Equitable long term care for the elderly immigrants

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ABSTRACT

Background: The recent studies conducted among the health professionals representing long term care have shown that working with the elderly immigrants involves a range of challenges. One of the typical challenges is to adjust care service to the individual needs so that it maintains the patient’s integrity and dignity. The Norwegian health care system is built on the principles of equal access, equal quality and equal health outcomes. At the same time, it requires that health care takes into account that people are different and have different needs, with other words those with unequal needs should receive unequal treatment. The challenges related to the individual adjustment of care service, however, may give various implications and negatively affect the equity objectives and thereby prevent health care from being fair and equitable.

Objective: This master thesis aims to explore the challenges the health professionals at nursing homes face while seeking to provide equitable care services for the elderly immigrants. Based on the empirical findings, this paper also discusses to what extent the principles of equity in health care are fulfilled.

Method: A qualitative study, using semi-structured in-depth interviews. Study has been conducted from the health care professionals’ perspective. The sample size includes eight respondents. The key informants are nurses and caregivers from two different nursing homes in Oslo area. The informants represent both somatic and psychiatric wards. The selection criterion is availability of working experience with elderly immigrants from non-Western countries.

Results: A range of challenges that affect work of the care personnel has been revealed. Health professionals reported that the challenges they faced include problems related to language barriers, unrealistic expectations from health care, lack of health literacy, intentions to maintain traditions, problems related to hygiene, religion and food habits. It takes more time to assist patients with ethnic minority background than their Norwegian counterparts. Of all the above-mentioned obstacles language barriers, cooperation with patients’ families, unrealistic expectations seem to be most significant. These factors prevent health personnel from successful adjustment of long term services to the individual needs. The significance of other challenges such as hygiene, food or religion is not diminished, but they are rather results of the intention to maintain traditions. The analysis of the findings also indicates that there is a wide span in implementation of the equity policy. The underuse of long term care by the aged immigrants may be a sign of the horizontal inequity. Uneven adjustment of health care to the individual needs may imply vertical inequity in the distribution of health care.
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CONTENTS

ABSTRACT .............................................................................................................................. 2

ACKNOWLEDGEMENTS ........................................................................................................ 3

CONTENTS ............................................................................................................................. 4

1. INTRODUCTION ................................................................................................................ 7
   1.1. Foreword ........................................................................................................................ 7
   1.2. Background ..................................................................................................................... 8
   1.3. Research question and research problem ...................................................................... 10
   1.4. Thesis structure ............................................................................................................. 11

2. THE RIGHT TO HEALTH AS A FUNDAMENTAL HUMAN RIGHT .......................... 11
   2.1. The right to health ........................................................................................................ 11
   2.2. Equality and non-discrimination as the critical components of the right to health ..... 13

3. THE CONCEPTS OF EQUITY, EQUITY IN HEALTH AND HEALTH CARE ............ 14
   3.1. Equality and equity ...................................................................................................... 14
   3.2. What does equity in health mean? ............................................................................. 15
   3.3. Why is equity in health so important? ....................................................................... 16
   3.4. Equity in health care .................................................................................................. 16
   3.5. Horizontal and vertical equity .................................................................................. 19

4. IMMIGRANTS AND IMMIGRANT POPULATION ...................................................... 21
   4.1. Immigrants, who are they? ....................................................................................... 21
   4.2. Multicultural diversity in Oslo .................................................................................. 22
   4.3. Focus on the elderly immigrants from Asia, Africa etc. ........................................... 23
   4.4. Health status of the elderly immigrants and need for adapted health care services .... 25

5. THE WHITE-PAPERS ADDRESSING MULTICULTURAL CARE FOR THE ELDERLY. 26

6. LITERATURE REVIEW ..................................................................................................... 28

7. METHODOLOGY ............................................................................................................... 33
   7.1. Study design and research design .............................................................................. 33
7.2. Qualitative research interview ................................................................. 34
7.3. Selection of the key informants ............................................................... 35
7.4. Designing interview guide ................................................................. 35
7.5. Conducting the interviews ................................................................. 36
7.6. Transcribing the interviews ................................................................. 37
7.7. Ethical issues ................................................................................................ 37
  7.7.1. Informed consent, confidentiality and voluntary participation .................. 37
  7.7.2. The Norwegian Science Data Services consent ..................................... 38
  7.7.3. Asymmetric distribution of power .......................................................... 38
7.8. Quality of the research .................................................................................. 39
  7.8.1. Reliability ................................................................................................. 39
  7.8.2. Validity ...................................................................................................... 39
  7.8.3. Generalization .......................................................................................... 40
8. PRESENTATION OF THE RESULTS .............................................................. 40
  8.1. How do health professions understand equity in general and equity in health care particularly? .................................................. 41
  8.2. Challenges related to communication ...................................................... 42
    8.2.1. Who are used as interpreters? ............................................................... 44
    8.2.2. Communication barriers associated with patient’s health deterioration .... 46
  8.3. Challenges due to the patients’ families .................................................... 47
    8.3.1. Intentions to maintain traditions ........................................................... 47
    8.3.2. Unrealistic expectations from health care ............................................. 48
    8.3.3. Lack of health literacy ............................................................................ 49
  8.4. Challenges related to grooming and hygiene ............................................ 51
  8.5. Challenges related to religion ................................................................. 52
  8.6. Challenges related to the food habits ...................................................... 53
9. DISCUSSION AND CONCLUSIONS .......................................................... 55
  9.1. Study limitations ....................................................................................... 55
  9.2. Discussion of the study results ............................................................... 56
  9.3. To what extent equity principles are fulfilled? ........................................ 59
9.4. Recommendations for the further research................................................................. 62
10. REFERENCES........................................................................................................... 64
11. APPENDIX.................................................................................................................. 67

APPENDIX I: Permissions from the Norwegian Science Data Services (NSD).......... 67
APPENDIX II: Permission from the Agency for nursing home services in Oslo municipality........................................................................................................... 68
APPENDIX III: Request for participation in the research.............................................. 69
APPENDIX IV: Interview guide...................................................................................... 70
1. INTRODUCTION

1.1. Foreword.

Numerous studies conducted by Statistics Norway as well as the reports issued by the Norwegian Directorate of Health emphasize that the elderly from non-Western countries have poorer health conditions and more complex diseases than the majority population (Mørk E, 2010). Recent studies conducted among the health professionals who represent municipal long term institutions have shown that working with the elderly immigrants involves a range of challenges (Ingebretsen, 2010). One of the typical challenges is to adjust care service so that it maintains the individual’s integrity and dignity, which requires extra focus on communication, care, nutrition and protection of religious and cultural values (ibid.).

The inability to maintain the individual’s integrity and dignity may have implications for the equity policy. The main objective of health care policy in Norway is to provide appropriate and equal health care services to everyone who needs it regardless of age, sex, residence, economical and ethnical background. Responsibilities to provide equitable health care are anchored in several laws and regulations such as the “Municipal Health Services Act”, “Health Authorities and Health Trusts Act” or “The Patients’ Rights Act” for example.

This master thesis attempts to investigate the experiences of health professionals working at nursing homes with the elderly patients from non-Western countries; what challenges they face while seeking to provide equitable care services for the aged immigrants. The obstacles related to the adjustment to individual needs may give various negative effects for the equity. The Norwegian health care system is built on the principles of equal access, equal quality and equal health outcomes. But at the same time, it requires that care services take into account that people are different and have different needs and that more resources should be allocated for those with more needs. The situation where those with unequal needs receive unequal treatment is known as the principle of vertical equity. A deviation from this principle has an implication on the allocation of health care in a system. This paper is also a discussion of the extent to which the equity principles in health care are fulfilled. Although both horizontal and vertical equity concepts apply in this context, this paper will focus on vertical equity in the delivery of long term care services. The discussion is based on the empirical findings in terms of the challenges which may bring implications for the equity and affect the distribution of health care in a system.
One reason why to explore these issues is because the high diversity may apparently lead to the increase of costs. Adjustment to the individual needs will involve the administrative costs compared with standard services (Djuve, 2011). Thus, an insight into the challenges associated with facilitation of health care for ethnic minority may positively influence long term institutions’ performance, provide high quality services and optimize resource allocation.

Another reason is that the fail of equity principles will have implications on the distribution of health care. Non-compliance with the equity principles means discrimination and thus violation of the right to health. The violation of the right to health may prevent from enjoying other human rights, such as the rights to education, work etc.

1.2. Background.

Over the last few decades, Norway has undergone large demographic changes. Today this relatively little country is inhabited by people representing more than 200 corners of the world. As a consequence of a continuous flow of immigrants, the homogenous population of Norway has become ethnically diverse society. According to Statistics Norway in 1970 number of foreigners living in Norway was around 1.5% (Østby, 2009), while by the year 2012 this number increased up to 13.1% (SSB, 2012). Based on the experience from previous years Statistics Norway assumes that the overall migration will keep increasing in the forthcoming years.

Among immigrants there are few elderly and a large number of young people and adults (ibid.). Totally, 9% of immigrants are over 60 years, where 4.5% out of them have non-Western origins (SSB, 2011). In the coming years, the number of non-Western immigrants aged 50 – 60 will increase rapidly. Population projections show that by the year 2015 there will be around 7732 non-Western immigrants over 67 years and 1205 elderly over 80 years. Compared to the immigrants from Asia and Africa, the immigrants from Western countries have more in common with the major population on a number of factors such as marriage, employment, migration pattern and participation in the Norwegian society. So if we take a look at the challenges associated with aging in Norway, it will likely be more demanding for those from Asia and Africa than their European counterparts.

Moving to a new country with unfamiliar language and culture requires that an individual gets adapted to the new environment. Moving brings heavy losses for people, e.g. they lose contact with family, relatives, familiar environment, one may lose his cultural identity and status, moreover, an individual does not have the equal prerequisites to
understand the new society’s norms and organization. Many immigrants experience deprivation, they may feel they are exposed to discrimination, racism and exclusion. The elderly are in larger extent affected by such factors as language barriers, social, educational, and economic status. For many people it is an exhausting process which may influence their mental health to a large extent.

The elderly with minority background may have more complex diseases (Mørk, 2010). Poor health and mental problems are caused by the various negative experiences related to poverty, hunger, war, torture, escape etc. (Valen-Sendstad A, 2009). Many of them have had a heavy physical work. These unfavourable circumstances are the underlying determinants that undermine the individual’s health. Beyond this, the immigrants’ health conditions very often reflect the socio-economic situation of their motherland. Research on the health status of immigrants have revealed that in some ethnical groups such diseases as diabetes, hypertension, cardiovascular, infectious diseases and mental disorders are more common compared to the ethnic Norwegians (Mørk, 2010). Many of these health conditions will lead to complications and additional illnesses and, as a consequence need for health care. Treatment of these illnesses may be long-lasting and will require specific conditions. Therefore, it is important that the health care services, long term care particularly, are adapted with respect to the needs of these people.

Special treatment will be needed when the cognitive capacity of elderly immigrants starts to weaken. Such conditions as dementia, for example, might require special care and treatment which cannot be given neither by family nor by home nursing services. In this case, only long term care institutions are the solely solution. Treatment of a cognitive failure among the elderly immigrants is more challenging. Firstly, because research on dementia among immigrants is more difficult due to communication challenges during investigation (Valen-Sendstad A, 2009). Secondly, immigrants who have learnt Norwegian can easily lose this knowledge as a consequence of dementia’s progression. They may experience problems with distinguishing their mother tongue from Norwegian as well (Kirkevold, 2008). Communication on the patient’s first language will be crucial for maintaining an optimal level of functioning. That is why it is important that health care workers have the sufficient knowledge and comprehension of disparities, and how one can facilitate health services so that the various needs are met in the equally good and adequate way.

Aging, culturally and ethnically diverse society will pose a range of challenges to politicians, local communities, helping agencies, health care services, social workers, psychologists etc. The main objective of health care policy in Norway is to provide
appropriate and equal health care services to everyone who needs it regardless of age, sex, residence, economical and ethnical background. Equitable health care does not imply that services should be the same for everyone, but it rather means that there are equal access, equal quality and equal health outcomes. Services should also take into account that people are different and therefore, they should be adapted with respect to individual needs. With other words, health care services should be distributed according to need. Patients with different needs and health conditions should obtain different treatment, which is adapted to their life situation, cultural religious background as well as the language abilities. This objective is anchored in various laws and regulations. In the white-paper No.45 “Better quality in municipal health care services” the government clearly expresses that the individually adjusted health care service is the best way to cope with the challenges associated with cultural diversity. Municipal health care to the highest possible extent should be organized with respect to the cultural and religious inhering of the health care consumer. Rituals, traditions connected with illness, death and funeral are mentioned as an example. Taking into consideration the challenges related to the increased immigration, integration and aging, the Norwegian government has issued a range of the regulations and white-papers directed to the promotion of equity in health care services. Thus, this master thesis will try to identify to what extent the equity principles are applied in practice.

1.3. Research question and research problem.

The topic of this master’s thesis is the challenges the health professionals face, and will focus on personnel at nursing homes who take care of the elderly from non-Western countries. First of all, it will be interesting to see what care personnel know about equity in health care; then, whether they consider the services as equitable. Further, their experiences from working with the elderly immigrants will help to reveal the obstacles preventing long term care service from being equitable. Finally, I will discuss to what extent the principle of vertical equity in health care i.e. unequal treatment for those with unequal needs is fulfilled.

The research problem of the study is as follows:
What challenges do health personnel at nursing homes face while seeking to provide equitable health care services for the elderly immigrants?

The research problem will be further broken into research question:
Research question: To what extent is the principle of unequal treatment for those with unequal needs is fulfilled?

1.4. Thesis structure.

This master thesis contains nine important chapters.

Chapter 1 is an introduction, where the background of the study, research problem and research question are presented.

Chapter 2 dwells on the right to health and its relationship with the human rights.

