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Health determinants that influence the seeking and utilization of health care

A qualitative study among non-natives

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Credits:	15 credits
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English title: Health determinants that influence the seeking and utilization of health care – A qualitative study among non-natives

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Abstract

Introduction: Research shows that non-natives residing in Sweden seek health care to a lesser extent than natives, despite the fact that non-natives suffer from poorer health than the general population. Non-natives also express greater dissatisfaction regarding the care provided. **Aim:** To study health determinants that influence the seeking and utilization of health care among non-natives residing in Sweden. **Method:** Five individual open interviews were conducted and analyzed in accordance with Grounded Theory methodology. **Results:** Based on the empirical data, the following five categories were created; *Labeling ill-health and disease, Expectations, Views on symptom and medication*, *Being ‘the Other’* and *The consultation*. These categories relate to and reflect the content of the interviews. Furthermore, the categories are central for an emerging theory. **Discussion:** Based on the results, six health determinants were identified (unmet expectation, cultural attitudes and perceptions, discrimination, negative experiences in the past, language and communication and dissatisfaction) and studied in detail. Non-natives are strongly influenced by their cultural and ethnic backgrounds. They have certain expectations about health care which are not always met. This causes great dissatisfaction and may contribute to the refraining of seeking and utilization of health care among non-natives in Sweden.

Keywords: Non-natives, health determinants, utilization, health care seeking, Grounded Theory

Sammanfattning

Introduktion: Forskning visar att utlandsfödda i Sverige söker sjukvård i mindre utsträckning än svenskfödda, trots att utlandsfödda har ett högre ohälsotal än övrig population. Utlandsfödda är också i högre grad missnöjda med erhållen vård. **Syfte:** Att studera hälsodeterminanter som påverkar vårdsökande och vårdutnyttjande bland utlandsfödda i Sverige. **Metod:** Fem individuella ostrukturerade intervjuer genomfördes och analyserades utifrån Grounded Theory. **Resultat:** Med utgångspunkt i vårt empiriska material skapades följande fem kategorier: *Definierande av ohälsa och sjukdom*, *Förväntningar*, *Synen på symptom och medicin*, *Att vara 'den Andra'* och *Vårdbesöket*. Dessa kategorier är på olika sätt relaterade till varandra och speglar intervjuernas innehåll. Vidare är kategorierna centrala i skapandet av en framväxande teori. **Diskussion:** Utifrån resultatet har sex hälsodeterminanter identifierats (ouppnådda förväntningar, kulturella attityder och föreställningar, diskriminering, tidigare negativa upplevelser, språk och kommunikation samt missnöje) och studerats i detalj. Utlandsfödda är mycket påverkade av sin kulturella och etniska bakgrund. Vidare har dem vissa förväntningar på sjukvården som inte alltid blir uppnådda. Detta skapar stort missnöje och kan leda till att utlandsfödda i Sverige avstår från att söka och utnyttja sjukvård.

Sökord: Utlandsfödda, hälsodeterminanter, vårdutnyttjande, vårdsökande
Grounded Theory

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1. Conceptual issues and definitions

Health

The most well-known definition of health was established by WHO in 1947 and has been declared as: ‘A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (Pellmer & Wramner, 2001, p. 14). Throughout the years this declaration has been refined. Between the 1980’s and the 1990’s the definition of health also came to include four indicators of quality of life, namely; a long, healthy, rich and equal life. Health itself was no longer considered the goal; rather health was considered a resource for the entire population as well as for the individual himself (Pellmer & Wramner, 2001). In this Bachelor’s thesis we would like to acknowledge health in the broadest sense, including all of the above mentioned aspects. For this purpose, we also allow a subjective definition of health by the individual.

Social disparities

Our definition of social disparities is rather broad and includes; education, occupation, gender, ethnicity, level of income and marital status (Janlert, 2000). When discussing differences in health care seeking and utilization we wanted to include aspects of the health care system as well as the entire political and economical situation in Sweden. As with the social attributes mentioned above, they have been found to have a determining effect (Adolfo, 2009).

Non-natives

We have accepted a broad definition of non-natives, where any individual born in a country other than Sweden is included in the definition. We acknowledge that non-natives, by no means, constitute a homogeneous group. Here we use the term non-native as representative of an individual who differ from each other in respect to language, culture, religion, place of birth, level of acculturation as well as historic background (Scheppers, van Dongen, Dekker, Geertzen & Dekker, 2006).

Health care and utilization of health care services

In this Bachelor’s thesis, we have chosen to include a wide spectrum of services in our concept of health care. They include primary care (i.e. health centers, general practitioners and telephone triage) as well as emergency care, long-term treatment in hospitals and psychological health care. Furthermore we have chosen to define the utilization of health care services in accordance with Scheppers et al., as: ‘the process of seeking professional health care and submitting oneself to the application of regular health services, with the purpose to prevent or treat health problems’ (Scheppers et al., 2006, p. 326).

Culture

In accordance with the US Institute of Medicine, we have chosen to define culture as; ‘The accumulated store of shared values, ideas (attitudes, beliefs, values, and norms), understandings, symbols, material products, and practices of a group of people’ (American Society of Health-System Pharmacists, 2007, p. 224).

Ethnicity

We have adhered to the definition of ethnicity as stated by the above mentioned institute, suggesting that ethnicity is: ‘A shared culture and way of life, especially as reflected in language, folkways, religious and other institutional forms, material culture such as clothing and food, and cultural products such as music, literature, and art’ (American Society of Health-System Pharmacists, 2007, p. 224). An ethnic group is described as: ’Socially distinguished or set apart, by others or by itself, primarily on the basis of cultural or national-origin characteristics’ (American Society of Health-System Pharmacists, 2007, p. 224).

We also want to emphasize that ethnicity in this Bachelor’s thesis is not to be confused with the term race, which is mostly used to distinguish specific physical characteristics between groups of people (American Society of Health-System Pharmacists, 2007). The underlying motivation for this exclusion is that we consider the term insufficient to capture the political, economical and historical factors included in the more comprehensive term ethnicity (Hedelmalm, 2007).

Differences in health

The concepts of ‘health disparity’ and ‘health inequity’ or ‘health inequality’ are often used interchangeably in the field of public health. However, disagreements exist in regards to the definition as well as how the terms should be used. The commonly used definition outside of the United States is ‘health inequity’ (Carter-Pokras & Baquet, 2002) which indicates an ethical judgment and includes an aspect of unjustness or unfairness (Walander, Ålander & Burström, 2004). The assumption is that inequity cannot exist without inequality and therefore it is vital to understand the underlying causes of inequality. In the United States the term ‘health disparities’ are used. Even though variations within the term exist; ‘health disparities’ commonly do not distinguish between differences in health outcomes that are avoidable, unacceptable or unfair (Carter-Pokras & Baquet, 2002). As the concept health inequity is highly complex and also somewhat problematic (for instance when deciding what is unjust and avoidable as well as who is deciding it) we have chosen to recognize the concept of ‘health disparity’ and its definition and use when writing this thesis.

Health care quality

What constitutes the quality of health care and treatment has been described in the Swedish Health and Medical Services Act. It includes; *quality of care* (patient’s need of security, availability and access to treatment and care), *reception* (respect for the patient, encourage self-determination and privacy), *promotion* (encourage good contact between patients and health care professionals) and *continuity* (access to medical contacts and access to information) (Sahlin, 2006). Health care quality and target areas in the field of health care have also been described in detail by the National Board of Health and Welfare. According to them, quality should permeate the following areas; treatment of patients, methods for diagnoses, treatment and care, qualifications of health care professionals, cooperation and collaboration, risk assessment, deviation management, technology and products, services guarantee and traceability (Socialstyrelsen, 2005). All of these areas are considered quality indicators throughout this Bachelor’s thesis.

2. Introduction

To ensure equity in health and health care for the entire Swedish population is one of the responsibilities of the social welfare system in Sweden. The health care sector, guided by the Health and Medical Service Act established in 1982 (Sahlin, 2006), also has an important role to play when it comes to equal distribution of health. One of the objectives firmly stated in this act is that Swedish health care should deliver ‘good health, on equal terms, for the entire population’ (Sahlin, 2006, p. 315). This objective is also in accordance with the overarching aim of the Swedish National Institute of Public Health (FHI, 2009). However, a recent report published by the Swedish Association of Local Authorities and Regions; *Health on (un)equal terms* (Adolfo, 2009), shows that large disparities between different groups in society in regards to the frequency of seeking health care exist. These social disparities are defined as for instance income level, educational status, country of origin and geographical setting (Adolfo, 2009).

The presence of health disparities in society was early recognized in the UK by a research group who concluded that in order to eliminate inequalities in health the British society needs to be better integrated (Gray, 1982). Their findings were presented in the Black Report from 1980 which described how health disparities were distinctly shown between rich and poor, those of different ethnicity and race and between different regions within the country (Sim & Mackie, 2006). Those who were socially disadvantaged suffered throughout life from ill-health at a much larger extent that those who were more socially advantaged. The utilization patterns were also quite different between cohorts in British society. Further, the Black Report concluded a greater under-utilization among the socially disadvantaged regarding primary preventive health care. They did, however, have higher attendants at GPs and hospitals compared to socially advantaged cohorts, but not to the extent that was needed according to the mortality and morbidity rates among them (Gray, 1982).

More than 25 years after the introduction of the Black Report, recent studies show that the same health disparities in health care seeking and utilization still exist in Sweden (Adolfo, 2009) (SCB, 2006) (Socialstyrelsen, 2008). From a public health as well as a health care perspective this is an important issue that needs to be addressed in order to meet the policy requirements and more importantly - improve the health of the *entire* population.

3. Background

The latest Public Health Report from 2009 by the National Board of Health and Welfare concludes that the life expectancy in Sweden is increasing. If one look at the main health indicators, the health of Swedish citizens is among the best in the world. Viewed from a macro level Sweden appears to be a country of privileges and opportunities where people enjoy good health and equality in society. If one looks at it from the micro level, however, there are flaws to be found. Socioeconomic disparities in health are increasing in Sweden and they are especially prominent in regards to diabetes, cardiovascular disease, cancer and self-rated health. Differences observed in the health status of non-natives compared to natives are among the most apparent (Socialstyrelsen, 2009). To make the situation even more complicated, there are large variations within the group non-natives, suggesting that being a non-native Swede can have entirely different meanings depending on many different factors (Adolfo, 2009). Thus, in order to gain a better understanding of the heterogeneous group non-native Swedes, it has to be viewed from a historical and more time specific perspective.

