Health system during their stay in the local asylum seeker centre. Newly arrived migrants like labour migrants, students or for family unification did not have sufficient access to comprehensible information adapted to their needs.

Family, friends or migrant associations, as well as colleagues or religious congregations were mentioned as the main sources of information. This also applied to information about health care systems in the resettlement period.

Both the assigned physicians and the immigrant key informants mentioned the need for extensive translation of information material and in medical consultations. Access to interpreters during medical consultations was a problem. The limited time available reduced the possibility for patients and GPs alike to express themselves

and feel understood. Because of this, the GPs' understanding of the complexity of the health problems of the patient could be less than satisfying.

Preliminary results from interviews both with the GP's and the migrant representative's show that newly arrived migrants are more likely to consult the emergency clinics as a replacement for an assigned GP.

Preliminary results show that immigrants' compliance with the GP scheme is positively associated with length of residence, language ability in Norwegian or English and educational level, and that it also varies according to reasons for migration.

Conclusion:

There are key gaps in the information about the health care system reaching especially labour migrants. If information was available in a format that the migrant would understand, we might see a reduction of inappropriate medical consultations.

Since strategies to gain information differ among immigrant populations, the information itself as well as the information channels need to be adapted to the target population.

In addition, in order to deal with ethnically diverse patients – our new “health care consumers”- the health care services in Norway also must adapt.

Providing information about health care services and -systems in a migrant's mother tongue upon arrival in Norway seems to be crucial. But the multitude of languages spoken by immigrants to Norway these days is a great challenge to the public health system.

Leading immigrant representatives and immigrant associations can play an important role, e.g. by spreading knowledge in an adapted way. By systematically informing those representatives about changes or important news, the immigrant populations could obtain socio-culturally adapted and comprehensive information.

With the influx of diverse immigrants, the management of health issues require an integration of national and global health initiatives. In order to achieve this, socio-culturally adapted channels of information must be established.

Sustaining the GP scheme, like implementing public health care interventions, depends on the right mix of both direct and indirect interventions.

Therefore, finding appropriate information channels will improve the use of services in the primary health care sector.

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