Chapter 3 describes the academic perspectives that lay the theoretical fundament for the analysis. It discusses the meaning and importance of equity, equity in health and healthcare particularly. Further this section focuses on main principles of equity in health care such as horizontal and vertical equities.

Chapter 4 presents statistical data on immigrants, their origin, age, health status etc.

Chapter 5 gives an overview of the normative legal acts addressing multicultural care for the elderly.

In Chapter 6 the readers will find a review of the relevant studies.

Chapter 7 is devoted to the methodological approach and the methods employed.

Chapter 8 gives the presentation of the results and lists the barriers revealed during the interviews and subsequent analysis.

Chapter 9 discusses the study limitations, study results and attempts to answer the question whether the equity principles have been fulfilled and gives recommendations for the further research.

2. THE RIGHT TO HEALTH AS A FUNDAMENTAL HUMAN RIGHT.

2.1. The right to health.

The right to health is a basic human right. Every individual is entitled to the enjoyment the highest attainable standard of health. The Preamble to the World Health Organisation’s Constitution (1948) declares that the right to health is one of the fundamental rights of every individual: “The enjoyment of the highest attainable standard of health is one of the
fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”.

The right to health is recognized and anchored in numerous international and regional human rights treaties as well as the national constitutions all over the world. Article 25.1 of the Universal Declaration of Human Rights (1948) states: “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”

In Article 12 of the International Covenant on Economic, Social and Cultural Rights adopted in 1966, the United Nations defined the right to health. The Covenant highlights that the stakeholders of the Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. But probably the most comprehensive article on the right to health is the General Comment No 14 “Right to health” issued by the United Nations in 2000. This paper expands on the original ideas from 1966 by exploring the historical context of this right, further defining the meaning of an adequate health care system. The General Comment underlines that the right to health should not be considered as a right to be healthy. The notion of "the highest attainable standard of health" takes into account both the biological and socio-economic preconditions of an individual.

Thus, genetic factors, individual predisposition to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to the individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health. In other words, the right to health implies the right to a system of health protection which ensures quality of opportunity for people to enjoy the highest attainable level of health.

Further, the General Comment states that the right to health extends not only to timely and appropriate health care, but also to the underlying determinants of health such as e.g. access to safe drinking water, adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy living and working conditions, access to health-related education and information and gender equality.

According to the General Comment No 14 the right to health contains four elements: Availability implies functioning public health and health care facilities, goods and services.
Accessibility means that health facilities, goods and services are accessible to everyone. Accessibility has four overlapping dimensions:
- non-discrimination
- physical accessibility
- economical accessibility (affordability)
- information accessibility

Acceptability implies that all health facilities, goods and services must be respectful of medical ethics and culturally appropriate.

Quality means that health facilities, goods and services must be scientifically and medically appropriate and of good quality.

Human rights are interdependent and indivisible. Individuals’ right to health cannot be realized without realizing his other rights. The violation of the right to health may hinder from enjoying other human rights, such as the rights to education, work etc. Because all human rights – economic, social, cultural, civil and political – are considered independent and indivisible, governments are responsible for gradually correcting conditions that may impair the realization of the right to health, as well as the related rights to education, information, decent living and working conditions and freedom from discrimination (Braveman, 2003).

2.2. Equality and non-discrimination as the critical components of the right to health.

Equality and non-discrimination are the key and fundamental principles in human rights and they are crucial to the enjoyment of the right to the highest attainable standard of health. They are critical components of the right to health since all human beings are born equal and free in dignity and rights. Article 2.2 of the International Covenant on Economic, Social and Cultural Rights identifies the grounds of discrimination and emphasizes that the stakeholders of this Covenant guarantee that the rights enounced in this paper will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Discrimination means the prejudicial treatment of an individual based on their membership - or perceived membership - in a certain group or category. It involves the actual behaviors towards groups such as excluding or restricting members of one group from opportunities that are available to another group. It involves excluding or restricting members of one group from opportunities that are available to other groups (Wikipedia, 2012). It is also exclusion or restriction which results in wiping out the recognition, enjoyment of human rights and fundamental freedoms. It is related
to the marginalization of specific population groups and is generally at the root of fundamental structural inequalities in society (Braveman, 2003). Traditionally discriminated groups are often more vulnerable and they are subject to more serious health problems. Numerous studies conducted on investigation of availability, access and quality of health care services for vulnerable groups showed that for example ethnic minority groups, indigenous people, undocumented immigrants have limited access to health care services, receive less health information, they are less likely to have adequate housing compared to the general population (The Human Rights Fact Sheet No 31).

Further, Article 2.2 of the International Covenant on Economic, Social and Cultural Rights indicates that non-discrimination and equality imply that participants must recognize and provide for the differences and specific needs of groups that generally face particular health challenges, such as higher mortality rates or vulnerability to specific diseases.

Along the same lines, the Committee on Economic, Social and Cultural Rights has made it clear that there is no justification for the lack of protection of vulnerable members of society from health-related discrimination. So, even if times are hard and resources are constraint, the vulnerable members of the society must be protected by the adoption of relatively low-cost targeted programmes. Strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification of legislation or the dissemination of information.

3. THE CONCEPTS OF EQUITY, EQUITY IN HEALTH AND HEALTH CARE.

3.1. Equality and equity.

Before looking at the concepts and principles of equity in health, first it will be necessary to define the difference between equality and equity. Culyer (2001) underlines that there is no single universal theory of equity, but it is widely agreed that equity implies equality. Although equality and equity are often joined, the words have two distinct meanings and are conceptually very different. Equality is sameness, and equity is fairness and justice. In any particular situation, equal may not be equitable, or equal may be precisely equitable (Bambas, 1999). Very often equality refers to a distribution that is equal, i.e. equal distribution of health across individuals, while equity is used to describe a distribution that is fair, i.e. distribution of health among individuals according to their need (ibid.). It is important
to notice that not equality of distributions but rather fairness of distributions is central to the definition. All human beings vary in health and it will be impossible to distribute health equally and to achieve a situation where everyone has the same level of health or suffer the same degree of illness. This is not an achievable goal, nor even a desirable one (Whitehead, 2000). The notion of equity instead, would be more reasonable to use, because we seek to distribute health in a way so that each individual gets as much health (we acquire health through purchasing health care services) as he needs to attain in order to conduct an adequate and fully valued life.

The term equity has an ethical and moral dimension (ibid.). The concept of equity is grounded in the principle of distributive justice. However, there exists some ambiguity about the above terms, as some use it to convey a sense of fairness while others use it to mean equal in a purely economical sense. Added to this, there is also the problem of translation in some languages, where there is only one word which covers both equality and equity. To avoid confusion, the term equity has been chosen by WHO for the European health (Whitehead, 2000).

3.2. What does equity in health mean?

It is widely agreed that health means health status, i.e. physical, mental and social well-being capacity. It is important to distinguish between health and health care since the latter is just one of many health status determinants (Braveman, 2002). Equity in health according to Braveman is:

“Equity in health is operationally defined as minimizing avoidable disparities in health and its determinants - including but not limited to health care – between groups of people who have different levels of underlying social advantage or privilege, i.e., different levels of power, wealth, or prestige due to their positions in society relative to other groups”. (Braveman, 2002)

Equity in health implies that all people attain the highest standard of physical, mental and social well-being that their biological limits permit (ibid.). However, the biological limits can be also modified, e.g. people with physical disabilities might be provided with facilities that will simplify their daily life.

Margaret Whitehead in her paper “The concepts and principles of equity and health” gives following definitions to the terms equity and equity in health.

“Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided”. (Whitehead, 2000).
“Equity is therefore concerned with creating equal opportunities for health and with bringing health differentials down to the lowest level possible”. (Whitehead, 2000).

3.3. Why is equity in health so important?

According to Whitehead (2000) in numerous countries with their different political and social systems, differences in the health of the population have been observed between various social groups and geographical areas within the same country. There is the strong evidence that people with poorer health have less chance to survive. Children born in well-off families have a greater chance to live several years longer than their counterparts from low-income families. There is also huge discrepancy in mortality numbers between urban and rural population and between different regions in the same country (ibid.). There are great differences in the experience of illness as well. Disadvantaged groups not only suffer a heavier burden of illness than others, but also experience the onset of chronic illness and disability at younger ages. When it comes to accessibility and quality of health care services, there are many examples demonstrating that those most in need of medical care are least likely to receive high standard services (ibid.).

That’s why it is important to take these differences seriously and to design the effective and efficient health policies combating health inequities.

3.4. Equity in health care.

It is the link between health care and health that is important in equity because health is important in ways that the other needs served by health care are not (Culyer, 2001). The absence of an agreed theory arises out the absence of a general definition of what equity in health care is (ibid.). Generally, equity in health care means that health care resources are allocated according to need, health services are received according to need, and payment for health services is made according to ability to pay. Whitehead (2000) indicates that equity in relation to health services implies equal opportunities for health and the minimizing of differences in health. According to Aday (1984), for example, health care is equitable when resource allocation and access are determined by health needs. Mooney (1987) notes two important aspects of equity: horizontal equity that is equal treatment for equal need; and vertical equity implying unequal use of health care services for those with unequal need. Culyer and Wagstaff (1993) state that the health care is equitable when there are equal access, equal utilization, distribution according to need and equal health outcomes. Several principles of equity are widely agreed and commonly discussed:
1. Equal *access* to available health care for those in equal need
2. Equal *utilization* for those in equal need
3. Equal *health outcomes*, or
4. Equal *quality* of health care

**Equal access to available care for equal need.**

According to Oliver (2004) equal access means that people with equal needs require equal opportunities to access health care (that is, horizontal equity), and people with unequal needs have appropriately unequal opportunities to access health care (that is, vertical equity). Oliver (ibid.) emphasizes that equal access to health care for those in equal need is the most appropriate principle of equity for the healthcare policy maker to pursue.

Whitehead (2000) states that equal access to available care for equal need implies equal entitlement to the available services for everyone, a fair distribution throughout the country based on health care needs and ease of access in each geographical area, and the removal of other barriers to access.

Further Whitehead emphasizes that a large number of studies show that even today there exists huge inequity in access to health care services in all corner of the world. An extreme example of unequal access arises when people are unable to use health services because of their lack of income, race, sex, age, religion, or other factors not directly related to the need for care. For example, migrant workers may be excluded from insurance-based services in some countries. Financial, organizational and cultural barriers confront people wanting to use services so that, although they may have a right to health care in theory, their access may be restricted in practice. Ethnic minorities may find the language and cultural barriers major obstacles to access.

Inequities in access also arise when resources and facilities are unevenly distributed around the country, concentrated in urban areas rather than in rural ones. As deprived communities tend to suffer the worst health, such unequal distribution means that medical services are least available where they are most needed.

**Equal utilization for equal need.**

When it comes to the principle of equal utilization of health care, Oliver (2004) indicates that equal utilization for equal need requires conditions whereby those who have an equal need for health care make equal use of health care.

For example, differences in lifestyle preferences, exposure to risk may lead to differences in the utilization of health care, but the principle of equal utilization for equal need
does not allow for these considerations. Whitehead (2000) indicates that interpretation of this concept requires a great care. There might be differences in utilization of certain health services by different social groups, but it does not automatically mean that the differences are due to inequity. This may be explained by the fact that some people just do not exercise their right not to use health services, probably for religious or ethical reasons.

**Equal health outcomes**

The principle of equal health outcomes implies the absence of health inequities. Whitehead (2000) defines health inequities as “differences in health which are not only unnecessary and avoidable but, in addition, are also considered unfair and unjust”. She specifies that there are seven main determinants of health disparities that can be identified:

1. Natural, biological variation.
2. Health-damaging behaviour if freely chosen, such as participation in certain sports and pastimes.
3. The transient health advantage of one group over another when that group is first to adopt a health-promoting behaviour.
4. Health-damaging behaviour where the degree of choice of lifestyles is severely restricted.
5. Exposure to unhealthy, stressful living and working conditions.
6. Inadequate access to essential health and other public services.
7. Natural selection or health-related social mobility involving the tendency for sick people to move down the social scale. I.e., if an individual initially had poor health, then the original ill health is considered as unavoidable, while the low income of sick people is unjust and avoidable.

However, Oliver (2004) states that the principle of equal health outcomes in terms of achieving for example, certain mortality and morbidity measurements is potentially highly undesirable because it would require too many restrictions on the ways in which people may choose to live their lives. Bambas (1999) shares Oliver’s opinion and goes on to specify that it is a robust concept of equity, encompassing a range of situations including outcomes, exposure to risk, living conditions and social mobility.

**Equal quality of care for all**

Some scientists in the field use another one more equity principle. This principle is equal quality of care for all. Whitehead (2000) is one of those who have chosen it as significant one. Equal quality of care for everyone, also implies that providers will strive to put the same commitment into the services they deliver for all sections of the community, so
that everyone can expect the same high standard of professional care. Inequities arise in this case when professionals do not put the same effort into their work with some social groups as with others, offering them less of their time or professional expertise. There is evidence of quality of care being compromised by poor quality of premises in disadvantaged areas and reluctance of more experienced staff to work in such conditions.

The report “Equitable services? Major cities’ services for ethnically diverse population” (Djuve, 2011) discusses various definitions of what equitable public service is. The authors explain that each single sector of the public services follow the equity principles depending on what type of services they deliver, though the majority of providers choose mainly the principles of equal access, equal quality and equal outcomes. However, Equality and Anti-discrimination ombud (LDO) gives a slightly different definition of the equitable services. LDO states that “equitable public services” have to take into account that people are different, identify the individual and group needs and adapt services in accordance with these and distribute public resources fair. Such interpretation of equity focuses on “difference” rather than “equality”. In the Strategy for prevention of discrimination (2009-2012) it is also pinpointed that organization of services must take into account that the consumers are different and have different needs. Thus the white-papers No 28, 30, 50, NOU 1997:12 discard the principle of equal outcome in favour of individual adjustment of services due to the different needs. The studies conducted among the health professionals working in long term care, as well as the information obtained from the informants, indicate that it is the adaption of health care services to the patients’ individual needs that is believed to be challenging. Thus, the discussion of the equity issues will focus on the principle of different treatment for those with different needs, known also as vertical equity.