3.1 History of immigration to Sweden

Globalization, increased trade opportunities as well as advancements in communication and technology have all caused more people to migrate and settle in a country other than that of origin (Socialstyrelsen, 2009). From the 1950's to 2007, the number of immigrants residing in Sweden increased from 200 000 (Hogstedt et al., 2003) to 1 500 000 and is expected to increase even more in the future (Socialstyrelsen, 2009). Over the years there have been various trends and patterns in migration to Sweden. During the 1950's and 1960's the Swedish industry was in need of labor migration which resulted in an increased number of immigrants from Southern Europe and Turkey. During the 1970's and 1980's a lot of refugees from Latin America, Iran and Iraq fled to Sweden due to political disturbance in their home countries. The last two decades have been characterized by migration from countries where civil war has threatened the life and health of people, such as Yugoslavia and Somalia (Hogstedt et al., 2003).

As immigrants have come to Sweden for many different reasons and because they constitute a very heterogeneous group, their situation in Sweden varies a lot with respect to how they adapt and experience their new country. The Public Health Report of 2009 describes three factors that influence how well immigrants adapt; factors that can be derived from the native society or its population, factors that can be derived from the migration process or how the process is handled once arrived in Sweden and factors that can be derived from the existence in Sweden after a person has been permitted residence (Socialstyrelsen, 2009). However, these factors alone cannot cover the full range of experiences found among immigrants. For asylum-seeking refugees, their lives are often marked by traumatic experiences, violence, stress and uncertainties. This situation is very different from that of labor immigrants who migrated on a voluntary basis and were selected for work before they came to Sweden. However, regardless of the reason for migration (forced or voluntary), it causes a break-up from a persons cultural and social coherence (Hogstedt et al., 2003).Immigrants in Sweden are also more often unemployed, hold jobs in unhealthy working environments and live in low status and often segregated areas (Socialstyrelsen, 2009). They also have a lower income than native Swedes after controlling for other factors such as years of schooling, experience, region of residence and civil status (Hammarstedt, 2003).

3.2 Health status of immigrants

Due to the often difficult situation and living conditions of immigrants (as described above), non-natives in Sweden experience worse physical and psychological health compared to natives (SCB, 2006). The differences between the groups are especially large in regards to self-rated health status, decreased ability to work and anxiety (Socialstyrelsen, 2009). These results are also found across Europe and have been presented at the Migrant and Ethnic Health Observatory (MEHO) pre-conference on migrant health in November of 2008. Independent of country of residence in Europe, migrants had an increased risk of reporting poor self-rated health, long-standing illness, poor physical functioning, physical and mental health complaints, poor psychosocial health and number of days ill. However, in Sweden as well as in the other European countries studied, there were differences in relation to age, sex and country of origin (MEHO, 2008).

3.3 Health care seeking and utilization patterns among non-natives

Despite the fact that non-natives in Sweden suffer from poorer health than the general population, there are a large number of non-natives who are in need of medical attention but refrain from seeking medical care. A study from Statistics Sweden (SCB) showed that 21% of non-native women had not sought health care despite being in need of it (during a three month period), compared to only 12% of native Swedish women. The corresponding numbers among men were 16% and 10% respectively (SCB, 2006). Another study by Westin et al. conducted in Sweden showed a similar finding. Men and women from another country of origin than Sweden were 2.73 times more likely to have refrained from seeking medical care, despite a perceived need. This finding was highly significant also after controlling for socio demographic factors and long-standing illness (Westin, Åhs, Bränd-Persson & Westerling, 2004).

When non-natives do consume health care, they more often visit the emergency room and on-call doctors instead of seeking primary health care. This was observed in a large population based study that showed that 12% of the non-native men had sought emergency health care compared to 8% of native Swedish men (SCB, 2006). Refraining from seeking medical attention when it is needed may force people to emergency care settings as a result of worsened health conditions or the occurrence of more severe symptoms of illness. An important aspect of public health work is that of prevention and to encourage people to seek health care at an early stage before severe illness and diseases arise (Pellmer & Wramner, 2001). Primary health care have the possibility of playing an important role in the preventive public health work. Accordingly, over the last few years an increased number of primary health care centers state that they have developed public health routines and programs in order to work more actively with prevention and health promotion. This type of public health initiative could save the health care system a lot of money as well as enable a reduction of the higher preventable mortality currently observed among non-natives in Sweden. Studies have also shown that the conditions for which non-natives seek emergency health care are more often treatable within the primary health care setting compared to the conditions for which native Swedes seek the same emergency care (Socialstyrelsen, 2008).

Apart from refraining from seeking health care when in need of it, non-natives also have a lower level of confidence in the Swedish health care system. They also express dissatisfaction in regards to the care and information received to a higher extent than natives (Socialstyrelsen, 2008).

3.4 The impact of socioeconomic status

It is a well established fact that an individual's socioeconomic status (SES) plays a large role in accounting for disparities in health (Williams, 2002) (Adda, Chandola & Marmot, 2003) (Williams, 2007). However, it has been shown that race, ethnicity and country of origin are more than just SES. A study in the US found that differences between natives and non-natives still exist at every level of SES (Williams, 2002). A similar observation was made by Bauman who analyzed data from the 'Survey of Income and Project Participation' in the United States. His study showed that even after controlling for a wide range of socioeconomic factors such as education, income, home ownership, employment status and transfer payments, as well as demographic factors including sex, age, marital status, children, residential mobility, health insurance and disability, African Americans were still more likely than whites to abstain from visiting a doctor even though it was needed (Bauman, 1998). A recent study from Sweden (Wamala, Boström, Akhavan & Bildt, 2007) has also strongly supported this idea by finding that non-natives' more frequent refraining from health care despite a need thereof, was not simply due to socioeconomic disadvantages between natives and non-natives.

Furthermore, another study in Sweden investigated whether SES was the explanatory factor for the differences observed in regards to absence due to illness between natives and non-natives. The authors concluded that SES alone cannot account for these differences. The really powerful predictor in this study was country of origin but the authors were unable to explain exactly what lies *behind* this factor (Bengtsson & Scott, 2005). Other studies have suggested that factors other than SES can account for differences in health care utilization; factors existing even in more equal societies such as Sweden (Wamala & Lynch, 1999).

Despite this being a relatively unknown area of study, some researchers have expressed that discrimination within the health care sector may be one of these underlying factors. This has also been supported by some studies (Wamala, Merlo, Boström & Hogstedt, 2007) (Hausmann, Jeong, Bost & Ibrahim, 2008) (Elster, Jarosik, VanGeest & Fleming, 2003) (Abreu, 1999), suggesting that perceived discrimination, stereotyping and prejudice in the health care setting can be part of the explanation for why non-natives refrain from seeking medical care as well as express a higher level of dissatisfaction with the health care received.

Having these overall findings and statistics in mind, there appears to be a pressing need to discover and highlight these *health determinants* (factors), independent of SES and universal access to health care, that lie behind and explain the differences in health between native Swedes and non-natives residing in Sweden. This Bachelor's thesis is therefore looking to study these non-SES related health determinants that contribute to non-natives' unfavorable health care seeking behavior and utilization. This will be studied both in regards to the refraining from seeking health care services when needed and the reasons for their larger dissatisfaction with the health care system compared to that of native Swedes.

4. Aim

The overall aim of this Bachelor's thesis is to:

Study health determinants that influence the seeking and utilization of health care among non-natives residing in Sweden.

5. Theoretical framework

In order to reach our overall aim, we had to consider the most appropriate way to come to a conclusion. Induction is usually called 'the explorative way' – most suitable when a new field is under investigation and where the empiricism does not yet have a theoretical foundation (Thurén, 2007). As the area of study we are examining here is not well researched, we strive to generate new data that enables the creation of a new theory (i.e. induction) as opposed to starting with a theory and using it to explain our findings (i.e. deduction) (Gilbert, 2008).

We wanted to conduct this study in an inductive manner and without preconceived ideas. Thus we did not want to be tied to a hypothesis which had to be rejected or accepted, suggesting that we would know what to find in our research beforehand. Our choice of theoretical approach can be satisfactory encapsulated by the following quotation: 'The ultimate aim is to develop tools to understand new types of problems and to cope with new situations' (Dahlgren, Emmelin & Winkvist, 2007, p. 15).

Due to the nature of our inductive research approach as well as our choice of conducting qualitative interviews, it appeared adequate to carry out this Bachelor's thesis in accordance with the ideas constituting Grounded Theory. For us Grounded Theory represented a simplified way of thinking about the reality of social disparities (Dellve, Henning Abrahamsson & Hallberg, 2002).

In the methodology chapter that follows, we want to argue for the benefits of Grounded Theory and how we intend to use this scientific perspective as a part of the practical and theoretical research process.

5.1 Grounded Theory

Grounded Theory was first created and introduced in the beginning of the 1960's by two American sociologists; Anselm Strauss and Barney Glaser. Their book; *The discovery of grounded theory* is considered the beginning of the rise of qualitative methods and has been much used since the end of 1960's (Dellve et al., 2002). Strauss had a background in the so called 'Chicago School', a research institution that, according to tradition, studied human science with qualitative methods such as observation and field work (Hallberg, 2006). Glaser, on the other hand, had mostly studied sociological methods through statistical and content analysis (Thulesius, Barfod, Ekström & Håkansson, 2004).

Grounded Theory consists of three core concepts; *symbolic interactionism*, *pragmatism* and *social processes*. *Symbolic interactionism* view human and social behavior in terms of a constantly changing and ever going process. *Pragmatism* is known as a philosophical movement where a theory is considered 'true' if it is practical and easily applicable on social life. In Grounded Theory the pragmatic approach is shown as the constant interpretation of the empirical data, i.e. 'reality' that is created by the individuals engaged in a research study. Further, *social processes* are an important part of human interaction. Every encounter and experience together forms the reality of which every individual is part of (Dellve et al., 2002).

Grounded Theory is suitable when the aim of a study is to analyze human and social processes. Hallberg argues that Grounded Theory applies well to 'life world research' (a scientific tradition that study how people perceive the world around them), because 'the emphasis is on the individuals as unique living wholes and the researcher focuses on the world as it is experienced by the individual' (Hallberg, 2006, p. 141).

An important aspect of the Grounded Theory methodology is the concept of saturation. This refers to the point where additional data no longer provides new insight to the emerging theory. As a researcher it is hard to know when this stage has been reached and is based on the researcher's subjective understanding of his data (Dahlgren et al., 2007).

A study by Jakobsson et al.; *Treatment seeking process for people with alcohol problems* provides a good example of the applicability of Grounded Theory when it comes to public health. Jakobsson et al. have motivated their use of Grounded Theory as highly suitable when studying a psychosocial process. Their study also provides a good example of a study that did not have a certain theory or model as their starting point. Furthermore Grounded Theory can highlight the complexity underlying help-seeking behavior, in this case in regards to alcohol problems (Jakobsson, Hensing & Spak, 2004).

As the aim of our Bachelor's thesis is to study health determinants that can be causing social disparities in health and health seeking behaviors among non-natives, we have found Grounded Theory to be the most suitable theoretical approach for us. We believe that this theory can really encompass the complexity of social and human life, something that other theories may be unable to do.

6. Method

6.1 Choice of method

As we are trying to identify and form a deeper understanding about health determinants which may contribute to non-natives reluctance or failure to seek health care, we have chosen to use a qualitative approach. Even though a quantitative method, like questionnaires (Fielding & Thomas, 2008), may provide important reasons why people may refrain from seeking health care, our main focus here is to achieve a deeper knowledge and understanding about possible reasons behind the refraining. We also aim to listen to the experiences non-natives have with the Swedish health care system. Qualitative method has proved useful when the results of a study are seeking to reflect the individual’s reality (Friedlund & Hildingh, 2000). We believe the use of a qualitative method will provide a deeper insight about what is really going on, or what is perceived to be going on, in the health care setting (Fielding & Thomas, 2008).

Research also shows that a qualitative methodology is suitable when the research problem is new or relatively unknown. It can also help to clarify (as well as eliminate) associations between variables as well as be able to describe social mechanisms generating a certain risk behavior (Dahlgren et al., 2007). We believe that both of these aspects apply to what we are trying to accomplish in this Bachelor’s thesis. We want to be able to highlight health determinants (possibly involving social or societal mechanisms) contributing to the refraining from seeking medical attention when needed amongst non-natives.

6.2 Interview method

We have conducted a smaller number of individual in-depth interviews. The major conclusive factor in our choice of using in-depth interviews over for instance a focus group was the time aspect and limitations following that. From a Grounded Theory perspective, in-depth interviews are also an appropriate method in order to obtain data (Dellve et al., 2002). Indeed, most of the published studies that use the Grounded Theory approach work with data collected through interviews (Dahlgren et al., 2007).

6.2.1 Interview and setting

Interviews were being held at various places in Gothenburg during the month of April in 2009. Places where the respondents could feel comfortable and relaxed, such as their workplace, home or café of their own choosing, were selected in order to enable the best possible conversation. The only request on our behalf, was that it had to be a quiet setting where the interview could take place uninterrupted.

The total time interviewing varied between 45 and 70 minutes. During the interviews, one of us took on a leading role in order not to confuse the respondent. The other interviewer had a more passive role and was in charge of the tape-recorder and took additional notes.

6.2.2 Tape-recording and transcription

All of the in-depth interviews in this study were tape-recorded and then transcribed in order not to lose valuable data. The transcribed interviews were complemented with memos. Using a tape-recorder enabled less time interviewing (compared to only note-taking), which was desirable considering the limited scope of this Bachelor's thesis. As there is no consensus among Grounded Theory researchers as to whether or not a tape-recorder should be used (Dahlgren et al., 2007), we did not consider the choice of using a tape-recorder problematic.

6.3 Target group and sampling strategy

Individuals participating in these in-depth interviews were both men and women with immigrant background (i.e. born in a country other then Sweden but now residing here) living in any of the 21 community boards which constitute Gothenburg Municipality (Göteborgs Stad, 2008) for at least five years. We believe that non-natives who have lived in Gothenburg for a shorter period have too limited language skills to be able to participate.

As recent statistics show that self-rated health is lowest for those non-natives in Sweden who were born outside of Europe or outside of the EU15 area[1], we have chosen to only include non-natives from these areas in our qualitative study. Thus, immigrants born in a Nordic country or a country from the EU15 area (OECD, 2009) were excluded on the basis of this criterion. Our interest in this study was to focus on adults of productive (working) ages. Therefore the target age group was set to 18-64 years.

The two most important requirements in order to meet the target group criteria were that the individuals must have suffered from either physical or psychological ill-health during the past year as well as have refrained from seeking health care despite being in need of it. They were also eligible if they had sought health care but had been dissatisfied with the care given or expressed dissatisfaction in regards to other aspects of the health care process.

Target group criteria in sum:

- Men and women
- Age 18-64
- Residing in Sweden for a minimum of five years
- Currently living in Gothenburg Municipality

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[1] EU15 refers to the number of countries that were part of the European Union prior to the accession of ten candidate countries on May 1st in 2004. EU15 include the following 15 countries; Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden and United Kingdom (OECD, 2009).

- Have suffered from physical or psychological ailments during the past year
- Have not sought care for this ailment, *or*
- Have been dissatisfied with the care received

The interview subjects were recruited through advertising and snowball sampling. Inviting posters with a detailed description about the study and its purpose were posted at various immigrant member associations, SFI (Swedish For Immigrants) educational settings, health care centers, emergency rooms and common billboards in more immigrant-dense areas and neighborhoods of Gothenburg. One participant was sampled through these posters, and voluntarily announced his interest.

Key informants and employees at work places and universities, all of whom are working with or specializing in immigrants or immigrant health, were identified and contacted over email and telephone. These professionals nominated individuals who met the target group criteria who in turn identified further sample members. This way of sampling through the effect of snowballing has previously been proven useful in obtaining a sample of smaller groups, such as ethnic minorities (Sturgis, 2008). The remaining four participants were sampled through this sampling method.

6.4 Interview guide

There are various ways of conducting interviews in public health and the interviews usually differ in regards to the degree of structure imposed on the interview format (Fielding & Thomas, 2008). A structured interview allows for minimal influence of the interviewer and specific questions are asked in the same way and order to every respondent. The very opposite of this is an unstructured interview where interviewers have a list of topics they need the respondents to talk freely about, without being ‘tied to’ order and phrasing of questions. The former being suitable when the researcher has an idea of what the respondents may answer in relation to the research topic and the latter being the better choice if the researcher is exploring a new phenomenon (Fielding & Thomas, 2008) As we wanted to, in accordance with Grounded Theory, study a relatively new topic and be open to new and unknown information, our interviews were based on semi-structured open-ended interview questions.

With these ideas in mind, an interview guide was developed (see Appendix 1, p. 41) based on four large themes; *Concepts and definitions*, *Health care in native country*, *Health care in Sweden* and *Future and improvements*. As public health professionals, we focus a lot on underlying causes for ill-health (and health). Therefore we found it important to have at least one theme that would cover information about their backgrounds and how the health care system works in their country of origin (i.e. *Health care in native country*). We did not consider the experiences they had in Sweden to be sufficient to get a deeper understanding about the issue. Furthermore, each theme had its main questions as well as suggested follow-up questions that enabled probing for more information when needed. The semi-structured format was considered suitable as we were interested in asking some major questions to all respondents but still wanted to gain the benefits of probing and asking additional questions that came to mind.

Upon completion of the interviews, a set of demographic variables were assigned to the respondents. These included; age, sex, country of origin, religion, citizenship, marital status, number of children, community board of residence, education, occupation, annual income and years residing in Sweden.

6.5 Preunderstanding

A discrepancy among Grounded Theory researchers exists regarding if and when a literature review should be conducted. We have chosen to adhere to the ideas described by Dellve et al., suggesting that an initial first review should be conducted in order to identify the reality of the problem and most importantly the lack of knowledge on the topic (Dellve et al., 2002). Here we do want to point out that this literature review is by no means a full-scale literature review in a methodological sense. It should rather be viewed as our preunderstanding of the research topic.

The materials that constitute our preunderstanding have been obtained from various sources of information. A lot of the material has been derived from reports, working papers and articles published by agencies in Sweden, both on the national and the regional level. Some information has also been obtained from International and European agencies, such as WHO and MEHO.

Scientific articles were identified using larger databases such as PubMed and Medline. A wide range of search terms were used depending on what articles that were needed at the time, but the most commonly used search terms included; health disparities, SES, racial and ethnic disparities, health care utilization, health care quality, health care seeking behavior, primary care, discrimination, non-natives, ethnicity, race, health inequalities and health inequity. The articles found were then chosen on the basis of its ability to apply well to the Swedish health care context and its relevance to our overall aim. Therefore, articles on the topic from the United Kingdom, Netherlands, Sweden and the United States made up our selection of scientific evidence. Studies from the US however, were only included if they had adequately controlled for access to health care and health insurance, as that is otherwise a major difference between the health care systems. These countries also appeared to be the most prominent regarding research on the topic. Further, articles dated before the year of 2002 were excluded unless they were of major importance to the area of study. This delimitation was done because we did not want to support our findings based on old and outdated information.

In order to support our choices of method, theory and research procedure, we have read theory, methodology books and dissertations on the topic. The books have largely focused on Grounded Theory and qualitative methodology applied to the area of public health and health care.

It was very important for us to not start out with too much information. We did not want to have preconceived theories or ideas in mind. However, the second literature review was more selective and done with the emerging theory in mind (i.e. after the collection and interpretation of data).

6.6 Method of analysis

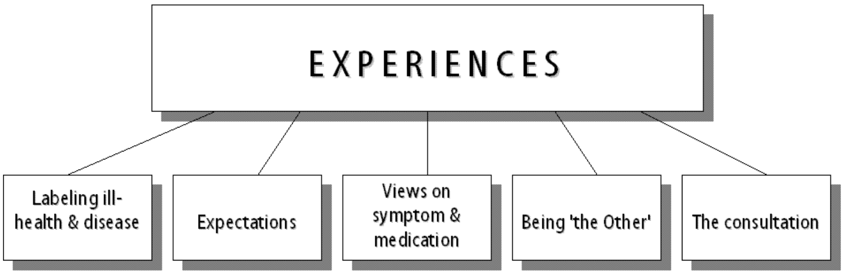
The interviews were transcribed the same day as they had been conducted and the analysis started as soon as the first interview was completed. In the transcription process, we divided the interviews between the two of us and the data was analyzed according to the methods of data analysis used within Grounded Theory. We found Charmaz's methods of analysis (Charmaz, 2006) to be the best applicable to our analysis and therefore chose to use the general concepts of her method.