3.5. Horizontal and vertical equity.

In order to describe the situation as equitable it is necessary to distinguish between the appropriateness of equal and unequal distribution, or so-called horizontal and vertical equity. Equity simultaneously requires that relevantly similar cases to be treated in similar ways, and relevantly different cases be treated in different ways (Bambas, 1999). Horizontal equity requires the like treatment of like individuals. Vertical equity refers to unequal treatment for individuals with unequal needs (Culyer, 2001).

Mooney (1997) specifies that the horizontal equity does not take account of individual characteristics, it does not consider differences in pre-existing health status and thus
differences in the 'need' for health care. Consequently where health disadvantage exists, *vertical equity*, defined as the 'unequal but equitable treatment of unequals', is important (ibid.).

Thus, horizontal equity implies:

- equal *access* for equal needs (e.g. equal waiting lists in different counties for comparable health problems);
- equal *utilization* for equal needs (e.g. same rate of visits to the GP for comparable health problems);
- equal health outcomes (e.g. same standardized mortality rate in different hospitals for the same disease categories or procedures).

Vertical equity means:

- Differing *access* to health services (e.g. outreaching preventive mother and child health services, especially for the poor);
- Different charges for health services according to ability to pay (e.g. progressive taxation, different charges for services according to income).

The requirement to ensure equitable health services is anchored in several laws and regulations. The Norwegian health care system is built on the principles of equal access, quality and equal health outcomes which represent horizontal equity. But at the same time, the equity policy requires that care services take into account that people are different and have different needs, that is vertical equity. It also pays attention to the fact that more resources should be allocated for those with more needs.

Most of the studies on equity issues are the economic analyses of equity in health care and focus only on the horizontal inequity, while vertical equity in health care delivery has been given very little attention. It is important to specify that this master thesis is not an economic evaluation or analysis of whether equity principles are achieved or not. This paper is a discussion of the extent to which the equity principles in long term care are fulfilled. Although both horizontal and vertical equity concepts apply in this context, this study will focus on vertical equity in the delivery of long term care services, i.e. the principle of unequal treatment for unequal needs. The discussion is based on the empirical findings in terms of the challenges associated with adaption of health care services to the individual needs which in their turn may bring negative effects for equity objectives. A deviation from this principle may have an implication on the distribution of health care in a system.
4. IMMIGRANTS AND IMMIGRANT POPULATION.

4.1. Immigrants, who are they?

Statistics Norway has introduced a new standard for categorizing persons with an immigrant background. The term **immigrants** implies persons who were born abroad to two foreign-born parents, and who have moved to Norway. Those born in Norway with two immigrant parents are defined as **Norwegian-born to immigrant parents**. Per January 1, 2012 there were 547 000 immigrants and 108 000 Norwegian-born persons with immigrant parents living in Norway. Together these two groups represent 13.1% of Norway’s population. Immigrants and Norwegian-born persons with immigrant parents are represented in all Norwegian municipalities (Statistics Norway, 2011). Oslo has the largest proportion with 28%, while Drammen is the second largest city with 22%. They have come as refugees, as labour migrants, to study or to join family living in Norway.

The majority of the immigrants are from Poland, Sweden, Pakistan and Iraq. 34% of the immigrants have Norwegian citizenship. Broken down by region, 287 000 have a European background, 210 000 persons have a background from Asia, 74 000 from Africa, 19 000 from Latin-America and 11 000 from North America and Oceania. Norway’s immigrant population is represented by 215 different countries and independent regions. Diversity is a key word for immigration to Norway.

Further, Statistics Norway distinguishes between the terms **Western** and **non-Western** immigrants, where the non-Western immigrant population refers to persons who are resident in Norway and were born outside Norway to two foreign-born parents (and four foreign-born grandparents), and children born to immigrant couples after the latter’s arrival in Norway. However, the above categories have been replaced with world regions. On the website of Statistics Norway stands that: “The terms "western" and "non-western" will no longer be used
by Statistics Norway. These are being replaced by world regions as the standard classification... In cases where there is a need to divide the world regions in two, it is recommended that one group is called "EU/EEA, USA, Canada, Australia and New Zealand", and the other "Asia, Africa, Latin-America, Oceania excluding Australia and New Zealand, and Europe outside the EU/EEA". Thereby group "EU/EEA, USA, Canada, Australia and New Zealand" refers to the former Western immigrants and group "Asia, Africa, Latin-America, Oceania excluding Australia and New Zealand, and Europe outside the EU/EEA" refers to the former non-Western immigrants.

4.2. Multicultural diversity in Oslo.

At the beginning of 2011, 170000 immigrants and Norwegian-born with immigrant parents lived in Oslo which is 28,4% of the capital’s population. Of the biggest groups, 21600 had a background from Pakistan, 12200 from Somalia, almost as many from Sweden and 10400 had background from Poland. 64% of Oslo’s immigrants come from Asia, Africa, South and Central America and Turkey. 19% come from Western Europe, North America and Oceania, while 17% come from Eastern Europe. The Table below shows the distribution of the immigrants in the districts of Oslo municipality.

**Immigrants and Norwegian-born with immigrant parents by district in Oslo as of 1 January 2010**

<table>
<thead>
<tr>
<th>District</th>
<th>Number of inhabitants</th>
<th>No of immigrants and Norwegian-born with immigrant parents</th>
<th>% of immigrants and Norwegian-born with immigrant parents in the district</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole of Oslo</td>
<td>599 230</td>
<td>170 206</td>
<td>28,4</td>
</tr>
<tr>
<td>Gamle Oslo</td>
<td>43 770</td>
<td>15 803</td>
<td>36,1</td>
</tr>
<tr>
<td>Grünerløkka</td>
<td>47 256</td>
<td>14 934</td>
<td>31,6</td>
</tr>
<tr>
<td>Sagene</td>
<td>35 115</td>
<td>8 455</td>
<td>24,1</td>
</tr>
<tr>
<td>St. Hanshaugen</td>
<td>33 137</td>
<td>7 870</td>
<td>23,7</td>
</tr>
<tr>
<td>Frogner</td>
<td>51 120</td>
<td>11 637</td>
<td>22,8</td>
</tr>
<tr>
<td>Ullern</td>
<td>30 744</td>
<td>4 719</td>
<td>15,3</td>
</tr>
<tr>
<td>Vestre Aker</td>
<td>44 320</td>
<td>6 361</td>
<td>14,4</td>
</tr>
<tr>
<td>Nordre Aker</td>
<td>47 433</td>
<td>7 679</td>
<td>16,2</td>
</tr>
<tr>
<td>Bjerke</td>
<td>28 226</td>
<td>10 847</td>
<td>38,4</td>
</tr>
<tr>
<td>Grorud</td>
<td>26 291</td>
<td>11 123</td>
<td>42,3</td>
</tr>
<tr>
<td>Stovner</td>
<td>30 178</td>
<td>13 964</td>
<td>46,3</td>
</tr>
<tr>
<td>Alna</td>
<td>47 025</td>
<td>21 498</td>
<td>45,7</td>
</tr>
<tr>
<td>Østensjø</td>
<td>46 244</td>
<td>9 678</td>
<td>20,9</td>
</tr>
<tr>
<td>Nordstrand</td>
<td>46 888</td>
<td>6 471</td>
<td>13,8</td>
</tr>
<tr>
<td>Søndre Nordstrand</td>
<td>35 843</td>
<td>17097</td>
<td>47,7</td>
</tr>
</tbody>
</table>

**Table 2.**  
*Source: Statistics Norway*
4.3. Focus on the elderly immigrants from Asia, Africa etc.

This research will focus on the aged immigrants and therefore, the age distribution is of greater importance than the number of immigrants in general. The age distribution among ethnic minorities is similar to the general population, i.e. the majority of population is young people and adults, while there are few old persons.

Per 1 January 2010, total of 23438 immigrants over 67 years were registered in Norway. More than two-third of them has immigrated from Europe, and the second largest group is the immigrants from Asia.

20 largest groups of immigrants aged 50-66 and over 67 years by country background per 01.01.2010

<table>
<thead>
<tr>
<th>Immigrants aged 50-66</th>
<th>Immigrants over 67 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>In total</td>
<td>459346</td>
</tr>
<tr>
<td>1. Sweden</td>
<td>6123</td>
</tr>
<tr>
<td>2. Poland</td>
<td>5543</td>
</tr>
<tr>
<td>3. Denmark</td>
<td>4937</td>
</tr>
<tr>
<td>5. Pakistan</td>
<td>3932</td>
</tr>
<tr>
<td>7. Bosnia-Hercegovina</td>
<td>3077</td>
</tr>
<tr>
<td>9. Iran</td>
<td>2170</td>
</tr>
<tr>
<td>10. Finland</td>
<td>2114</td>
</tr>
<tr>
<td>11. USA</td>
<td>1871</td>
</tr>
<tr>
<td>13. Chile</td>
<td>1712</td>
</tr>
<tr>
<td>15. Russia</td>
<td>1551</td>
</tr>
<tr>
<td>16. Turkey</td>
<td>1465</td>
</tr>
<tr>
<td>17. The Netherlands</td>
<td>1449</td>
</tr>
<tr>
<td>18. India</td>
<td>1421</td>
</tr>
<tr>
<td>20. Kosovo</td>
<td>980</td>
</tr>
<tr>
<td>All countries</td>
<td>72048</td>
</tr>
</tbody>
</table>

Table 3. Source: Statistics Norway

Research on living conditions conducted by Statistics Norway in 2005-2006 has shown that immigrants who belong to this group differ to a greater extent from the rest of immigrants originating from EU etc. Compared to the immigrants from Asia and Africa, the immigrants from the USA, EU-EEA countries have more in common with population without immigrant background on a number of factors such as e.g. marriage, employment, migration pattern and
participation in the Norwegian society. So if we take a look at challenges associated with aging in Norway, it will likely be more demanding for those from Asia and Africa than their European counterparts. The elderly immigrants in this group will definitely want to receive care services from healthcare workers with common language and similar life experience. It will become more important as soon as the cognitive capacity starts to decrease and recently acquired knowledge of Norwegian disappears, that is why this group is so different from the others (Mørk E, 2010).

Just in a few years the group of immigrants aged 50-66 will be categorized as “over 67 years”. By the year 2020, for example, the number of the immigrants from Asia and Africa will increase up to 2% (Table 4). And if we turn to the Table 3 again, we will find that the three largest groups of non-Western immigrants in fifteen years will be the elderly from Pakistan, Bosnia-Herzegovina and Vietnam.

**Population aged 67 years and older projected for the middle variant to 2060 for the whole population of immigrants from Asia, Africa etc.**

<table>
<thead>
<tr>
<th>Year</th>
<th>Whole population 67+</th>
<th>Immigrants 67+</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>625143</td>
<td>7487</td>
<td>1.2</td>
</tr>
<tr>
<td>2015</td>
<td>719597</td>
<td>10885</td>
<td>1.5</td>
</tr>
<tr>
<td>2020</td>
<td>816860</td>
<td>16200</td>
<td>2.0</td>
</tr>
<tr>
<td>2025</td>
<td>921991</td>
<td>23651</td>
<td>2.6</td>
</tr>
<tr>
<td>2030</td>
<td>1025917</td>
<td>34339</td>
<td>3.3</td>
</tr>
<tr>
<td>2035</td>
<td>1138697</td>
<td>47299</td>
<td>4.2</td>
</tr>
<tr>
<td>2040</td>
<td>1248802</td>
<td>61776</td>
<td>4.9</td>
</tr>
<tr>
<td>2045</td>
<td>1321080</td>
<td>77170</td>
<td>5.8</td>
</tr>
<tr>
<td>2050</td>
<td>1382317</td>
<td>93605</td>
<td>6.8</td>
</tr>
<tr>
<td>2055</td>
<td>1443081</td>
<td>108333</td>
<td>7.5</td>
</tr>
<tr>
<td>2060</td>
<td>1523278</td>
<td>119826</td>
<td>7.9</td>
</tr>
</tbody>
</table>

Table 4. Source: Statistics Norway

How large the group of immigrants from Asia, Africa will be, depends mainly on two factors, these factors are life expectancy and whether they stay in Norway for long time (Mørk E, 2010). As to the life expectancy, it is difficult to give any numbers on mortality among non-Western immigrants because a very few observations were conducted and data are not available. However, it was learnt from the previous Norwegian projections of immigrant population that the mortality rate is similar to the major population (ibid.). The situation with the length of stay in Norway is relatively clear. A range of studies underlines that elderly immigrants do normally not come back to their homeland.
4.4. Health status of the elderly immigrants and need for adapted health care services.

As it was mentioned before, in 2005-2006 Statistics Norway conducted a comprehensive research on living conditions of 10 largest non-Western immigrant groups. The respondents were posed a range of questions about their physical, psychic and self-reported health. The immigrant groups reported poor health condition more often than the Norwegians. The main findings indicate that the elderly assess their health as poor compared to the young people, and difference among immigrants and majority population increases with age. For example, 73% the Norwegian men aged 55-70 consider their health status as good or very good, compared to 40% of the male immigrants. Further, 69% of the Norwegian women aged 55-70 consider their health status as good or very good, while this number for the female immigrants makes up only 27% (Mørk E, 2010). More problems related to the health status of non-Western immigrants were reported here. The elderly immigrants have the largest average number of mental diseases compared to Norwegian population. Ethnic minority is more affected by the mental problems. This problem influence 42% of immigrant women aged 55-70 and 34% men, compared with only 5% and 7% of the elderly in majority population, respectively (ibid.). Also international studies from the USA and other countries in Europe have shown that non-Western immigrants have worse health conditions than the majority population (Ingebretsen, 2010).

The fact that majority of non-Western immigrants come from poor countries where infectious and other diseases prevail and access to health care services is limited, may explain why the health status of the elderly immigrants is poor compared to the health status of majority population (Mørk, 2010).