The first step in the process was an open coding which has been described as: 'the process of breaking down, examining, comparing, conceptualizing, and categorizing data' (Dellve et al., 2002, p. 144). We scrutinized the transcribed interviews line-by-line and asked questions like: 'What is expressed here?' and 'What does this mean?' (Dellve et al., 2002, p. 144) One of us created codes that were close to the data and labeled with expressions used by the respondents, i.e. vivo codes (Charmaz, 2006). The other one created codes on the basis of characterizing important information and subtle meanings in the material. By doing this we were able to get the most out of the analysis and data.

Secondly, a code-to-code comparison was conducted in order to find similarities and differences between the emerging concepts. At this time we also compared our codes with each other as they were created individually. We wanted to identify actions, events and perceptions of the respondents. The codes that captured the same phenomenon and content were clustered (Charmaz, 2006) in five different categories and named so that they clearly highlighted the phenomena included; *Labeling ill-health and disease*, *Expectations*, *Views on symptom and medication*, *Being 'the Other'* and *The consultation.*

Thirdly, the five categories were studied in depth and one core category, *Experiences*, was developed. This core category, referring to experiences both in non-natives' country of origin but also in Sweden, was central to the data and related to all five categories (Charmaz, 2006) The core category was also of major importance for the emerging theory, presented later in this Bachelor's thesis.

Figure 1



The figure shows the core category and five categories that created using Charmaz's method.

6.6.1 Memo writing

As part of the data analysis within the methodology of Grounded Theory, the researcher’s own inductive writing is used as a step between the coding and the comprehensive analysis. When the categories need further development and new insight, the memos can provide guiding. The memos were created individually in conjunction with the transcription process. We used our memos while analyzing our findings as they gave us ideas and thoughts about our upcoming categories, how they were related and how they could be used to reach our overall aim. Memos are stressed as important when moving from open codes to more focused categories, as inductive thoughts more and more develop into a hypothesis or theory (Charmaz, 2006).

6.7 Ethical considerations

Part of being a researcher is to continuously consider the ethical and moral aspects of a research study (especially those concerning human science). Even though research is regulated by laws and rules, much of the responsibility lies on the researchers alone (CODEX, 2009). When designing this study, we especially considered Halvorsen and some of his ideas regarding codes of professional ethics. The codes that we really wanted to keep in mind when designing our study included; showing respect for fellow workers’ ideas and not make something into our own that is not, being stringent with sources in order to avoid plagiarism and to generate data that can contribute to a cumulative research (i.e. creation of new knowledge) (Halvorsen, 1989).

The Declaration of Helsinki, developed by the World Medical Association, proclaims that all research involving humans have to: ‘protect the life, health, dignity, integrity, right to self-determination, privacy, and confidentiality of personal information of research subjects’ (World Medical Association, 2009). Having this statement in mind, we carefully made sure that informed consent was obtained from all participants in the study. The respondents were given all information available regarding the purpose of the study as well as information about anonymity, confidentiality, storage of data and that our supervisor at University of Skövde would have access to it. They all participated voluntarily with the knowledge of optional drop-out. Informed consent was also obtained regarding tape-recording of interviews. Upon completion of the transcription, all the tapes were destroyed.

6.8 Disposition

The *Results* chapter includes the empirical findings from the five interviews. Furthermore, the chapter is divided into, five categories which all capture the actions, events and perceptions described by the informants.

The *Discussion* chapter that follows consists of three consecutive parts; first a detailed discussion of the results found. This part ends with a presentation of an emerging theory and is also complemented with a figure which aims at more clearly illustrating the theory. Secondly, methodological considerations are discussed. The chapter ends with a discussion about practical implications, where some important aspects of public health are highlighted.

In the *Conclusion*, some final words are expressed regarding the most important findings. This section also includes suggestions for future research. At the very end of this Bachelor's thesis all of the *References* used can be found as well as an *Appendix* with the complete interview guide.

7. Results

The results that emerged from the five interviews that we conducted are consequently described. Each of the subheadings clearly illustrate the actions, events and perceptions described by the respondents.

7.1 Labeling ill-health and disease

When analyzing the respondents' perceived view of ill-health and disease, they presented somewhat conflicting ideas. Some of them agreed that ill-health is something that will pass or that presents itself periodically, whereas those exact same words were used by other respondents in order to describe disease. However, there was an overall consensus that there was a distinct and important difference between the two concepts. One of the respondents explained this further:

" No, it's not the same thing. To me, ill-health may eventually cause disease. [...] *A less severe version of overweight could be ill-health... And a severe case of obesity could be disease. You know, when one's tied to the bed, unable to get up, having developed cardiovascular diseases and all kinds of other diseases because of the obesity."* - Woman, Bosnia

An important determinant for disease appeared to be that of diagnosis. Many of the respondents stated that a person does not have a disease until it has been confirmed and carefully diagnosed by a skilled health care professional. Another significant difference between ill-health and disease frequently mentioned among the interviewees was that disease could be cured or treated with medication. Ill-health, on the other hand, was described as unspecific, comprehensive and therefore not easily cured with medication or other treatment. These ideas about the two concepts were summarized by one of the respondents:

" Well, disease is something you know you're having. Let's say cancer or diabetes or whatever it could be. But ill-health, that sort of involves the whole body. And there is no medication for it." - Man, Palestine

A younger woman expressed similar ideas about disease and ill-health:

" Most of the time doctors are the once who give you a diagnosis. You have this and that disease. You yourself can't say you have a disease unless you have been to see a doctor." - Woman Russia

Just like the above mentioned respondent, several others expressed that visiting general practitioner services or a doctor was highly important as they provide you with a diagnosis and then tell you how to go about to treat the condition or disease. Neither of the interviewees stated that doctors can treat ill-health, unless ill-health is closely connected to having a disease or a diagnosed medical condition. One respondent therefore suggested that suffering from ill-health is far worse than being diagnosed with a disease of any kind. Her thoughts about this were expressed accordingly:

“ If you have a disease, yeah, then you can treat it. But if you feel bad, or just don’t feel well, you don’t know where to turn to. When you have pain somewhere in your body you will go [to the health center] *right away and receive treatment in order to get better.”* - Woman, Iran

Psychological ill-health appeared somewhat harder for the respondents to label. Many of them suggested that mental health problems were a part of experiencing ill-health, whereas some thought about psychological ill-health as a disease. When discussing the topic with a Russian woman she seemed to be strongly influenced by how mental ill-health is viewed as a disease by people in her country of origin. She explained to us:

“ In Russia, psychiatrists are more like psychopathologists. Like if you have very serious problems that can be diagnosed, such as schizophrenia. [...] *You would never see a psychiatrist otherwise, for family counseling or whatever it may be. You have to solve that on your own.”* - Woman, Russia

Another respondent described mental ill-health as something very bad and stigmatizing in the country where he comes from. This became very clear by the following statement:

“ If someone finds out [that one has been to see a psychiatrist] *that person is completely screwed.* [...] *You wouldn’t get a job or be able to get married.”*
- Man, Palestine

7.2 Expectations

As the themes in the interviews covered both experiences of health care in the country of origin as well as experiences of health care in Sweden, we could see a pattern of a constant comparison of the two different settings. It was found that the health care in the country of origin often was viewed with positivism. As expressed by one respondent:

“ If you had been to one specific doctor once, you would get a referral to that same specialist once or twice a year. Just to prevent…or to treat disease, so it did not get worse … And this kind of manner doesn’t exist in Sweden.” – Woman, Russia

The waiting associated with the Swedish health care system was criticized to a large extent by all of the interviewees. The waiting was described both in regards to the emergency room, where an endless ‘sitting around’ was emphasized; as well as to some extent waiting in telephone queues; and thirdly the waiting of being examined by specialists. One respondent had waited for one and a half year to see a specialist and expressed his feelings about this accordingly:

“ I have lost all my desire for this consultation; really I don’t even want to see her or him any longer. I have been waiting for so long, really I have been waiting for so long that anything could have happened during this time. Am I supposed to wait until I get worse or entirely ill, or even close to death?” – Man, Palestine

The endless waiting was clearly related to disappointment since the sacrifice of time was not recognized or given the expected response. This pattern frequently recurs and was expressed by the same respondent as:

“ Six hours of waiting... For what? [When the doctor says] *No, I cannot see any problems, you are alright, don’t worry.”* – Man, Palestine

It was spoken that one did not visit a health care setting just for fun; rather the visit had a purpose; and all of the interviewees expected ‘to get something’ from the consultation. One of the respondents argued that the medicine dosages were too low and she missed the ability to treat her child with some kind of medicine, as expressed with her own words:

“ For children they don’t have many drugs here in Sweden, for example, to cure a cold. It’s so very different in Cuba, there they have everything. But here in Sweden they say: drink water and juice, what is this?” – Woman, Cuba

Another interviewee from Iran emphasized the rapidity of the health care in her country of origin by giving an example of a visit to a doctor during a vacation some years earlier. She explained that as soon as she reached the hospital she was sent to a doctor and given an ‘injection’ after which ‘all the illness was gone’.

Perceptions and attitudes towards the medical profession were also discussed and a comparison between country of origin and Sweden was once again central for the informants. The doctors were described as more familiar, and accessible. The ‘family doctor’ was always ‘on-call’, as explained by a Cuban:

“ If something happens during the night, you can always knock on his or her door [the doctor] *and they will open and take care of you without any problems.”*
- Woman, Cuba

This statement was also recognized by an Iranian who mentioned that everyone in Iran has a family doctor and because of that did not have to visit the emergency room very often.

It appeared as if most respondents came from a country where the health care system is characterized by ‘family doctors’ who are easily accessible. They did not find the doctors in GP settings in Sweden as readily available and expressed a desire for regularity also in the Swedish health care context. A Bosnian who was diagnosed with epilepsy wished she had a direct number or at least an email address to her specialist. If she would have a seizure she was concerned that she would not be able to reach her doctor as fast as she wanted to. Regularity was also stressed as an important factor for the understanding of ones background, as expressed by another respondent:

“ It would save time to have one long conversation with one and the same doctor instead of many 10 minutes ‘chats’ with different doctors…I find it exhausting to tell the same story about my symptoms and illnesses over and over again.”
– Man, Palestine

The hierarchy between doctors and nurses was recognized to a larger extent in Sweden than in the respondents’ countries of origin, where the term familiarity was a good description. The doctors were described with admirable respect, stated with words like; ‘holy’, ‘competent’ and ‘well-educated’. Nurses were thought of as helpful people, but below doctors in the hierarchy. The nurses were associated with having an assistant role, as the ones who helped the doctor. It was stated that the district nurses and other nurses did not have the same authority as doctors. Furthermore ambivalence regarding doctors working in different settings within the health care sector was acknowledged and explained by the following experience:

“ My first thoughts were that they [the doctors] *weren’t so professional at the general practitioner services…I mean the doctors there…I got really good care once when I visited the emergency room, but that time it was a specialist that examined me…but at the general practitioner services I thought; wow, what is this?...Do they have any experience or education whatsoever?”*

She further continued:

“ And the doctors I met there [at the general practitioner service] *were pretty old and had only a few years left until retirement, so it wasn’t much engagement there.”*
– Woman, Russia

When the interviewees were asked to further develop their thoughts and feelings connected to doctors a sense of security was illustrated, described as when you arrived at the doctor’s room you knew you would be alright. The doctor was then portrayed as not being an ordinary person rather someone above ordinary. But these statements were not the interviewees’ true experiences, as a great concern and disappointment was expressed. For example a Palestinian said he no longer had any confidence in one particular GP, since the GP’s appearance was so insecure:

“ He was so insecure about my condition. He said; should I write this prescription or this prescription? You know I have lost all…I can not trust him…I mean he did not know if it was an infection…I have lost my confidence in him.” – Man, Palestine

The lack of confidence in doctors was reinforced by another respondent:

“ Yes, once when I visited a doctor he asked me if I wanted to take some tests and if I wanted a prescription of antibiotics. They asked me...if I wanted to…then I lost all my confidence in that doctor. How can they ask me? I am not the doctor.”
– Woman, Russia

We found that the doctor had a significant role in many of the answers we got. Even when we asked them if they had any specific requests for the future or wanted to see some adjustments in regards to the health care system, the doctors were mentioned as possible barriers or supporters for these changes to actually happen. A more holistic perspective[2] on their health situation was requested as they did not consider the questions asked by doctors to be sufficient in order to provide a comprehensive picture regarding one’s medical background. They specifically believed that life experiences or other important events in one’s life were missed out on. Also more preventive work was sought after in Sweden, as compared to for example Russia where your doctor frequently sends you to ‘health resorts’ during cold season.

7.3 Views on symptom and medication

A frequently discussed topic was that of medication and alternative medicine. For instance, two of the respondents verbalized that they purchased drugs, such as antibiotics, in their home countries when visiting or getting them from non-native friends. They would then use them if they felt it was needed or in cases when the doctors did not take their perceived symptoms seriously. One of the respondents explained this further:

“ When I talked to him [the doctor] *he was unsure of what was wrong with me, he did not know what to prescribe me. So instead I took these other pills for infection, not the once that he prescribed, that I got from a friend who had been to Egypt. He had purchased them from the pharmacy down there.”* – Man, Palestine

Similarly, another interviewee described that by getting drugs in countries where they are available without prescription; she did not have to convince Swedish health care professionals that she was sick and needed antibiotics:

“ Instead I usually purchase antibiotics, you know these non-prescription once, from Bosnia. So I really don’t have to visit the doctor that much.” – Woman, Bosnia

Several respondents stated repeatedly having to nag and put a lot of pressure on the health care system in order to pursue their health requests. The man from Palestine revealed that in order to get what he felt he really needed, he had to argue with the health care personnel as they would ignore his pain and symptoms. He expressed his struggle accordingly:

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[2] The holistic model of health suggests treating an individual as a whole person. It incorporates mental, physical, social and spiritual aspects of health. It does not only focus on medical interventions, but rather integrates alternative medicine and therapies. The holistic model provides a more complete understanding of what health is (Shi & Singh, 2005).

“ So I called them back two or three days later telling them I’m still in pain: Now what? I need to get a consultation! Several times I’ve had to fight with them over the phone [...] *Especially the primary care I have to argue with, they simply refuse to give me a consultation.”* – Man, Palestine

All of the non-natives interviewed showed positive attitudes towards homeopathic drugs and traditional home remedies. They all had faith in its ability to ease pain or prevent disease. They also expressed a preference to treat themselves and not be as reliant on health care professionals. Many of them did not understand why doctors in Sweden are so reluctant towards alternative medicine and treatment options. This was insightfully expressed by one of the respondents:

“ Our doctors are not strictly conventional medics, if you know what I mean? Our doctors can also recommend the alternative medicine. Like: Drink chamomile tea if you are having a cold. But the way I understand it, things like that are completely unthinkable here. Folk medicine or the equivalent...it, well... is considered bad.”

She continued to express her ideas on the topic:

“ Here it’s like: we’re a real health center, a real hospital and we only prescribe antibiotics or other chemical substances that are well-tried or scientifically proven. They don’t even wanna get back to their roots and see, well, how people cured themselves back then. 50 years or 100 years ago in Sweden... what herbs they used and so on.” – Woman, Russia

Another respondent explained that she had visited the emergency room with her small child that was unable to eat due to a purported mouth infection. After five hours of waiting she was told to just give her child water and not do anything else which made her feel very frustrated and powerless. In order to reclaim control over the situation and her daughter’s health she turned to traditional home remedies used in her country of origin:

“ Children in Cuba also have germs and stuff they can get in their mouths and all you do is to treat it naturally. Honey and bicarbonate... I gave that to her and the day after she was able to eat and drink again. We use a lot of homeopathic drugs in Cuba. You can treat yourself.” – Woman, Cuba

7.4 Being ‘the Other’

A lot of the answers from the non-natives interviewed included a reference to natives and how they felt no different than other people in Sweden. When asked about how, and if, information is provided in the health care setting, a young woman expressed the following thoughts about it:

“ I don’t think anyone informed me that all of us have it [epilepsy] *latent within ourselves. No doctor ever told me that* [....] *We all have it inside of us, but it doesn’t present itself in all of us.”* - Woman, Bosnia

The Palestinian man expressed a similar desire of wanting to show that he was no different than other Swedes when he told us where he would first go to seek health care if he was ill: ‘Just like everybody else I turn to primary care or the emergency room.’

None of the respondents had experienced any racism or perceived discrimination in the health care setting. However, many of them had had experiences that left them wondering if the treatment option, or non-treatment in many cases, offered to them were due to the fact that they were non-natives. A woman with epilepsy tried to explain her feelings in regards to this:

“ I was never offered one [dietitian] *or given the information that I should consider seeing one. A friend of my mom’s, however, her daughter was offered a dietitian right away, so she keeps track of what she eats, how she eats and how many times a day she eats. All that. I don’t really know why this is. I thought a lot about it. Could it be because I’m an immigrant?”*

She further continued to describe her feelings as:

“ A thought that crosses your mind. No signs that indicates it, nothing that I’ve experienced. I don’t have any racist experiences from the health care, but it’s a thought that crosses your mind. Her name is Isabelle and mine is Samela[3]*.”*
– Woman, Bosnia

One respondent, who was diagnosed with hepatitis B during her early pregnancy, was subjected to preferential treatment at the maternity ward after giving birth to her daughter. Earlier she had been classified as having a very low level of infectivity; she was still able to breast feed and had not infected her husband[4]. Her unsatisfactory experience with the Swedish maternity ward was captured by the following statement:

“ There [the maternity ward] *they treated me like a dog. I swear.* [...] *I didn’t feel well and they treated me like I was bad and stupid.”* – Woman, Cuba

She continued to explain how the nurses in various ways separated her from the other patients and created bans only for her which made other patients look suspiciously at her during the entire course of her stay:

“ In the morning when I was gonna take a shower they told me that I could not shower there [the shower room], *I had to shower at a different place. Then they put up a large note on the toilet door stating that I was the only one that should shower there. Just like I had the plague or something.* [...] *They told me that I could not walk down the hallway with these clothes.* [...] *When I was hungry I was told that I could*

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[3] Samela is a pseudonym

[4] Hepatitis B is caused by a virus and transmitted through sexual contacts as well as blood. It has different levels of infectivity, ranging from very low to high or even chronic (Smittskyddsinstitutet, 2009).

not touch the sandwiches; we have to serve them to you. Everybody who sat in the room having breakfast just stared at me as if I was... you know... not being able to do what other people do. It felt awful." – Woman, Cuba

Due to these unpleasant experiences, this Cuban woman told us that she will never ever go back to this hospital. The way they treated her during her stay even encouraged her to leave the hospital two days earlier than was recommended, despite her being in desperate need of a blood transfusion as she lost a lot of blood during labor.

7.5 The consultation

Misunderstanding was the first word one of the respondents uttered when asked about her experiences with the Swedish health care. This statement was further developed:

" I find it very difficult to be understood by the doctors…or I explain everything in the way you are supposed to on a regular visit to the general practitioner services…but the doctor did not understand me, and I was not received in the same way as is common in Russia." – Woman, Russia

The same respondent believed that people in general like to generalize and when one can not speak the native language very well that person may be extra vulnerable. She stressed that doctors need to be adaptable to the specific situation:

" It is good to know that it is a different situation to meet a foreigner [as compared to a native Swede]*, if you* [as a doctor] *ask a question you have to be prepared for a complete different answer then that of a native Swede."* - Woman, Russia

The importance of good language skills was well-emphasized by the respondents. The Russian remembered that when she was unable to speak as good Swedish as she could now, she felt as if they treated her like a child:

" I was treated like a child and not like an intelligent grown-up who have an education and have been working for many years…it was a sort of infantilization that happened to me then." – Woman, Russia

There was consensus among the interviewees that a deprecatory voice should be avoided as well as the stultifying manner that sometimes was practice, and not at all justified. As for example when health personnel raised their voices and talked 'as if I was deaf.'