Migration itself and a start of a new life in a foreign country may be perceived as stressful, it may also lead to the poor socio – economic conditions and weak social integration into new society, and thereby will increase the risk of health deterioration. Stress associated with immigration and adaptation to the new life and environment has made them more vulnerable to diseases than their Norwegian counterparts. For many of them, longing for motherland, worry about their family staying there, can easily disrupt the mental balance and affect their physical health (ibid.).

The elderly immigrants who moved to Norway being already aged will most likely have health status that would reflect the situation in public health as well as access to health care services in the country of origin (Ingebretsens R, 2007). Being aged at the moment of immigration will also bring more stress and higher degree of risk for health compared to the
young people. Opportunities to be employed and participate in social activities in the new homeland are more limited than in the country of origin. The ability to integrate, adapt and learn new language decreases with age usually. Therefore, taking into account all the above-said, it would be reasonable to expect that the elderly immigrants will be more affected by diseases than the same age group of the majority population.

Special treatment will be needed when the cognitive capacity of elderly immigrants starts to weaken. Such conditions as dementia, might require special care and treatment which cannot be given neither by family nor by home-based nursing services. In this case, only long term care institutions are the only solution. Treatment of cognitive failure among elderly immigrants is more challenging. Firstly, research on dementia among immigrants is more difficult due to communication challenges during investigation (Nielsen R, 2009). Secondly, immigrants who have learnt Norwegian can easily lose this knowledge as a consequence of dementia’s progression. They may experience problems with distinguishing their mother tongue from Norwegian as well (Kirkevold, 2008). The communication on the patient’s first language will be crucial for maintaining an optimal level of functioning (ibid.). White paper No.49 (2003-2004) emphasizes that “the main challenges for health care are believed to be people with special needs, e.g. people with dementia, those who need pain relief and people in the life’s final phase”. So in order to provide the elderly immigrants with an adequate life, it is important to keep their special needs in mind. It is essential that health professionals have the sufficient knowledge and comprehension of disparities, and that they do their best to facilitate health services so that the various needs are met.

5. THE WHITE-PAPERS ADDRESSING MULTICULTURAL CARE FOR THE ELDERLY.

The main objective of health care policy in Norway is to provide appropriate and equal health care services to everyone who needs it regardless of age, sex, residence, economical and ethnical background. Responsibilities to secure equitable health care are anchored in several laws and regulations such as the “Municipal Health Services Act”, “Health Authorities and Health Trusts Act” or “The Patients’ Rights Act” for example. Apart from the laws and regulations, a number of white-papers addressing the challenges of multicultural care for the elderly there was issued. These papers confirm growing attention to the issues of provision of the adequate health care services and their adjustment to the individual needs of the elderly patients with ethnic minority background.
White-paper No.50 (1996-1997) “Plan for elderly care. Safety, respect, quality”. This paper emphasizes that it would be preferable to facilitate services so that the elderly immigrants have possibility live together with those who speak the same language, have the same cultural background when they no longer are able to take care of themselves. The Government believes that the needs of the elderly people will be met thereby. In addition, as to the provision of health care services for immigrants, it is of great importance to hire health personnel who speak several languages and have knowledge of various cultures and religions. Another main message is that the consumers’ needs should be placed in focus, and information about various health care services for the elderly immigrants should be prepared.

White-paper No.28 (2000) “Content and quality in health care services”. It is mentioned that the health personnel from home-based services experience problems when it comes to taking contact with elderly immigrants, partly because the elderly themselves do not wish any help, partly due to the lack of information on services. Lack of information about available health care services is considered to be a challenge for the public services. Further, the Government states that it is important to provide elderly immigrants with adequate and equitable health care and social services.

White-paper No.45 (2002-2003) “Better quality in municipal health care services”. The Government clearly expresses that individually adjusted health care services is the best way to cope with challenges associated with the cultural diversity. The municipal health care to highest possible extent should be organized with respect to the cultural and religious belongings of the health care consumers. Rituals, traditions related to the illness, death and funeral are mentioned as examples. Further, the paper mentions that several municipalities have already taken these challenges into consideration and started to work with adjustment of health care to the individual needs of consumers with minority background.

White-paper No.49 (2003-2004) “Diversity through inclusion and participation”. This paper deals with the integration of people with minority background in general. Chapter twelve is devoted to the consumers’ needs and adjustment of the public services. It emphasizes that the number of the elderly immigrants will increase and therefore, health care services must be able to meet the prospective groups of elderly patients. Each single municipality by its own efforts should initiate mapping the number of residents with minority background, their age and nationality. In addition, this paper mentions that the use of
interpreters or translated information on services is an important component of a successful provision of equitable health care.

White-paper No.25 (2005-2006) “Mastering, possibilities and opinions. Future challenges in long term care”. As the title implies the future challenges in long term care and the main users of the municipal health and care services are focused on in this report. Figures from the surveys indicate that one out of five non-Western immigrants live with their family, i.e. four out of five do not. Based on these numbers, it is expected that in future there will be many older non-Western immigrants without those who can take care of them in their household. In light of this, the Government states that the future consumers of health care services will represent a greater cultural diversity. Facilitation of health care assumes adaptation and adjustment based on the individual’s background and needs, but it should not lead to the new forms of special care for different groups.

White-paper No.47 (2008-2009) “The Coordination reform” reminds us that the equal access to good, equitable and balanced health care services, regardless of residence, economical background etc. remains the most important cornerstone of the Norwegian welfare model. It is stressed that the main objective of the Coordination reform is to meet consumers’ needs for coordinated services. Further, it is pointed out that good health care should reflect the consumers’ preferences and these preferences should be realized. It is important to remember that these preferences may be expressed in different languages, and needs may be defined in another way than we used to. Knowledge about various minority groups and individuality of each single consumer is required therefore. It is challenging to make services accessible, facilitate for good communication and make them able to meet the consumers’ needs (Ingebretsen R, 2010).

6. LITERATURE REVIEW.

In Norway, most of the investigations on the adjustment and adaptation of health care services for the elderly immigrants as well as the challenges related to this were conducted by Norwegian Social Research (NOVA). NOVA is one of the largest social research institutes in Norway. This institute conducts research on different aspects of society and the welfare state.
In 2005 NOVA published report named “Care services with diversity? Mapping of the municipal resources and needs when it comes to facilitation of care services for the elderly with minority background”. This study describes experiences and challenges in 17 municipalities having at least 200 non-Western elderly immigrants (persons over 60 years). This study has revealed that the challenges are associated with three main issues.

The first problem is related to the information, language and communication. There are wide variations in the knowledge of Norwegian among the consumers. Exchange of the information on different languages and its oral dissemination to the elderly and their families will be important in the coming years.

The second problem deals with clarification of the expectations and facilitation of health care services. On the one hand, the elderly with ethnic minority background may be invisible for health care system and report low expectations. On the other hand, the elderly consumers may have too high expectations with respect to the frames the services have. The challenges with clarification of the consumers’ expectations for services are due to the lack of information and language barriers. Expectations for family care and other cultural and religious conditions play also an important role. The experiences from preventive care indicate that for facilitation of care services understanding of cultures, following-up and illness perception, based on the patient’s cultural background, are essential moments.

Challenges related to education, cooperation and guidance of health care personnel are mentioned as a third concern. The authors of the report indicate that municipalities are in the different positions with respect to how active they are in issues of health care services for elderly immigrants. Care personnel having minority background may promote to the facilitation of communication and better understanding of cultures. The special attention should be paid to education, guidance and interpretation services.

In 2007, NOVA published “The elderly with minority background. Adjustment of long term care services”. This report seeks to answer how the elderly with minority background can benefit from health care on equal terms with the majority population.

According to the research, the use of nursing and care services among elderly immigrants is much lower compared to the corresponding age groups in the majority population. This should be considered in terms of information, communication, consumers’ expectations and their opinion on how services suit them.

There is the lack of knowledge on use of services. It is impossible to assess how big the underuse is, since the there are no systematic investigations on the use of the health care
services compared to the elderly with majority background. The demand should be considered with respect to the type of services. While the demand for financial help from government to the elderly immigrants’ families is quite high, the demand for nursing homes remains very low.

Review of Norwegian, Nordic and international literature shows that many similar issues recur in studies on the elderly immigrants’ use of nursing and care services. The international studies do not provide clear answer to whether it is best to develop culture-specific health services or whether to focus mainly on general services and make them more culturally sensitive. Experiences from countries where many cultures are represented show that it can be difficult to provide culture-specific health services to all relevant ethnic groups. Multicultural living and service center can be one of the solutions.

In Sweden, there are numerous examples of own living and service centers for the elderly with minority background. The studies conducted in Sweden show that some groups wish care services on their own language, while other groups prefer segregated services. In Danish studies it is argued to focus on differentiated information at the same time as provision of services is carried out on equal terms with majority population.

As care services are supposed to meet the consumers’ needs, the relationship between caregiver and care receiver will be of a vital importance. Interviews with health personnel from municipalities and districts where nursing and care services have experiences with non-Western immigrants, emphasize the will and interest to learn about and from those they encounter. Communication and best possible conditions for mutual understanding and contact will be the primary objective of challenge for everyone regardless of ethnic background. This goal is closely related to skills development and culture. It requires follow-up of the health care personnel with training, supervision and teamwork.

"Elderly immigrants and their use of nursing and care services. Report from five Norwegian municipalities" was issued by NOVA in 2008, and included five municipalities, such as Oslo, Bergen, Trondheim, Stavanger and Kristiansand. This project seeks to investigate how the elderly with minority background use health care services as well as to learn municipalities’ experiences in providing services to these consumers. This information was obtained through interviewing of the health managers and health care personnel.

The elderly with minority background prefer to use home-based nursing services rather than long term institutions. Health personnel from home-based nursing services explain that sometimes they find it difficult to get acceptance, reach the families with ethnic minority background and persuade them to accept their care. It happens because families prefer to get
money from the government and take care of their elderly by themselves, rather than seek help from home-based service. The all five municipalities have reported on the increasing demand of financial help from government.

The interviews with municipal health managers and health personnel have revealed that health service consumers with non-Western background, regardless of age, often represent challenges for health personnel and other consumers. Insufficient skills of Norwegian, different experience and cultural background, along with unusual family traditions make facilitating of health care services demanding. T. Nedgård assumes that there is a reason to believe that the language barriers and the fact that very few elderly immigrants live alone is one of the reasons why so few of them help from health care.

The majority of health personnel from long term institutions consider themselves as more "multiculturally" composed, than the consumer groups. Personnel with immigrant background, however, represent a minority of the total staff. Some municipalities try to match health personnel and elderly patients with the same national or language background. It is not always easy to achieve in practice. Some patients tend to "occupy” their countrymen carers and expect extra services from them.

Two years later, in 2010 the next report was issued by NOVA. The main objective of the report “Experiences with care services for elderly immigrants. Consumers, their families and health care personnel views” was to find out what old immigrants themselves, their relatives and health personnel think about cooperation and facilitation of care services. The report emphasizes importance of individual adjustment of various facilities, the complex role of families and importance of cooperation with them. A multicultural group of care personnel with knowledge of various languages and cultures is a big advantage.

Findings, based on the interviews with health care personnel, indicate that one of the typical challenges in long term care institutions is to maintain the individual’s integrity and dignity. This requires extra focus on communication, care, nutrition and protection of religious and cultural values.

The authors of the report explain that they have got impression that health care personnel, working at municipal care institutions, are open to understanding, finding practical arrangements; they are willing to inform consumers about health care services as well as to take into account the individuals’ special needs. This is in accordance with the main requirements on individual adaptation and adjustment of care services based on each single customer’s background and need. Health care personnel’s experiences indicate that the need for use of interpreters may be high. The time factor is crucial when one needs to quiet a
patient, and make him feel secure. Requirements for efficiency and individual adjustment of services, however, are far from perfectly compatible, according to care workers.

The same year “Care for the elderly immigrants. Experiences collected from various projects” saw the light. This report summarizes and discusses experiences from the two previously mentioned reports: “The elderly with minority background. Adjustment of long term care services” from 2007 and “Experiences with care services for elderly immigrants. Consumers, their families and health care personnel views” from 2010. These two papers shed the light on the issues of long term care services, their adjustment to the individuals’ needs, cooperation with families and understanding of cultural diversity among care personnel. The authors mention other reports that have not been discussed here. These papers dwell mainly on preventive care, interest groups and non-governmental humanitarian organizations for elderly immigrants.

“Equitable services? Major cities’ services for ethnically diverse population” is one of the latest reports issued in 2011 by Fafo (Institute for Labour and Social Reserch).

This report seeks to answer how the welfare services of major cities could be designed in such a manner that they could pave the way for recognition of ethnic diversity and simultaneously ensure equality. In this report, experiences form Oslo, Kristiansand and Stavanger, within the service sectors day-care centres, home-based nursing services and the Qualification Programme have been mapped. The authors mark out several dimensions of the challenges associated with diversity. First and foremost challenge among service consumers is deficient Norwegian language skills that rise communication problems and the need for interpretation, and thereby may increase the time needed for provision of services. Second, diversity has an effect on knowledge and understanding of Norwegian society or what may be referred to as “bureaucratic skills”. Consumers with few bureaucratic skills may lack familiarity with the services as such, or they may have unrealistic expectations of what the service sectors can provide. A third aspect of diversity has to do with differences in socio-economic backgrounds – facilitation for the group that combines deficient Norwegian language skills and few socio-economic resources will be an especially challenging task. A fourth aspect of diversity that may be perceived as challenging is associated with cultural and religious preferences.

In relevant planning documents, the goal of delivering equal services is not invariably formulated with the required precision, and interpretations of this concept tend to vary from
one employee to another and form one service sector to another. The day-care sector, for example, has put great effort into ensuring equal access to services. When it comes to the home-based services, they have only to a limited extent made efforts to recruit users, but will often adapt their services to the users’ needs and preferences.