When it comes to information made available for non-natives one of the respondents requested more information about different diseases and how they could be diagnosed. The respondent felt a need to talk about diseases and how to recognize them. He also felt that Sweden was so secretive and he desired a more open discussion about specific diseases and illnesses in society in general. Also the medical model[5] was stressed as too rigid and dominant among the doctors. The consultation itself was described as having a healing function and not enough time was given to acknowledge this. The individual story was also missed out on. The consultation was described by the respondents as being a highly stressful and stringent situation; one informant expressed it metaphorically, as a ‘production line’.

“ It is the conversation between me and the doctor that is one of the factors that could cure me…of course it provides psychological support…it is not always a diagnosis or medicine that I need to be able to live ‘happily ever after’, it is also important to meet someone who listens…and knows the area and can give real answers.” – Woman, Russia

One of the respondents had an experience from an in-patient stay where she really had been longing for some compassion in the consultations with the health care personnel. She argued that a more ‘human approach’ and communicative dialog would have given her a sense of comfort.

Some obscurity regarding the emergency room was also expressed, as one of the respondents asked himself; for whom is the emergency room really intended? What kind of people and what kind of pains? After almost 20 years in Sweden he still could not figure this out and he explained that when something is emergent it is a rather subjective feeling. His subjective feeling of emergent pain was not acknowledged as he expected:

“ I would like to know what emergency room means. Is it only for fever? Is it only for stomach-ache, or is it only for headache?” – Man, Palestine

Doubt was expressed concerning the knowledge of doctors, as one of the interviewees expressed it: ‘A doctor should take serious notice of the story that is told. You are not supposed to feel insecure after a visit at the GPs’. The doubt was further linked to the inadequate communication which we were given many examples of. One woman said: ‘if I say I am ill and they answer; drink some water or juice…but I know that water will not help…why won’t they just listen?’ The listening itself was pointed out as sometimes being neglected and the time aspect was once again stressed as the main reason for that. Also the characteristics of some doctors who were described as inaccurate could be an explanation. One woman pointed out that the personnel did not even talk to each other, rather there was ‘communication through papers’, using her own words.

The respondents asked for a broader cultural understanding among the health personnel as they should know how different one country could be from another. One well-educated participant came up with the idea of recommending health care providers a course in medical anthropology. She said that no one seemed to pay any

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[5] The medical model of health assumes the existence of illness or disease. It has an emphasis on clinical diagnosis and suggests medical interventions in order to treat disease or its symptoms. The medical model defines health as the absence of illness or disease (Shi & Singh, 2005).

attention to the different mentalities and approaches that exists in other health care systems in the world. Another woman had a similar thought as she suggested seminars about how to receive patients as well as handing of questionnaires to patients where viewpoints and suggestions regarding reception could be given. She emphasized the importance of questioning people about how they would like to be treated. She also thought that it was possible to influence the health care system, but many people just do not bother to try.

The method of adapting to the Swedish health care norm was described as an 'ever going process' of 'trying to solve the cultural codes' and gradually one would learn more and more about how to nestle oneself into the health care system, described by the following:

" Yes, step by step I understood the system, the differences, and I became a little disappointed but started to adapt…so it's a process…and I don't think I have learned exactly everything yet…like what to tell them…they don't always want to hear everything [referring to the doctors].*"* - Woman, Russia

This process of adapting was described by another respondent as 'some kind of sport or game', referring to how she needed to carefully choose her words when calling the GPs in order to get a consultation. She concluded that: 'if I describe my situation well, I mean according to them, they might give me a consultation'.

8. Discussion

The discussion of this Bachelor's thesis includes three parts; at first we discuss the results and present the health determinants found one by one. The discussion of results ends with the emerging theory. Secondly, a methodological consideration was made including a discussion about merits and demerits regarding interview method, preunderstanding and credibility. Thirdly some practical implications that we believe concern the field of public health in general were highlighted.

8.1 Discussion of results

The aim of this Bachelor's thesis has been to study health determinants that influence the seeking and utilization of health care among non-natives. Based on our core category (*Experiences*) we have been able to create several health determinants which will be discussed more in detail throughout this chapter. One can therefore say that Grounded Theory has served as a means to link the categories created from the results with the health determinants identified in the discussion chapter.

Several studies and reports (Socialstyrelsen, 2009) (Williams, 2002) (Adda et al., 2003) (Williams, 2007) have concluded that socioeconomic status plays an important part in the utilization and seeking of health care. SES has therefore been suggested as a central determinant of ethnic disparities in health. Indeed, studies show that many non-natives are of lower socioeconomic status (Socialstyrelsen, 2009). The Swedish

National Board of Health and Welfare recently stressed the impact socioeconomic status has on health and provided critical figures in regards to socioeconomic disparities in their latest health care report in 2009 (Socialstyrelsen, 2009). For instance they showed that the death rate for treatable diseases is threefold among the low-educated compared to highly educated. Surprisingly, our results did not indicate that socioeconomic status was a dominant predictor in the refraining of seeking health care among non-natives. For example, an unemployed, divorced, low-educated father of two described similar, if the not the same, issues in the interview as a working, high-income woman with a university degree. When analyzing the results, of the in-depth interviews it did not appear to be either lack of education nor financial hardships that was the major health care concern for the respondents. Rather there was something specific about them being non-natives. One of the major finding of our study was that the respondents were strongly influenced by their cultural and ethnic backgrounds, which in various ways affected their ideas and conceptions about Swedish health care, treatments and medication. We believe that this in turn affects the seeking and utilization of health care among non-natives.

Because of the above mentioned discussion, it has been important for us to identify and study health determinants specific for the group non-natives, i.e. determinants that do not affect everyone with low socioeconomic status. However, we do once again want to emphasize the large variation within the group non-natives and stress that individual as well as cultural and historically specific difference in regards to attitudes and practices may exist.

8.1.1 Health determinant 1: Unmet expectations

Many of our respondents stated that they had expectations of a more holistic approach to health care in Sweden. This was also described by them as a much more appropriate way of viewing one’s health. As have been concluded in a major review study (Scheppers et al., 2006), they were clearly used to health care that involves the entire human being and not just parts of the body. It appeared as if GPs in their native countries would look above physical conditions and try to find causes in for instance the social or spiritual context of the individual. Having their backgrounds in mind, it is by no means strange that several respondents questioned the very strict medical model of health being practiced in Sweden. Nearly all of them expressed themselves in terms of disappointment when concluding that health care providers here do not take on a wider perspective of health. The medical and holistic approach (Shi & Singh, 2005) provide an obvious example of the conflicting views that may arise between the patient and provider, which may easily result in unmet expectations on behalf of the non-native patient. Other studies, too, have suggested that only adhering to the medical model will cause dissatisfaction among ethnic minority patients (Scheppers et al., 2006).

For most respondents the real difference between ill-health and disease had to do with the way people think about symptoms and diagnosis. Many of the respondents did not consider a condition to be a disease until they were provided with a diagnosis by a health care provider. A major finding, however, was the importance of a *doctor* in order to get, and to really trust, the diagnosis. Skilled nurses were largely seen as competent, but the respondents did not consider them suitable to provide one with any type of diagnosis. If non-natives are unpleased with the diagnosis, expectations are again unmet.

In accordance with previous research (Adolfo, 2009) (Scheppers et al., 2006) several respondents in our study expressed a desire to have a regular source of care in Sweden. It has been found that women, especially from Arabic and other non-western countries, do not feel that they have access to a regular doctor (Adolfo, 2009) (Axén & Lindström, 2002). Having a regular source of care, or having your own 'family doctor' as some of the respondents referred to them, was described as very common in many of the respondents' home countries and also highly valued. That request, however, had not been answered in Sweden. Here we would like to highlight the numbers from Statistics Sweden which show that 21% of non-native women had not sought health care despite being in need of it, as compared to only 12% among native Swedish women (Westin et al., 2004). We suggest that the lack of regularity in primary care may be one of the explanatory factors for the refraining of seeking primary care among non-natives.

8.1.2 Health determinant 2: Cultural attitudes and perceptions

A topic frequently discussed by the respondents in the interviews was the role of physicians. Their attitudes and perceptions in regards to the profession especially. Doctors were both praised and criticized, as they were described in terms of being competent and well educated but also as insecure and unassertive. Physicians were also assigned several different roles that they were expected to take on. However, in Sweden these roles are often occupied by other professionals, for instance psychiatrists or priests, thus resulting in conflicting cultural views which in this context may be problematic.

Doctors were also described as those in charge of the prescribing of drugs and many respondents seemed to automatically connect the two. This is an interesting finding as statistics show that non-natives visit the emergency room to a larger extent than native Swedes (SCB, 2006). There may be reason to believe that this phenomenon could be due to the fact that in people's minds physicians are closely tied to the emergency room. Non-natives may think that their chances of getting a prescription or instant treatment will increase by going there instead of seeking care at the GPs. The larger dissatisfaction observed among non-natives in Sweden (Socialstyrelsen, 2008) may also be because they do not feel completely satisfied with their Swedish health care experience until they have seen a physician or specialist, or at least left the consultation with a prescription.

According to our respondents, diseases are conditions that can be diagnosed, but also cured or treated, by doctors. Suffering ill-health on the other hand, such as being obese which one of our interviewees suggested, was not considered a condition that could be treated by doctors. A reason why non-natives refrain from seeking health care, primary care in particular may be that they are unaware of the services available at their disposal. This problem of low primary care attendance may have its explanation in the Swedish health care system or information in regards to it, as it cannot be considered a universal problem. For instance, Netherlands does not have a problem with low attendance among non-natives (Uiters, Devillé, Foets & Groenewegen, 2006) (Stronks, Ravelli & Reijnevald, 2001). As mentioned earlier, several primary care centers focus on primary and secondary prevention of ill-health, such as prescribing physical activity (FaR) (FHI, 2008) to individuals with risk factors for being overweight or obese. However, if non-natives do not know about these services they may be unlikely to seek primary health care. This idea has also been supported by previous research and stated as a potential barrier to the use of health care services (Scheppers et al., 2006).

Another issue is the fact that the non-native patient and health care provider may have different cultural understandings and ideas about symptoms. This obviously complicates the possibility of arriving at a ‘correct’ diagnosis (as seen from the patient’s point of view). Our study gave some indications of this. One example is of the Cuban woman who really questioned the advice of treating her daughter’s purported mouth infection with water and juice. Her way of emphasizing: ‘What *is* this?’ clearly shows that she had a different opinion than the doctor. These concerns about conflicting cultural views in regards to symptom identification have also been expressed in other studies (Admson, Ben-Shlomo, Chaturvedi & Donovan, 2003) (Scheppers et al., 2006).

Our participant from Russia explained how she had experiences of ‘generalization’ in the Swedish health care context. Research shows (Abreu, 1999) that stereotyping and prejudice in health care is not uncommon and we believe that in the long run it may cause non-native patients to feel uncomfortable and dissatisfied. It has also been stated that stereotypical attitudes towards ethnic minority patients may hinder their use of health care services (Scheppers et al., 2006).

Mental health problems and psychiatric health care was another interesting topic discussed in the interviews. It was viewed by many of our respondents as something intimidating, that one would not discuss with family members or friends. It was described in such shameful terms that we got the idea that many non-natives probably do not seek treatment for psychological illnesses, even though being in the most desperate need of it, due to the stigma attached to it. This finding may be able to explain the results of other studies which have suggested that non-natives refrain from seeking psychological treatment and care to a larger extent than natives, despite a perceived need thereof (Östman, 2008) (Scheppers et al., 2006). A large population based study in Malmö municipality for instance, found that inhabitants of Rosengård (the most ethnically diverse part of Malmö) consumed less psychiatric health care than inhabitants in other parts of Malmö even though their calculated need for that kind of care was the highest and most urgent (Östman, 2008).

8.1.3 Health determinant 3: Discrimination

Wamala et al. have concluded that: ‘perceived discrimination, even in the absence of socioeconomic disadvantage, was associated with threefold to nine fold increased odds for refraining from seeking medical treatment’ (Wamala et al., 2007, p. 412). If a person considers himself discriminated against, even though it cannot be proved, this perceived feeling indisputably has been shown to contribute to worsened health as well as a decline in the utilization of health care (Socialstyrelsen, 2009). Another study by Wiking et al. suggested that discrimination and acculturation may be two factors that explain the association between ethnicity and poor health. These were not explained by other socioeconomic factors (Wiking, Johansson & Sundquist, 2004).We found it quite interesting that it appeared so important to many respondents in our sample to point out that they were just like anybody else. They all claimed that they had not been subjects of racism or discrimination in the health care setting, yet they had to constantly point out how they were just like other Swedes. By doing so there may be reason to think that they actually feel very different and that they would like to be treated like everybody else.

Despite carefully pointing out that they did not feel discriminated against because of their ethnicity, most of our respondents had experiences where they questioned if the treatment they received from health care providers was the correct one or if it was offered to them because of their status as non-natives. They did, however, point to other reasons for the treatment, or lack of treatment. The Cuban woman, who felt like the nurses had treated her like a dog, concluded that this treatment was only due to the fact that she was diagnosed with hepatitis B. The Russian, who expressed having been treated like a child, suggested that this only had to do with her inability to speak Swedish properly, not because she was a non-native. Even though the first thing that comes to mind when most people think about discrimination is racial or ethnic discrimination, to treat someone preferentially in a way that makes them feel uncomfortable or less worthy (due to for instance a medical condition or disability) is still considered discrimination according to Swedish law (DO, 2008). The results of this study therefore reveal that discrimination in the health care setting exists. But more importantly, it appears to occur due to characteristics that people (health care providers and others) *associate* with ethnicity, rather than ethnicity itself. Such as the inability to speak Swedish (the Russian woman) or associating race or ethnicity with diseases, possibly far worse than those actually confirmed and diagnosed (the Cuban woman), which leave non-natives treated accordingly.

8.1.4 Health determinant 4: Negative experiences in the past

It was clearly emphasized by most respondents that they had previous experiences with Swedish health care where they had been forced to nag and persevere in order to receive the health care that they felt they needed. This process of constantly having to convince the health care providers that they really *were* sick seemed to make them very frustrated and some of them even completely despondent. The Palestinian man for instance seriously wondered if it was a prerequisite that he should have to get severely ill or even die before they would schedule him for a consultation.

All of our respondents had negative experiences in regards to long waits prior to receiving health care in Sweden. It is not at all impossible that these waits prevent non-natives from seeking primary care if they have previous experiences of having tried so hard and waited for so long in order to get a consultation that they simply give up trying. We are aware that waits affect not only non-natives but also others, but the way some of our respondents described the amount of time waiting made us question if not their waits were longer than they should be. Indeed, previous research has shown that some ethnic minority patients have to wait up to twice as long for a specialist as their European counterparts (Scheppers et al., 2006).

8.1.5 Health determinant 5: Language and communication

We believe that an important health determinant is that of language and communication. Swedish language skills were stressed by the respondents as highly important in order to express his or her feelings, symptoms and background to the health care provider. It was clearly emphasized that health care professionals needed to listen and allow non-natives to really take time to explain their symptoms. If the communication was not satisfying the respondents felt insecure and their confidence for the health care was, to various degrees, lost. We suggest that this may contribute to the refraining of health care seeking in the long run. As stated in another study, the hierarchy in the patient-provider situation may also become even more prominent if the language skills of non-native patients are insufficient, again possibly leading to patients' insecurity and dissatisfaction. Scheppers et al., also found lack of local language skills, which often complicates communication and accurately expressing one's feelings, to be a major factor that could impede the use of health services (Scheppers et al, 2006).

When addressing the topic of Swedish language skills, we found the discussion about infantilization, as mentioned by the Russian respondent, to be especially interesting and fruitful. Because of the inability to speak proper Swedish she felt reduced to a person no more intelligent than a child. There may be another aspect to this other than merely the fact that it makes non-native patients feel upset and less worthy than other adult patients (which itself is clearly problematic). We would like to suggest that it may be related to the likelihood of non-natives' symptoms not being taken seriously as well as them not receiving the treatments or drugs which they feel they need. Several respondents explained how they, despite clearly knowing that something was wrong with them, were sent back home without treatment or medications. They were often told that they were probably just fine but if the symptoms were to last or worsen, they should come back again for another consultation. We believe that this may have something to do with the way adults (in this particular case; health care providers) not only *talk* to children in a certain way but how they also have preconceived ideas about children and their *behavior*. We would like to illustrate this with an example; envision a child who has fallen from a chair and hurt himself. He tearfully comes running to his parent who blows air on the wound and displays great concern over the minor injury. However, while doing this the parent knows that this is not very serious and that the child will be up and running again shortly. We consider it possible that the infantilization of patients by health care providers may be a possible explanation as to why several of our respondents express having left their consultations with a recommendation to 'just drink water' or not to worry about the symptoms because 'they will probably pass'.

8.1.6 Health determinant 6: Dissatisfaction

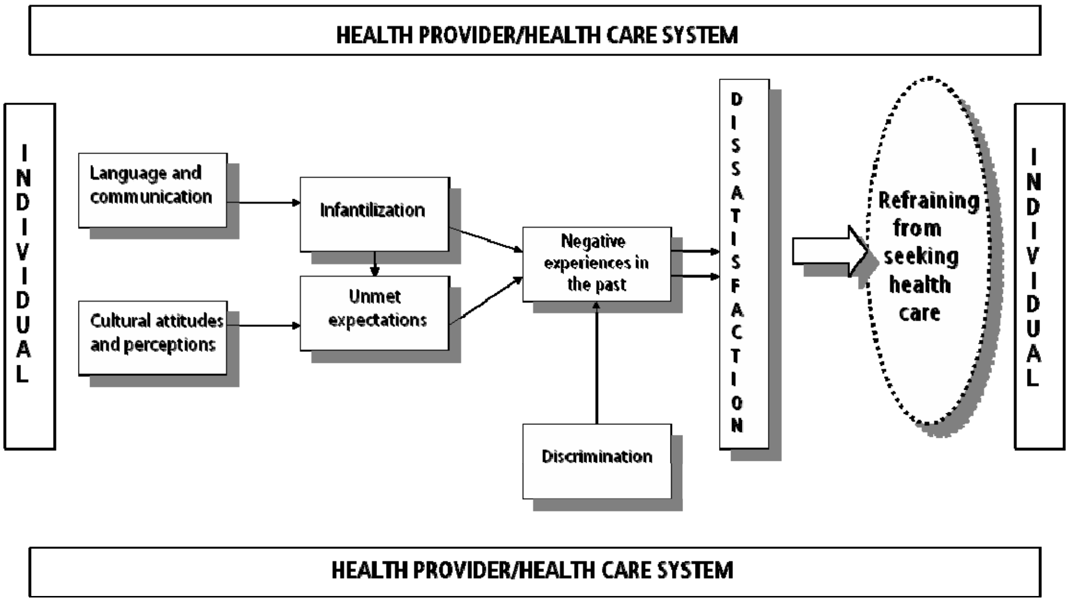
When expectations are not met they tend to create great dissatisfaction. The five health determinants previously presented in this chapter are related in the sense that they all include, or eventually may lead to, some level of dissatisfaction for non-native patients. We would like to argue that when patients' expectations are not met, their cultural attitudes and perceptions conflict with those of the provider. When discrimination, negative experiences in the past as well as infantilization (language and communication) exist in the health care setting, non-natives end up being dissatisfied with the Swedish health care system and the care provided.

8.1.7 Emerging theory

As with most inductive research with a Grounded Theory approach, the findings from the qualitative data set should preferably emerge into either new or already existing theory (Dahlgren et al., 2007). Thus, based on the study and discussion of health determinants mentioned above and how they all relate to one another, an explanatory model as to why non-natives refrain from seeking and utilizing health care in Sweden was developed. As creating a model was not part of the aim of this Bachelor's thesis, it should be viewed more in terms of a clarification of the health determinants and their possible significance in the context of seeking and utilization of health care among non-natives.

An important process for Grounded Theory researchers is to investigate how one's findings and an emerging theory meet with already existing theories. Do they support them, are they possibly contradictory or have a completely new theory being discovered? (Dahlgren et al., 2007) It was not our intention to investigate whether our model presents a new theory or is similar to previous models. Therefore, exactly how or to which degree this model and theory contribute to research on the topic remains unclear.