7. METHODOLOGY

7.1. Study design and research design.

This master thesis aims to explore the challenges the health personnel at nursing homes face while seeking to provide equitable care services for the elderly immigrants. Based on the empirical findings, this paper also discusses to what extent the principles of equity in health care are fulfilled.

The principal rule of any research is to choose a method that is appropriate to the research problem. To acquire information on a matter of concern, I have chosen a qualitative method of research. Qualitative methods are research strategies which are most suitable for description and analysis of the characters, properties or quality of a specific phenomenon (Malterud K, 2002). Compared to the quantitative research methods which are based on the numeric data, the material from qualitative methods include texts produced under conversations or observations (ibid.). A qualitative method gives possibility to pick up various research strategies, from observation to interviews with a single person or groups. Using interviewing, for example, the researcher stimulates the respondents to describe their experiences, thoughts and their evaluation of a specific situation.

To get deeper comprehension of health personnel experiences from working with elderly immigrants, I have chosen to conduct in-depth interviews. Interviewing is a commonly used method of collecting information from people. Kumar (2011) gives several definitions of interview. According to Monette, “an interview involves an interviewer reading questions to respondents and recording their answers”. According to Burns, “an interview is a verbal interchange, often face to face, though the telephone may be used, in which an interviewer tries to elicit information, beliefs or opinions from another person”. Any person-to-person interaction, either face to face or otherwise, between two or more individuals with a specific purpose in mind is called an interview.
7.2. Qualitative research interview.

The structure of the interview depends on the nature of investigation, the geographical distribution of the study population and the type of the study population (Kumar, 2011). As an appropriate tool for getting as much information as possible, I have chosen in-depth interviews, semi-structured with open questions.

In-depth interviews are appropriate when the researcher is interested in the detailed information about the respondent’s thoughts, experiences, behaviour or wants to explore the issues in depth. To define *in-depth interview*, Kumar (2011) uses definitions given by Taylor and Bogdan: “interviewing is repeated face to face encounters between the researcher and informants directed towards understanding informants”. This definition underlines the essential characteristics of in-depth interviewing. First, it involves face to face, repeated interactions between the researcher and his informant. Then, it seeks to understand the latter’s perspectives (ibid.). The main advantages of in-depth interviews are that they give to the scientist much more detailed information than what is available through other research methods. They also may evoke unexpected for the researcher knowledge, as well as provide an opportunity for informal atmosphere.

Further, when it comes to the structure of the interviews, they are formed as the semi-structured with open questions. Semi-structured interviews combine various elements of both structured and unstructured interviews, thus allowing for different levels of specificity and flexibility (Kumar, 2011). The interviewer makes a draft with the questions he believes will be the answers to the issues he is interested in. By the researcher’s wish, the questions may be broken down into several thematic parts, for example. Using semi-structured interviews, the researcher uses an interview guide as basis, but remains flexible with respect to the order of questions, and prepares the follow-up questions (Bryman, 2008).

Purpose of this thesis is to reveal what the meaning of what the respondents say about the challenges and possible barriers in long term care with respect to the elderly immigrants. A semi-structured interview is a way of giving specific descriptive information the way the interviewee sees the world in the context of a specific phenomenon. The aim is not to generalize opinions, but to portray personal perspectives in a specific context of the lives of the participants (Kvale, 2007).
7.3. Selection of the key informants.

My intention was to form the sample so that it would include all possible categories of health care workers at nursing homes, namely heads of the wards, nurses, caregivers and assistants from both somatic and psychiatric wards. The purpose was to get in contact with those who have been involved in work with elderly immigrants and had first-hand knowledge of challenges related thereto.

To find relevant informants I used Table 2. where I picked up the districts of Oslo with the highest number of immigrants. Further, I gathered information on all available nursing homes situated in these areas. The inquiries on availability of elderly with minority background together with the description of the study problem were sent out to 19 receptions in these institutions. In the inquiries I also kindly asked to provide me with the e-mails and phone numbers of those who might be potential respondents. The responses were following: eight nursing homes never gave any reply, eight institutions answered that they did not have any elderly immigrants, and three institutions said they had elderly with minority background. After having found that three nursing homes have had elderly immigrants as their patients, I contacted the heads of the wards of two nursing homes where the elderly of interest were staying. The ward heads have got the written request for participation in the research (see Appendix III). Finally, they have chosen those who had the necessary experience from working with elderly immigrants. A total of eight informants from two nursing homes have agreed to participate in this study. This would be a manageable group considering the size of the thesis. The key informants are both men and women aged 19-56. Six out of eight respondents are Norwegian, while two out of eight have minority background. They represent all categories of health care workers at nursing homes; one of them is a head of the ward, one respondent is a nurse, while the majority of the informants were caregivers from both somatic and psychiatric wards. The length of working experience varies from 2 to 38 years.

7.4. Designing interview guide

Kvale (2007) mentions that an interview guide should be drawn up so that it reflects the research problem of the study. When drawing up my interview guide I decided to break the guide into several thematic blocks of interest.

I decided to start broad. Questions one and two are supposed to elicit information on how the respondents understand equity in general and equity in health care particularly, as well as whether these terms are used at their workplaces. Question three is aimed at revealing the current situation relative to work with the elderly immigrants at the ward, e.g. the
background of the patients, age, their health status, whether they have physical or mental
diseases etc. In the next fourth question I ask the respondents about their personal experiences
from working with elderly immigrants, as well as the challenges they face while giving care
to that kind of patients. This question is meant to unveil the main obstacles and barriers and
thereby answer the research problem. The fifth and sixth questions, in my opinion, will be
helpful to map and realize the scope of variation in individuals’ needs, and at the same time to
learn what long term institutions do in order to adjust services to the individuals’ needs. Last
question seeks to receive information on the possible ways of improvement.

I used this interview guide for all informants because it was interesting to see how the
informants viewed the same issue. A range of follow-up questions was used. If the respondent
is nervous for example, the interviewer might feel more relaxed by having follow-up
questions. The follow-up questions were also used in cases if the informants did not give
enough information, they were accidentally skipping the question, or jumping over from one
topic to another. Follow-up questions may be helpful if the researcher intends to keep focus
on each topic and the whole interview generally (Kvale, 2007).

7.5. Conducting the interviews.

The informants were offered to choose the place and time that was most convenient for
them. All of them wanted to be interviewed at their workplace.

I started the interviews with introduction of myself, brief description of the study, its
objective and reasoning why exactly this respondent’s experience is so valuable for the
research. Further, I thought it was important to remind the interviewee that his/her name,
workplace and obtained information are anonymous. I also mentioned that participation in the
study is absolutely voluntary and that the participant may withdraw from the study at any time
without giving a reason. Finally, I informed that the interviews would be recorded with a
digital recorder and conversation would be transcribed into written texts afterwards. After
having received oral consent from my interviewees, we have proceeded to the interview.
During the interview I was taking down the notes so that I could follow up conversation and
have overview over what the respondent has answered to what questions. At the end of the
interview I did a short summary of all challenges and specified whether I understood the
answers correct, and whether the informant wished to add before we ended interview. Most
interviews took half an hour in average.

I expected that conducting of the interviews will be very challenging for me however it
turned out to be easier that I expected. At my first interviews I kept thinking that I had to
follow the interview guide and not to miss any follow-up questions. But after some practice I was using the interview guide only as a check list, and the interview got acquired the form of conversation, and I also perceived my respondents as being more open and relaxed.

7.6. Transcribing the interviews.

After having conducted eight interviews I switched to the next phase of the study, namely transcribing the recorded interviews. According to Kvale (2007), when the researcher transcribes from oral into written form, the interview conversations will be structured so that they become more appropriate for analysis. When the oral material gets the form of text, it will be simpler to have an overview, and structuring itself is a beginning of analysis. The scope of material and form of transcription will depend largely on the nature and purpose of the study.

Transcription took much time and patience. I was lucky to have a digital recorder of a high quality, so all interviews I had conducted were clear and understandable. For-for-word transcription was used in order not lose the valuable information. During the interviews all informants were speaking Norwegian and therefore, the oral material was transcribed into the Norwegian text. My option to keep the original language of conversations can be explained by the wish to save time and to stay as close to the original source as possible. The analysis of the collected data was made based on the original language. During analysis all quotations giving, in my opinion, the best evidences of the challenges were picked up and translated into English subsequently.

7.7. Ethical issues.

7.7.1. Informed consent, confidentiality and voluntary participation.

When doing the scientific research it is important to remember about ethical guidelines. Majority of scientific studies whether they have quantitative or qualitative nature deal with people who are considered as the sources of information. The prospective respondents therefore must be informed about the study’s purpose and the consequences of their involvement. Kumar (2011) reminds that in every discipline it is considered unethical to collect information without the knowledge of participants, and their expressed willingness and informed consent. Informed consent implies that subjects are made adequately aware of the type of information you want from them, why the information is being sought, what purpose it
will be put to, how they are expected to participate in the study, and how it will directly or indirectly affect them (ibid.). In the present study the health care personnel have received the information about study in the request for participation in the research (see Appendix III).

This request informed also about confidentiality. Sharing information about respondent with others for purposes other than research is unethical (Kumar, 2011). It is unethical to identify an individual respondent and the information provided by him/her. Therefore, you need to ensure that after the information has been collected, its source cannot be identified (ibid.). During the interview the researcher may gather the sensitive information from his respondent therefore, it is important to give this informant anonymity.

All the informants were informed about voluntary participation as well as possible withdrawal at any stage of the research.

7.7.2. The Norwegian Science Data Services consent.

In order to conduct this research I had to receive permissions from the Norwegian Science Data Services (NSD) and the Agency for nursing home services in Oslo municipality. When asking the ward leaders for permission to contact the health care personnel from their wards I had to show them the approval for the project given by the NSD, the Agency for nursing home services in Oslo municipality and my request for participation in the study with the detailed information about the research. NSD evaluated the current study and send me their final decision that they have reviewed the information described in the registration form as well as other enclosed documents, and they have concluded that the present study is not mandatory for registration or licensing (Appendix I).

7.7.3. Asymmetric distribution of power.

Kvale (2007) mentions that the scientist should be aware of asymmetrical distribution of power between the researcher and interviewee. The interview is a specific form of conversation and differs very much from those conversations we use in our everyday life. The objective of any interview is to obtain information on specific area. Interview involves face to face, repeated interactions between the researcher and his informant, where one person ask questions and one give response. Thus, the interviewer and interviewee have different roles, and there is a place for asymmetry of power. The researcher has control over the situation, asks the questions, steers the course of interview. Such situation may give impression that the interviewer has certain dominance over the interviewee. Therefore it is important to minimize
asymmetric power distribution and make informants feel they are equal and on the same line with researcher and their experience is the precious knowledge the researcher is looking for.

In order to minimize asymmetric distribution of power I gave my respondents information on the study’s purpose in advance. I also made an effort of giving the informants possibility to steer and dwell freely on the topics they believed were especially important.

7.8. Quality of the research.

The three concepts of reliability, validity and generalization provide a basic framework for conducting and evaluating traditional quantitative research. Understanding of these concepts in qualitative research differs from those in the quantitative field. In contrast to the quantitative research, the concepts of reliability and validity are tightly interrelated. Below the three basic concepts will be introduced.

7.8.1. Reliability

If a research tool is consistent and stable, hence predictable and accurate, it is said to be reliable. The greater the degree of consistency and stability in an instrument, the greater its reliability is. Therefore, “a scale or test is reliable to the extent that repeat measurements made by it under constant conditions will give the same result” (Kumar, 2011). However, reliability is mainly concerned with quantitative studies. So, the reliability of this thesis will concern its ability to be replicated and repeated by other researchers.

The interviews were conducted in two nursing homes. And the results of the interviews are responses of those nurses and caregivers who were available during that time. This reflects the opinions of caregivers from two definite nursing homes. The results of this study, on a contextual setting, will be of low reliability. Quite low reliability of the present study can be explained by the fact that it cannot be repeated by other researchers.

7.8.2. Validity.

Kumar (2011) gives several definitions of what validity is. According to Smith (1991) “validity is defined as the degree to which the researcher has measured what he has set out to measure”. According to Kerlinger (1973) “the commonest definition of validity is epitomized by the question: Are we measuring what we think we are measuring?” Babbie (2007) writes,
“validity refers to the extent to which an empirical measure adequately reflects the real meaning of the concept under consideration”.

During analysis I saw that there exists coherence between the theoretical issues and study results, they match to a high degree. Empirical conclusions can then be made. Validity is evident in this study because the research problem, challenges and barriers intended to be answered are appropriately answered. The key informants were selected from different nursing homes and from different wards and they give similar responses, meaning that study is valid. To be certain of validity I was critical during analysis of collected information. I have tried to illuminate all experiences of my key informants and avoid my own subjective opinions.

7.8.3. Generalization.

Another important issue that should be addressed is generalization of the findings. Generalization and lack of objectivity are the aspects of qualitative research which continue to be criticized. Generalization is known as the degree to which the findings can be generalized from the study sample to the entire population. Since this research study was qualitative and not quantitative, generalization is not a very crucial part of the research.

The purpose of the current study is to investigate what challenges health personnel at nursing homes face while seeking to provide equitable health care services for the elderly immigrants. It also discusses to what extent the principle of unequal treatment for those with unequal needs is fulfilled. This study presents the key informants’ perceptions and therefore cannot be generalized. On the other hand, the study did not have many participants, which may be criticized in terms of validity, but qualitative study does not require high number of participants, but the quality of the findings.

8. PRESENTATION OF THE RESULTS

This chapter provides answer to the research problem: “What challenges do health personnel at nursing homes face while seeking to provide equitable health care services for the elderly immigrants?” The experiences and challenges particularly, have been described by the nurses and caregivers, and afterwards the results have been examined and carefully interpreted and presented in this chapter.
As I have described before in chapter “Methodology”, the interviews were conducted in two nursing homes situated in Oslo, in areas with high number of immigrants. The main condition for choice of the key informants was their experience from working with elderly patients from non-Western countries. The interviews took place in the nursing home A and the nursing home B, in somatic and psychiatric wards respectively. A total of eight informants agreed to participate in this study. Two out of eight participants are men and six are women. Six of the informants were born in Norway and have Norwegian background, while the other two have non-Western background. The age of the interviewees varies from 19 to 56, however most of the informants are over 46 years. Two of the participants are educated as nurses and work in the same positions. The six other respondents work as caregivers and they have relevant education. Most of them have been working in health care sector for over 20 years.