Figure 2



Our emerging theory was developed with the core category (*Experiences*) in mind. The foundation of the model consists of important aspects of being non-native (the individual); the heritage of cultural attitudes and perceptions as well as language and communication barriers. These may lead to either infantilization or unmet expectations, which in turn will translate into negative past experiences. Discrimination is not part of the characteristics, cultural heritage or behaviors of non-natives, but rather a phenomenon created by others (health care providers or the health care system itself). Therefore discrimination is not to be considered an individual attribute, but it still contributes to non-natives' negative experiences of Swedish health care. All of the previously described processes will eventually lead to dissatisfaction, which we believe may possibly cause non-natives to refrain from seeking and utilizing needed health care in Sweden.

8.2 Methodological considerations

8.2.1 Interview method

When deciding what qualitative method to use when interviewing, we made a choice between conducting a focus group interview and doing a smaller number of in-depth interviews. As with all research methods, they both have their advantages and disadvantages. The major conclusive factors in our choice of using in-depth interviews over a focus group were the time aspect and limitations following that. We considered it unfeasible to be able to recruit the right number of people as well as to agree on a time and place, suitable for everyone, to meet for a focus group interview within the time frame of 8-9 weeks. In-depth interviews also allowed for more flexible scheduling of interviews and to be more attentive to the requests by each individual respondent. Furthermore, we did not have to consider possible cultural and religious barriers such as the impropriety of interviewing men and women together. Therefore we were able to gain the benefits of larger demographic variation among our interviewees.

Research also suggests that more in-depth information can be obtained from individual interviews (Cronin, 2008). An important factor to keep in mind when conducting focus group interviews is that people may be uncomfortable to speak in front of a group, especially in another language than their mother tongue. This could limit their information in the interview. However, when individuals are sharing an experience in a focus group and one person begins expressing a line of discussion, others are often willing to join in. More data can sometimes be obtained from that type of interview discussion (Fielding & Thomas, 2008). In our case we considered the possibility that the respondents had very different experiences (after all they constituted a highly heterogeneous group) of the health care in Sweden. Thus, in-depth interviews again seemed like the better option for us.

From a Grounded Theory perspective, in-depth interviewing is also an appropriate method in order to obtain data. We do believe that 'theoretical sensitivity' (i.e. the way researchers need to have an open mind when addressing the data, as all possible explanations of a phenomenon provide valuable information) was carefully considered throughout the process of gathering and analyzing data. This is something very important and specific to the Grounded Theory approach (Dellve et al., 2002).

8.2.2 Sample size

Given the time limitation for this study, we decided to conduct a total number of five individual interviews; this number of interviews was also in accordance with general guidelines for a Bachelor’s thesis of 15 credits at Gothenburg University (Gothenburg University, 2009). According to Grounded Theory, data collection should be continued until saturation has been reached (Dahlgren et al., 2007). However, because of the size of this study (five interviews) we cannot safely say that we have reached saturation in our material. On the other hand, we did get some indications that we were probably quite close to saturation as the last interview did not provide any new data than what was previously collected.

8.2.3 Tape-recording

We did carefully consider the advantages and disadvantages before deciding on using a tape-recorder for our interviews. Especially since Glaser, one of the founders of Grounded Theory, advices against the use of tape-recording (Dahlgren et al., 2007). It has also been suggested that a tape-recorder may impede the willingness to talk in interviews if one is dealing with sensitive groups or topics (Fielding & Thomas, 2008). Despite these concerns, we still considered it more important to be able to fully capture everything that was said during interviews. Not just for ourselves and the sake of analyzing but also for our respondents in order for them to feel confident that we would not be able to quote or misuse their statements. Even though dealing with minorities, we did not consider the topic to be sensitive enough for a tape-recorder to have a major impact on the answers.

8.2.4 Sample and sampling strategy

Snowball sampling appeared to be an efficient sampling strategy for us as it did involve a smaller group in society (non-natives) and it seemed to enable recruitment of five interview subjects within the time limit of this Bachelor’s thesis. A major advantage of this way of sampling is that we did not have to identify all of the respondents ourselves, but rather a smaller number of key respondents who then identified the other people for us.

When it comes to our sample, we would have preferred a more equal distribution of the sexes. We interviewed four women, but only one man. It is possible that the uneven distribution may have had an impact on the results. On the other hand, the geographical distribution was very satisfying. The respondents represented a wide range of countries (Russia, Cuba, Iran, Bosnia and Palestine) which we suggest may have influenced the generalizability of the study in a desired way. Furthermore, the participants were of varied socioeconomic status which we believe also reinforces the generalizability.

The age distribution, however, was somewhat dissatisfying. The youngest respondent in the sample was 23 years old whereas the oldest was 39, but the target age group was as inclusive as 18-64. There are several reasons why a more diverse distribution of ages in the sample would have been better. As we get older we tend to get sicker and therefore we consume more health care. Older people may have more, as well as different, experiences than younger people. To get their point of view may have had an important impact on the results. Distribution of age and sexes clearly constitute two major limitations of our study.

8.2.5 Preunderstanding

The discussion about preunderstanding in regards to Grounded Theory has been an ever going debate. Strauss and Glaser argued that no background information or subjectivity should be included while conducting a study from a Grounded Theory perspective (Dellve et al., 2002). Other researchers claim that one should not start out with a preconceived theory in mind, but on the other hand emphasize the necessaries of studying literature beforehand (Dellve et al., 2002).

Due to the results of previous research we did have an idea that discrimination on the basis of ethnicity or immigrant status may be one of the health determinants that contribute to social disparities among non-natives in Sweden. However, we wanted to (according to the principles of Grounded Theory) be open to new and prior to our study unknown information. Therefore we were constantly ready to ‘kill our darlings’, i.e. to abandon some of our favorite ideas (for instance about discrimination) that originated from our preunderstanding (Dahlgren et al., 2007). By being open minded we were able to see not only other health determinants than discrimination, but also other aspects of discrimination previously unknown to us.

8.2.6 Credibility

An important aspect in general is if the study design and methodology really capture what was intended (Halvorsen, 1989) (Dahlgren et al., 2007). We believe that our questions and themes were very suitable as they all generated some new information and understanding about the health care experiences of non-natives that was unknown to us. The fairly open structure of the interview guide was important as a lot of the really useful information was obtained after probing. We would therefore like to argue that our study is credible.

As many of the results found are similar to findings of other studies, we would like to argue that the dependability of our study is quite high. We predict the study results to be similar if repeated in other parts of Sweden. As mentioned earlier, the geographic distribution of the sample was diverse which reinforces the idea that results may be similar if repeated elsewhere.

The transferability may not be as high as the previous two concepts discussed. We would like to note that most of the experiences with health care described here are specific to Sweden, thus limiting its transferability to other contexts. However, it is possible that our results may still apply to other Nordic countries or other countries with similar health care systems.

As researchers, and native Swedes, we did not share the most important characteristic of the study with the respondents (i.e. being non-native). We believe that this enabled a greater level of neutrality when conducting the research, as we did not know what their experiences might have been. We therefore had even greater reasons to be open and receptive to what the respondents had to say. On the other hand one can argue that by *not* being non-natives ourselves we may have prejudice and preunderstanding about the group which may affect confirmability. Despite working actively towards not adhering to possible preunderstanding, the risk of bias in regards to this can never be completely ruled out.

8.3 Practical implications

Non-natives in our sample have expressed negative attitudes and experiences towards health care in Sweden, primary health care in particular. As previously suggested in our explanatory model (Figure 2, p. 30), we believe that this dissatisfaction may contribute to the refraining of health care seeking amongst non-natives. This is of major concern as primary care services also include public health work. Today, health centers not only treat diseases, but also have the possibility of preventing ill-health and disease at an early stage. The importance of well-functioning primary health care services as a means to improve public health has also been emphasized in the latest health care report by the National Board of Health and Welfare, released on May 14th 2009 (Socialstyrelsen, 2009). Non-natives reluctance towards primary care may result in them refraining from seeking care until their symptoms or ailments have developed into such serious diseases that they may possibly be mortal. This is clearly a highly undesirable trend for this large, constantly growing segment of the Swedish population.

Most countries in the world today, Sweden included, are heavily burdened by escalating health care costs (Shi & Singh, 2005). Awaiting care until invasive surgery has to be performed for a condition highly preventable as well as treatable in primary health care settings is not a financially sustainable situation. We need to get non-natives to feel well taken care of and comfortable in the primary health care. Our Bachelor’s thesis suggests that health care providers have to be more sensitive to the requests and stories told by non-natives. They need to be treated as capable, intelligent human beings and the ethnocentric ideas of some physicians have got to be eliminated. The consultation should not feel rushed or unfinished. Preferably non-natives also need to be given a regular contact within Swedish primary health care, as this has been shown by others to be one of the strongest predictors of preventive health care use (Jenkins, Le, McPhee, Stewart & Ha, 1996).

9. Conclusion

While the findings of our study are consistent with previous research on the topic, it also adds some new insight. Non-natives are strongly influenced by their cultural and ethnic backgrounds, which affect their ideas and conceptions about Swedish health care, treatment and medication. This may lead to certain expectations when they seek or utilize health care in Sweden. However, these expectations are not always met, which may cause dissatisfaction. We believe that this affects their seeking and utilization of health care. Important health determinants were defined as; *unmet expectations, cultural attitudes and perceptions, discrimination, negative experiences in the past, language and communication* and *dissatisfaction*.

Non-native patients being infantilized by health care providers may be a possible predictor in the seeking and utilization. This is an interesting finding in that, to our knowledge, has not been acknowledged in other studies. We would like to emphasize the importance of further research regarding this possible relationship. We suggest that part of the solution can be found in the consultation where a more patient-focused health care needs to be emphasized. Health care providers need to listen and pay more attention to requests made by non-natives. Sufficient time needs to be devoted to each consultation and physicians have to inspire confidence and knowledge. It is highly important that non-natives find their way to primary care, especially since that is where preventable health care is performed. It is of urgent importance that primary care becomes visible for its preventable and more holistic health care. Primary care with a focus on prevention in combination with a patient-focused approach may be one step closer to a more equitable health care. It is also a possibility for Swedish health care to reach the targets described in the Swedish Health and Medical Services Act (Sahlin, 2006).

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