8.1. How do health professions understand equity in general and equity in health care particularly?

The English equivalent for equity/equality sounds in Norwegian as likeverd so if we take a look at its composition, we will easily find that lik(e) has the meaning of equal, while verd implies value (in this context in terms of significance). Thus the combination of two words equal and value will automatically bring us to the idea that each single individual has an equal value. Most of the respondents gave exactly this answer, i.e. that all human beings have equal value and have an equally high importance.

From the interviews I have got impression that all of the participants have very clear and quite precise understanding of what equity means. All of the informants have clearly defined that all people have the same value and significance regardless their race, colour of their skin, country background, language they speak, education, disability, economical situation, disease or social background etc.

Further, the interviewees were asked how they understand the notion of equity in health care. Most of the answers are directly connected with the respondents’ understanding of equity as such i.e. the majority said that equitable health care services mean equal services in terms of treatment that meet the patients’ needs regardless their race, language, education and so on. What I noticed during the interviews is that the informants were thinking in the context of their own work. Only one respondent gave a broader answer where he discussed the problem at national level and stated that health care services should provide equally good treatment not only within a particular municipality, but all over the country. However, none of
the respondents named basic principles of equitable health care services, namely that they should ensure equal access, equal quality, equal health outcomes or adjustment to the individual needs.

Finally, the interviewees were asked to answer whether the above-mentioned notions are used at their workplaces. Majority of the respondents said they have heard these words before, but never used them at their wards. Only one person said that he knows this word from internal meetings which are organized from time to time at their nursing home. He also mentioned that equity issues have been taken up at the ward in connection with directives they receive from Agency for nursing home services in Oslo municipality. Moreover, many of them do not associate equity with its true meaning, they rather interpret equity as kindness, respect or attention to the patients. The interviewed health professionals understand equity in health care rather as the adjustment of care services to the patients' individual needs and therefore the challenges they mentioned they associate with the adaption to individual needs.

Based on the careful analysis of the collected information, the following challenges were unfold.

**8.2. Challenges related to communication.**

The largest category of the challenges mentioned by the health care personnel is associated with the barriers due to communication. The elderly users of the health care services and those who use nursing homes particularly have different background and therefore, there are wide variations in the knowledge of Norwegian among the consumers. All the informants without exception mentioned barrier to communication as the most challenging one. Many elderly immigrants speak Norwegian very bad, many of them do not speak at all. This challenge is considered to be one of the crucial in the coming years because many of the first generation immigrants are getting older and just in a few years they will become the prospective users of the health care institutions. The elderly who have come to Norway for family reunification is a vulnerable group with regard to language. Another large group is the minority women, especially those from Middle East. The majority of them are house wives, they spend most of their time staying at home and taking care of their families. Normally they have contact only with their counterparts, they do not mingle with the Norwegian, they do not participate in social activities and stay usually isolated from the Norwegian society. Such
exclusive lifestyle prevents them from learning Norwegian and thus, they will represent the potential challenges and large costs for the health care services:

“What I am thinking about is the language. All main challenges are associated exactly with this issue. We have started to get a number of first generation immigrants, they are very often Pakistanis who came to Norway that time; majority of them speak hardly Norwegian and this will be the enormous challenge for us Norwegian”.

Health care personnel have often experienced that being unable to understand Norwegian and to express what patient actually wants lead very often to misunderstanding, dissatisfaction and mistrust to health care personnel:

“I remember we had an old man from India. He did not speak Norwegian, only Urdu and English. So the communication with this man was very difficult for me since I speak neither Urdu nor English. And this guy, he could become very angry and irritated if I did not understand what had said”.

Different linguistic backgrounds and deficient knowledge of Norwegian makes communication very problematical for all actors, patients and care personnel:

“The main challenge is the language, definitely. We can understand single Norwegian words and expressions the elderly say, but the problem is that they do not understand what we tell to them. All caregivers both with majority and minority background have noticed that. And what we often see is that the immigrants want to be polite and say “yes”, although they do not catch what we have said to them. I think this phenomenon - that they nod and later it turns out that they did not realize anything - may be explained by the cultural difference”.

The impressions acquired from this investigation are confirmed by the studies mentioned in Literature review of this master thesis, in overview of the relevant literature. Reports from Norwegian Social Research (NOVA) “Care services with diversity? Mapping of the municipal resources and needs when it comes to facilitation of care services for the elderly with minority background” (2005), “Elderly immigrants and their use of nursing and care services. Report from five Norwegian municipalities” (2008) and report “Equitable services? Major cities’ services for ethnically diverse population” (2011) issued by Fafo (Institute for Labour and Social Research) confirm these findings. All of them mark out challenges associated with diversity as language barriers. Thus, the first and foremost challenge among service consumers is deficient Norwegian language skills that rise communication problems and the need for interpretation, and thereby may increase the time needed for provision of services.
8.2.1. Who are used as interpreters?

*Health care personnel*

Information obtained from the respondents indicates that the challenges associated with communication are recognized by everyone. As they recognize that this problem exists the leaders of the wards, having the elderly immigrants as their patients, try to find the ways how to facilitate services so that they meet the requirements of each single patient. Health care personnel with minority ethnic background may contribute to the facilitation of communication. All of the respondents stressed that at their wards leaders do their best in order to match caregivers from other countries than Norway with the elderly patients speaking the same foreign language. Hence, the use of the multilingual personnel is the key strategy how to cope with language barriers in nursing homes:

“Our ward is quite multicultural and we try to make use of it. Currently, we have Philippine and Pakistani patients and if a caregiver feels he is stuck, then we can bring those who speak the same language”.

Alternatively, to overcome the communication barriers some wards turn to the help of the trainees with minority background who have their practical training at different organizations where they learn Norwegian performing single assignments. One of the informants mentioned that:

“Here we have many trainees, purpose of their stay with us is to learn and improve their Norwegian. They are here pretty often and sometimes it happens that they speak the same language as the elderly and they can interpret for us. We have been practicing this strategy for many years”.

The informants also explained that sometimes matching of a caregiver with an elderly patient may fail due to various circumstances such as illness of health personnel for example, and then the Norwegian caregivers have to cope without interpretation:

“If the caregivers with the necessary language are not available, we are in trouble. We have to use sign language, gestures, facial expressions to explain what we mean. It helps, but it is not always that the patient understands what you want”.

One of the informants mentioned that she has been working as a caregiver for 25 years, and since 2000 the number of the elderly with minority background at nursing homes started to increase. This phenomenon was absolutely new for the health personnel, so they had to adjust to the new trends and come up with the new solutions. Thus “The communication book” was prepared in their ward. This tool was created by the personnel and it has been used
as a way of communication with the elderly who do not speak Norwegian. It includes variety of pictures, picture of a cup, clock with arrows and hours or dinner for example. Under each image there are words for cup, hours or dinner respectively; these words are written in Norwegian and one foreign language. There are also transcriptions of the most necessary daily expressions so that caregivers can explain for a patient in his language what they are going to do. There are books in Somali, Vietnamese, Moroccan Arabic and Urdu languages.

“We asked the patients’ families to help us with translation, and they were very eager because they are aware of the language barriers. This “communication book” has been very helpful and it does work, however not at most, but we get better communication and we are able to meet the patients’ needs”.

**Family members**

Use of the patients’ families is also a common way of communication with the elderly immigrants who have poor language skills. The families do normally not stay the whole day with their parents and therefore cannot be used as interpreters permanently. Health personnel use them mostly at the beginning, when the elderly patient moves in the nursing home and caregivers wish to learn more about their patient. In this case, meeting with family can give important information about patients’ habits, preferences with respect to food, hygiene, activities etc. that is essential for the further well-being. Health personnel mentioned that they may call to the families to clarify some details, however they always try to do their best and find alternative ways of communication and call families only in the extraordinary situations:

“We use family members as interpreters quite often, it is true. Sometimes, I am just unable to understand what this patient means. That time I had to call to his wife and she had to explain me what I was supposed to do in this situation. She had to explain me what he had intended to tell”.

**Interpreters**

Most of the respondents said they do not remember the interpreter services have been used at their wards. Moreover, as far as they know their nursing home did not have any budget for the use of interpreters. They remind that they have ethnically diverse team and usually use each other and sometimes family members. Two caregivers came up with examples when they had to seek interpreters’ help. In the first case a patient with non-Western background was moving to another country and the nursing home ordered interpreter to help him with insurance and translation of other papers. The second case is more common and
concerns situations when both patient and his family had very poor language skills. Fortunately, most of the families have fairly normal language skills and therefore they are able to explain what they mean:

“It may happen that they use interpreters when patients’ families do not speak Norwegian and we need to explain in details the disease course and other things relevant to health condition. Then, we can call and order an interpreter. But if we can use relatives, then we do that”.

8.2.2. Communication barriers associated with patient’s health deterioration.

While interviewing caregivers and nurses, I also asked whether the language skills of the patients change as the clinical picture of disease is changing. All of the respondents agreed that as the disease develops, the language abilities are getting worse and worse. They mentioned that such states as stroke, paresis, dementia are most common illnesses that take the speech away:

“There is an old man in our ward, he used to speak Norwegian fairly well, but the disease made him unable to speak clearly, he mumbles and we cannot understand what he says. So in order to understand what he says you must be very patient and listen to what he tries to tell”.

It is well known that special treatment will be needed when the cognitive capacity of elderly immigrants weakens. Such condition as dementia for example, might require special care and treatment which can be given only by long term care institutions. Treatment of the mental health problems among elderly immigrants is very challenging. Firstly, because the research on dementia among immigrants is more difficult due to communication challenges during investigation. Secondly, immigrants who have learnt Norwegian can easily lose this knowledge as a consequence of dementia’s progression. They may experience problems with distinguishing their mother tongue from Norwegian as well. Communication on the patient’s first language will be crucial in order to maintain an optimal level of functioning.

“What I mean is that the communication is a challenge because many of the elderly get so sick that they forget their mother tongue. One of our patients used to speak Urdu, English and his Norwegian was fairly good. But now, as the disease started to progress, his lost all these languages, and the only language he remembers is Urdu”.
That is why it is important that health care workers have the sufficient knowledge and comprehension of disparities, and how one can facilitate health services so that the various needs are met in the equally good and adequate way.

8.3. Challenges due to the patients’ families.

“It is not the patients who are challenging, but their families...”

The second largest challenge according to the respondents’ opinion arises due to the communication with the patients’ family members. Within this category they name such barriers as overestimated expectations from health care services, health illiteracy among quite many families, and their wish to maintain traditions.

8.3.1. Intentions to maintain traditions.

In addition to the communication problems there exists some challenges associated with patients’ families wish to give over their culture, religion and traditions i.e. that the elderly get the same access to the procedures, rituals and orders related thereto while they are in the nursing homes. These traditions concern all aspects of life food habits, religious believes, grooming as well as the routines related to death. When it comes to the challenges related to food habits, religion and personal care they will be described later in the following sections. What I want to emphasize here is that most requirements originate not from the patients directly, but rather from their relatives. Muslim religious rules state that when people get old they are exempt from practices and should devote their life to praying and reading of Koran. In addition, majority of the elderly staying at nursing homes have multiple severe diseases that prevent them from any activities at all. Unfortunately, elderly with complicated diseases often develop depressions and do not enjoy their life any longer. Their clinical picture does not allow them to have the full-valued life and practice their religion as they did before. However, far not all families realize that their father or mother are sick and want to avoid unnecessary activities. From time to time this misunderstanding may result in the conflicts.

Generally, the respondents do not mind the families’ intentions to maintain traditions, especially when it comes to the rituals associated with the death. All of the caregivers with one assent said that it is very important to show respect to foreign traditions and let the relatives to practice their ceremonies when their nearest passed away. They do not consider this as a challenge as long as it does not disturb other people:
“One of our patients from Pakistan was about to die, and then all his relatives came to see him. There were so many people here, we believed the whole district came to our ward. People kept coming all the time. And what we saw is that the visitors spread out their prayer rugs just in the middle of the hall and started praying. Other patients got very frustrated with these rituals, and it looked like they were disturbed and embarrassed at the same time...”

### 8.3.2. Unrealistic expectations from health care.

Several interviewees have expressed their concern over too high expectations with respect to the frames the services have. Many respondents agree that the families of the elderly immigrants have too high requirements and expectations regarding the help they can get. These impressions are confirmed by the research study “Care services with diversity? Mapping of the municipal resources and needs when it comes to facilitation of care services for the elderly with minority background” (2005). This report states that the immigrants very often overestimate the scope of the health services they are granted. Further, this report underlines that the challenge with clarification of the families’ expectations for services are caused by the lack of information and language barriers.

Almost all families expect from health care personnel to help the elderly to follow their routines with respect to ritual purification, personal hygiene and religious shaving etc:

“What I think is difficult is when family members ask us to do this religious shaving. Once, son of one patient asked if we could shave away all possible hair from father’s body. We never do that. We respect these rituals, but we informed family that we shave only the beard, no more than that. But if the family wants, they can do this religious shaving by themselves”.

Another example illustrates the families’ misunderstanding of what health care personnel are responsible for, i.e. the scope of their duties. It also shows that there is the lack of knowledge on how the health care system works and what kind of treatment the elderly patients may expect at the nursing homes. Some families believe the Norwegian health care has no limits and is able to get cured all the sick.

An old man has become bedridden and very weak, but at the same time he was very aggressive as a result of disease. Caregivers complain that it is very difficult to help him with personal hygiene because of his aggression and because he hits personnel. The patients of this kind are usually very aggressive in the morning and it is really very challenging to provide them with any help. That is why before to start morning care, nurses give them medicines which make them quiet and then caregivers can start their work:
“But this family does not want him to take “too much” medicines and they want us to treat him and treat him until he dies”.

Later on this patient became suddenly very sick, so sick that they had to bring him in a hurry to the emergency unit. As soon as his life was in safety, the nurse called to the family to inform about the situation:

“They become very angry at the nurse because she called to the emergency at once, and this guy was hospitalized immediately. The family meant she had to call to them to ask whether they want him to be hospitalized or not. And this case makes me to think over enormous difference in cultures, it is where the challenges lie. The challenges are not related to the elderly, but rather to their families. I believe that the source of a conflict is exactly there”.

The last message this family got from the nurses in hospital is that probably there will be no next hospitalization. They also informed family that their father was very sick and they advised to stop any treatment and bring him back to the nursing home. Later the head of ward had a talk with this family and explained that if he gets the slightest infection, it will be his last one:

“But the family has another opinion, they want him to be treated and treated, while we think that when you see that the patient is at his final stage, a worthy death in this case is more reasonable solution. Then we would plan in other way, we would find the ways how to make his last days as painless as possible, but not to treat him actively. But I do not believe we are going to agree on something. They will expect us to treat him and treat. I think that it is a cultural difference that makes us to think so oppositely”.

The problem of the overestimated expectations from health care services is mentioned in Fafo report “Equitable services? Major cities’ services for ethnically diverse population” (2011). This report states that consumers with few bureaucratic skills may lack familiarity with the services as such, or they may have unrealistic expectations of what the service sectors can provide.

8.3.3. Lack of health literacy.

Newcomers to Norway tend to be unfamiliar with the Norwegian health system. Health professionals report difficulties in communicating effectively with patients’ families. Many of international studies confirm that lack of health literacy among immigrant families is very common. Linguistic, religious and cultural factors contribute to the newcomers’ social isolation (Zanchetta, 2006). These factors influence health literacy of immigrants and lead to the ineffective communications with health care personnel. As one can see from the above-
described case, family was informed about poor health state of their father, and they were advised to switch from active treatment to the palliative therapy, however, the family kept insisting on the active form of treatment. In my opinion such behavior can be explained by absence of knowledge on the disease course as well as the reluctance to listen to the health professionals’ opinions.

Several interviewees had impression that many of the patients’ families do not understand that the sick people might have special nutrition and their diet must correspond to the doctor’s prescriptions. In such cases, the health personnel try to invite families to the meeting where they discuss the heath condition of the concerned person, and where they refer to the diagnosis and doctor’s recommendations:

“In some foreign cultures people are used to eat a lot of sweets, cakes etc. and this can be challenging for us to make families understand that their mother has diabetes and sweets will harm her health. And then these families get surprised and ask why it is, because mother used to eat cakes all the time before she has moved to a nursing home”.

Families are not easy to work with. It takes long time to build up the trustworthy relationship. The respondents specify that all families are different and some of them are very nice and grateful, however the majority is difficult to cooperate with. They wish the relatives had better knowledge of the disease, and then it would be easier to talk to them and avoid misunderstanding. They have too high expectations, but they do not have the knowledge of the disease history. One of the respondents tells that in nursing homes most of the patients have an “after dinner nap”. First of all because they are old people, secondly these people are sick and are unable to be physically active for long time and get tired very fast. So she came up with an example where the family came to visit their father. The patient felt tired and was having a nap after dinner and suddenly his son pulled his father out of a bed and made him to take shower and cut his hair:

“You should not react like this because your father is lying in a bed, you should not think that he did not get his morning care. These families do not believe that old and sick people get tired faster than us, and they need resting”.

One more example gives better insight in the challenges related to the families’ health illiteracy. One of the patients had very often visitors from his family who always came with a lot of food. The health personnel had to talk to the family and limit amount of food they had brought with them:
“In addition, this patient had pharyngeal palsy and diabetes, and his relatives, they were pushing all this food in his mouth. It is very dangerous. If we were sure that he is able to swallow, then it’s ok, but it was not that case. So we had to limit their visits and explained what consequence of their behaviour might be. But they always did the opposite of what we said. We had very difficult relations with this family”.

As said before, a large number of international studies state that the ethnic minority groups very often do not have the necessary health literacy. Most common barriers preventing them from getting this knowledge are access to information, specifically written material. Electronic information helps little for those with language and literacy limitations. Educational resources and approaches only partially reach people from cultural minorities. Linguistic, religious and cultural factors also contribute to the immigrants’ literacy limitation. Multidisciplinary work to enhance health literacy and awareness about health will allow minority groups to develop their comprehension of health issues.

8.4. Challenges related to grooming and hygiene.

Next category of challenges is associated with grooming and personal hygiene. The elderly patients at nursing homes normally get help with grooming in the morning when they wake up and in the evening when they go to bed. Once a week they are offered a shower bath. The challenges related to hygienic procedures occur when the patient denies help because of his religious believes. For example, the most typical obstacle with personal hygiene is when a Muslim male patient refuses to get help from a female caregiver, or when a female patient rejects any help from male caregivers. Such situations may be challenging because it may happen that the male or female caregivers are not available exactly this day. Weekends are the days when permanent caregivers are free and only care assistants are available. And it implies double challenge because the male/female caregivers may be unattainable and matching of the patient with caregiver with similar language background may fail:

“We find it challenging when the male patients do not want to get help from the female caregivers. It is not always that we have male caregivers during the evening shifts. It is really challenging because sometimes we have troubles in terms of denial of help from female caregivers. Very often these patients get very aggressive and even can hit personnel who are supposed to groom them. In the worst case, these patients will not be helped. We are not allowed to force them to get groomed and cleaned, but it is clear that we have to respect if they say no”.

In addition, some requirements with respect to the personal hygiene come from the families, particularly their desire to maintain the traditions typical for their religion. Similarly,
the family members ask health professionals to follow traditions and match female and male caregivers with the elderly patients respectively.

As it was mentioned in previous sections, some of the families expect health care personnel to help the elderly with religious shaving. Caregivers think it is challenging and usually do not agree.

Further, it follows from the interviews that some families want to assist with grooming, hygiene and dressing by themselves. Some relatives come to visit their elderly every day and ask if they could clean and groom their parents’ bodies by themselves. Sometimes, this initiative comes from the elderly too:

“We had a patient before, he insisted on the help from his wife only, he did not want other female caregivers to take care of him. However, he was very heavy and his wife did not manage to help him alone. Then we had to find a solution and we decided that if he feels safe together with her, then she can stay and give him a drink or food, but grooming is our work”.

“Multicultural elderly care” (2005) is a project mapping the elderly immigrants’ preferences and needs living in Norway. This investigation highlights among others the elderly preferences relative to the personal hygiene, particularly their wish to match female caregivers with female patients, the same applies for male.

8.5. Challenges related to religion.

According to the answers provided, a range of challenges are related to the religious rituals and practices. Those of elderly immigrants who practice such religions as Protestantism, Orthodoxy or Catholicism are not considered as challenging since they do not have very strict requirements in terms of religious purification, shaving or frequent praying. In addition, their spiritual needs may be met by the priest available at each nursing home. However, practices related to the Muslim religion are believed to be challenging.

Those of the elderly Muslims who are relatively well may insist on active practicing and thereby bring challenges for health personnel and disturb other patients:

“Once I found a lot of water on the floor in the hall and I was puzzled over what had happened. Later, we realized that this water came from a Pakistani lady who was washing her feet before she started praying. She did it in the middle of the hall. Then, we had to explain her that she ought to do it in her room or in a bathroom...”

“I think it would be a problem if someone wanted to pray, here in a nursing home. They must wash themselves thoroughly...”
The Muslim patients grew up with the culture and traditions where there exists strong segregation between the sexes. Based on these religious rules it is important that routines connected to personal hygiene are performed by the caregivers of the same sex as the patient is. From examples described in the previous sections one can see that the most typical obstacle with personal hygiene occur when a Muslim male patient refuses to get help from a female caregiver. However, a caregiver of a necessary sex may be often unavailable.

Another example of problems with personal hygiene concerns religious shaving of pubic and armpit hair. Health care professionals think this part of sanitary routines is challenging for them.

For a woman to sit next to a man during breakfast or dinner is also frowned. As a consequence, health care personnel have to find a place for an elderly female Muslim only among women. The same rule applies to all social activities.

The older an individual becomes the more considerable meaning the religion acquires. Religion is an inalienable part of the life, culture and traditions of the majority of Muslims. Although the elderly are allowed to be exempt from religious practices and spend the rest of their life in praying, many of them, depending on their physical condition, prefer to follow traditions. Compliance of religious needs plays an important role when it comes to the adjustment of health care services to the individual needs. Thus majority of informants pinpointed that they respect other believes and recognize the significance of other religions, however some particular procedures still bother them:

“We have had a patient here before who used to practice religion that provides presence of the mourners when a person dies. And one day these mourners came to our ward. So I considered it as a challenge because they were too many, and I felt that our ward become a chaos. They were sitting in the hall and making too much noise. And I also felt that other patients become very confused and wondered what was happening. It was pretty challenging for us all, so in future, I believe it will be more difficult because Norway has become an ethnically diverse country, and in ten years there will be even greater challenges”.

Furthermore, the informants also mentioned that the adjustment of health care services to the religious needs of an individual may be difficult because the prayer rooms are not provided in the Norwegian nursing homes. However, health personnel have thought over this issue and they can usually offer small rooms instead of traditional Muslim prayer rooms.

8.6. Challenges related to the food habits.

The next challenge in this section is requirements to food. Meal is an important part of culture and therefore is crucial for quality of life. The elderly staying at nursing homes
whether they came from Africa or Asia want to maintain their traditions in terms of getting the same food as they used to have at home. Due to the religious believes Muslims do not eat pork and all other types of meat they are allowed to eat should be slaughtered in a halal way. The term *halal* is applied to many facets of life; and one of the most common utilization of these terms is in reference to meat products, food contact materials, and pharmaceuticals. Hence, the elderly patients and their families think that preparation and serving of the meal should be adapted for different ethnical groups.

As it was mentioned before the interviews were carried out in two different nursing homes. During the investigation, it became evident that the main difference between these establishments is the number of immigrants and how long they have been working with patients with minority background. There was a large discrepancy in compliance of the needs related to nutrition in these institutions. Nursing home A has got their first minority patients long time ago and has acquired pretty good experience in this area. They claim that now facilitation of meal preparation for different ethnical groups has become much better, especially for those who prefer halal meat. They have become very good at arranging certain type of food for the ethnical minorities, both for dinner and breakfast. There is a big communal kitchen which prepares and sends the food out to several nursing homes in Oslo. So they do not have any personal kitchen that belongs to their institution. They receive ready-made dinner in plastic bags then they warm it up and serve to the patients. All the bags with halal food have special labels on them, so if there are some patients who eat only this type of meat, they can check it in the card-index. And patients, they trust them generally. The informants mention that it is difficult to see if the patients who unable to speak like this food or not, but you can see it from whether they have eaten up or not:

> “We also use families to collect information on preferences what kind of food their elderly like etc. We do our best to order what they like. Two of our patients do not eat pork and consequently they do not get anything containing this stuff, desserts with gelatine for example. They have a special diet”.

Moreover, in order to attain best possible adjustment of health care services to the individual needs with respect to food preferences one of the caregivers was offered to attended a special course in food cultures in the different part of the world.

Nursing home B has not got so many minority patients as nursing home A and has relatively little experience. The informants from this institution consider facilitation of meal preparation for various ethnical groups as challenging. As they explain it is mostly because
the patients do not trust the cook. The respondents confirm that they do not serve halal meat and therefore patients have to eat fish or food brought by their families:

“We had a Muslim man, he denied any food whether it was halal or not. He said he could not trust us and was eating only fish and pasta. In addition his family said they did not want him to get any meat or chicken, they were sure that an animal had not been slaughtered in a halal way. So they kept bringing food with them all the time”.

Another explanation for absence of the halal food may be its unprofitability:

“Two years ago one family came to me and asked to find out if our kitchen personnel can serve the halal food. Then I came to the chief cook and asked, and he answered that the halal food had been served here before. But those patients who got this food, they did not trust us. So there was mistrust from patients, and serving of the halal food was stopped and we still do not order it. In addition, exactly now there are around two patients who need this type of food, and I also think that administration of the nursing home probably find it unprofitable”.

They also mention that it is possible to arrange delivery of the food without pork, or food slaughtered in a right way, but the patients and their families will stay sceptical any way.

9. DISCUSSION AND CONCLUSIONS

9.1. Study limitations.

In any research study the findings revealed during analysis may have a range of limitations. This study aims to answer what challenges health personnel at nursing homes face while seeking to provide equitable health care services for the elderly immigrants. It also discusses to what extent the principle of unequal treatment for those with unequal needs is fulfilled. The results of this thesis may be limited by several factors.

As it has been mention in methodological section, Kvale (2007) stated that the use of a qualitative analysis only measures perceptions and experiences of participants and cannot be generalized to a larger population.

As it has been mention in methodological section, Kvale (2007) stated that the use of a qualitative analysis only measures perceptions and experiences of participants and cannot be generalized to a larger population.

In addition, there were only eight respondents, this number is not very large and may therefore only represent the experiences and perceptions of those parts of the study during the interviews. A larger sample size may give more comprehensive and richer challenges description within this analysis. At the same time a larger sample could contradict to the challenges revealed.
Further, the informants were those that accepted the invitation to take part in the interviews and share their experiences and perceptions of the topics for the interviews. The extent to which the participants’ reports are representative of all health care professionals, nurses and caregivers part of study is not known.

9.2. Discussion of the study results.

The discussion of the empirical findings presented here is based on the informants’ understanding of equity, i.e. how they interpret the concept of equity in health care.

The findings of this paper have shown that none of the respondents know the true definition of equity in health care. Many of them interpret this notion as respect, kindness and attention. When defining the equitable health care several respondents used an expression “to allot time” thus implying that it takes time to assist the elderly immigrants. The interviewed health professionals understand equity in health care rather as the adjustment of care services to the patients’ individual needs and therefore, for them the challenges related to the adaption to individual needs are the challenges associated with attaining equity in health care.

Generally, few respondents said that they associate long term care for the aged immigrants with enormous challenges, they rather mention that they are experiencing challenges to some extent. The informants indicated that to provide patients with the adequate and proper care that maintains the individuals’ dignity and takes into consideration their needs is not easy due to a number of obstacles.

A thorough analysis of the information collected during the interviews revealed the challenges related to communication, language barriers particularly, cooperation with patients’ families, intentions to maintain traditions, overestimated expectations from health care, lack of health literacy, challenges related to the grooming and hygiene, religion and food habits. According to the informants, it takes more time to assist patients with ethnic minority background than their Norwegian counterparts. Generally, the information about challenges given by the nurses and caregivers was to a higher degree similar.

Of all the above-mentioned challenges language barriers, cooperation with patients’ families, unrealistic expectations as well as the intentions to maintain traditions seem to be most crucial for the health professionals and considered as the main obstacles. The significance of other barriers associated with hygiene, food or religions are not diminished, but they are rather results of the main obstacles. Interrelation of all these barriers is evident. Thus, the intention to carry on traditions will be tightly connected with such aspects as
religion, hygiene and food habits. For example, if a Muslim patient will insist on maintenance of his traditions he will necessarily ask about a male caregiver to assist him as well as the food without pork and halal meat.

However, communication problems and cooperation with the families remain the issues number one. Deficient language skills among elderly and very often among their relatives prevent health personnel from successful facilitation of the long term services. The elderly patients have different background and therefore, knowledge of Norwegian varies very much. This obstacle should not be underestimated since the number of the elderly immigrants will increase in the forthcoming years. Most vulnerable groups will be the first generation immigrants and minority housewives from Africa and Asia. These conclusions are supported by the earlier conducted studies reflected in “Care services with diversity? Mapping of the municipal resources and needs when it comes to facilitation of care services for the elderly with minority background” (2005), ”Elderly immigrants and their use of nursing and care services. Report from five Norwegian municipalities” (2008) and report “Equitable services? Major cities’ services for ethnically diverse population” (2011). The studies confirm that the above-described challenges are true and they mostly concern elderly and women with minority background.

As it was mentioned in the methodological section, the interviews were conducted with representatives of both somatic and psychiatric wards. While doing analysis I expected that obstacles would differ very much, especially when it comes to the communication. But, it turned out that there is no difference in terms of communication in these two wards. However, the respondents from both wards agreed that communication barriers become harder as the clinical picture of disease is getting worse. Although the communication challenges are approximately on the same level in somatic and psychiatric wards, language skills and communication have considerable significance when it comes to treatment of mental disorders.

To overcome language barriers, the ward leaders hire multilingual personnel so that it would be possible to match them with the elderly patients speaking the same foreign language. Further, use of the family members is also a common way of communication with the patients.

Another substantial challenge is the problematic cooperation with families. As it follows from the interviews, intention to maintain traditions, unrealistic expectations from health care and lack of health literacy is the next obstacle on the health professionals’ way to facilitation
of care services. Report “Equitable services? Major cities’ services for ethnically diverse population” (2011) points out that the correct expectations of what services should be able to provide may be due to the consumers’ low bureaucratic skills or lack of knowledge about services at all.

The next typical obstacle is the intention to maintain the religious tradition which in its turn is related to the personal hygiene and food habits. E.g. a Muslim patient will always deny any help related to grooming from a caregiver of the opposite sex. Normally, such situations are solved by matching of the patient with a caregiver of the same sex. When it comes to the facilitation of the meal preparation for different ethnical groups it has become much better. Some wards have become very good at arranging certain types of food for ethnical minorities.

Some of the informants, however, expressed their concern about the fact that elderly patients do not have the same access to the social events as the majority patients. They eagerly attend gym and swimming pool, but when it comes to the common activities like movies, trips to museum and other social events, they hardly participate there. This is partly due to the language barriers and to some extent due to the formal character of traditional Norwegian events.

The majority of the respondents mentioned they wish they had a better cross-cultural understanding and cultural competence. Those of the caregivers who have recently finished their education in caregiving highlighted that they were offered a subject devoted to a cross-cultural understanding and cultural competence in healthcare. Course in a cross-cultural understanding has appeared a few years ago, so those who graduated a long time ago did not have this opportunity. All the respondents expressed their concern about lack of course or training that would give health professionals the knowledge of how to work with people of different cultures. Cultural competence is important in every aspect of the public lives, but it is a crucial skill for health care personnel. It is essential to overcome cultural barriers between patients and health providers in order to ensure effective healthcare delivery and medical compliance. When misunderstood, cultural differences can adversely affect communication between the care personnel and patient, thereby adversely affecting healthcare outcomes. Therefore, it is important that the health professionals could have an adequate training in cross-cultural understanding since cultural competence is a crucial means for attaining patient satisfaction, patient safety, and improved health outcomes.
9.3. To what extent equity principles are fulfilled?

This master thesis has sought to investigate the challenges the health professionals face while seeking to provide equitable health care services for the elderly immigrants.

The interviewed health professionals understand equity in health care rather as the adjustment of care services to the patients’ individual needs and therefore the challenges they mentioned they associate with the adaption to individual needs.

The demand to adjust health care with respect to the individual needs is based on the principles of distributive justice. The Norwegian equity policy requires that care services take into account that people are different and have different needs and that more resources should be allocated for those with more needs. The situation where those with unequal needs receive unequal treatment is known as the principle of vertical equity. A deviation from this principle has an implication on the distribution of health care in a system.

Further, the present study has unveiled a range of challenges such as communication barriers, unrealistic expectations from health care, lack of health literacy etc. These challenges may bring various implications and negatively affect the equity principles and thereby prevent health care service from fair distribution and being equitable.

As it comes from the interviews with health professionals, the challenges related to the individual adjustment of care service are very often associated with the higher time consumption. Hence, the distribution of the time among minority and Norwegian patients may be uneven and therefore unfair and inequitable. Caregivers may spend more time with the minority patients who have worse health state and do not have Norwegian skills, and thereby less time will remain for the majority patients. Though this situation perfectly meets the vertical equity requirements - individuals with unequal needs for health care receive unequal treatment - it is obvious that the situation of the ethnical majority is worse-off, since they might get less attention and help.

The similar situation, but projected into the distribution of financial resources may be considered as inequitable. The distribution of resources among minority and Norwegian patients due to the greater needs of the former may be uneven and therefore unfair and inequitable. Here, the aged minorities attract more resources, while the general population gets less, however the situation is in accordance with vertical equity requirements, but the fact of unfairness stares in the face.
Underuse of long term care

The elderly with ethnic minority background are generally underrepresented at nursing homes. Usually, people with poor health tend to use health care more often than those with good health. The investigation of living conditions among immigrants conducted by Statistics Norway in 2005-2006 showed that the respondents reported bad health conditions more often than the Norwegians. A logical way of thinking requires the elderly immigrants, who reported bad health state, to use health care more often than their Norwegian counterparts. However, the empirical findings show that the elderly immigrants are underrepresented in long term care. This finding may be a sign of the situation where people with equal need make unequal use of health care, known also as horizontal inequity.

A general underuse of long term care by the elderly immigrants may be explained by several factors. First, In Norway at the beginning of the year 2010 there was only 1.2% elderly people over 67 years belonging to the group Asia, Africa (SSB, 2011). Such low numbers make elderly non-Western immigrants invisible for the health care.

Another explanation is that the elderly are not aware of the available care services. Those who have been living in Norway for a long time usually have good knowledge of how health care is organized. It is not known how the elderly get health care offers as well as the knowledge about available care services. Yet, the respondents informed that most of the immigrant families learn about nursing homes through the home-based care services. General practitioner was also mentioned in connection with referring a patient to a nursing home.

Next possible cause is that the families from non-Western countries prefer to take care of their elderly by themselves, they avoid sending their parents to nursing home and instead choose the home-based care services. This tradition may partly justify the underuse of long term care.

The fact that the elderly patients with ethnic minority background are generally underrepresented at long term care may be also an echo of the deficient bureaucratic skills. Bureaucratic skills are tightly connected with the length of stay in the country, degree of integration into Norwegian society and education.

In addition, the underuse of nursing homes among elderly immigrants might be result of the improper work of health care institutions and health care authorities particularly. Information about available care services disseminated orally or published in the languages of different ethnical groups may be deficient.
Individual adjustment of care services

Except from providing equal access, quality and equal health outcomes for those with equal needs, health care service is also supposed to take into account that people are different, so those with unequal needs should be provided with unequal treatment. It implies that health care services must meet the requirement of vertical equity and should be adapted to individual needs not only in terms of medication and treatment, but also take into consideration cultural and religious background as well as the language abilities of the patients.

An important finding is that the long term institutions in Oslo have different experiences with patients with minority background. Study results indicate that facilitation of care services does not run smoothly. The interviews were carried out at two municipal nursing homes, the difference between them was the number of elderly immigrants and the length of their working experience with such patient groups. From interviews with the informants it became evident that there is a substantial discrepancy in to what extent the care services are adapted to the individual’s needs. The nursing home having a longer experience with ethnically diverse patients has succeeded to meet most of individuals’ needs. For example, health care personnel have composed a “communication book” where they can find most necessary phrases for communication with minority patients. They have also thought about patients’ food preferences and ordered halal food for breakfast and dinner for their Muslim patients. Compared to this success history, another nursing home with relatively little experience did not manage to solve communication problems neither meet patients’ food preferences. So, the degree to which nursing homes have succeeded in facilitating of care services differs.

Awareness of the individual adjustment of services is generally large. These requirements are recognized and accepted by most health professionals. Moreover, as it became clear from the interviews, the respondents believe that the equity in health care is the adjustment to individual needs itself. They mention that had they become a patient one day, they would appreciate their individual needs to be satisfied too.

The empirical findings point out that there is a wide span in how the adaption of health care to the individual needs is going. Such discrepancy to some extent can be justified by the lack of experience and the fact that the number of the aged immigrants in nursing homes is extremely low and therefore, the health professionals did not have an opportunity to learn about individual adjustment sufficiently. On the other hand, the uneven individually adjusted care also can be a result of how the administration of nursing homes prioritizes, in other words how far the administration is willing to go and how many resources it is willing to spend in order to meet the patients’ needs.
Though having spent much time at studying literature on equity issues as well as the guidelines, regulations and white-papers, some questions have still remained unclear and unanswered. People are different and thus their needs may vary enormously. So the question is how large the frames defining limits to the individual preferences should be. What threshold for measuring the individual needs should be used? At the same time, the size of the expenses connected to the individual adjustment seems to be unclear and not regulated.

As mentioned above the empirical findings have shown that there is a wide span in implementation of the equity policy. Unfortunately, the scope of this study does not allow concluding precisely whether the long term care attains the equity objective or not. The underuse of the long term care among the aged immigrants as well as uneven individual adjustment of services imply unequal distribution of health care and may indicate the presence of the horizontal and vertical inequities respectively.

In the case of underuse of health care, the conclusion was drawn based on the empirical findings as well as the investigation conducted by Statistics Norway six years ago. This finding may be a sign of the horizontal inequity, but on the other hand, it can be explained by the difference in cultural traditions and families’ intention to take care of the elderly by themselves.

In the second case, only two municipal nursing homes were participating in the investigation and the study sample including only two institutions can hardly be generalized to the entire population. Thus, the gap in the individual adjustment between these places may be explained not only by the vertical inequity, but also by a small sample size.

9.4. Recommendations for the further research.

During the interviews several respondents mentioned that except their work at nursing home, many of them have experience from the home-based care services. Among others their patients were the elderly immigrants living at home together with their families who are supposed to take care of them. It is known from the reports that those who first contact the home-based care services are very sick and need help urgently. According to the respondents’ observations the elderly patients do not get appropriate assistance from their relatives. Very often the relatives do not want to burden themselves with help and put off helping until the last minute because they wait for caregivers to come and assist the elderly. Thus, it might be interesting and useful to learn how families with immigrant background understand the appropriate care, and whether they actually provide it.
Last, but not least it would be interesting to get better insight into “bureaucratic skills” of the ethnic minority families. Bureaucratic skills involve knowledge of the Norwegian society, welfare state system, organisation of public sector and so on. One of the challenges reported in this study is related to the unrealistic expectations from health care services. Wrong expectations of what services should be able to provide may be due to the consumers’ low bureaucratic skills or lack of knowledge about services at all. Length of stay in the country, education, country background, degree of integration into Norwegian society are factors that affect the individuals’ premises to understand how health care system operates.

Health care services struggle to meet individual needs and as we have seen some requirements are easier to satisfy than others. In the light of the reported findings, a further research directed to unveiling preferences of the elderly health care consumers might be necessary. As it has been mentioned before all people are different and therefore the requirements are different too. Unfolding preferences and defining their scope will allow attaining the right balance in matching of individual preferences with the feasible possibilities of health care.
10. REFERENCES


11. APPENDIX

APPENDIX I: Permissions from the Norwegian Science Data Services (NSD)

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Trond Tjerbo
Avdeling for helseledelse og helseøkonomi
Institutt for helse og samfunn
Universitetet i Oslo
Postboks 1089 Blindern
0317 OSLO

Vår dato: 19.02.2012
Vår ref: 29785 / 3 / LMR
Deres dato:
Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 10.02.2012. Meldingen gjelder prosjektet:

29785 Hvilke utfordringer står helsepersonell på sykehus sammen sett fra sjukehusets sikt
likeværdige helsepersonell for eldre innvandrere

Behandlingsansvarlig: Universitetet i Oslo, ved institusjonens øverste leder

Daglig ansvarlig: Trond Tjerbo

Student: Olena Ponomarina

Etter gjennomgang av opplysningene gitt i meldeskjemaet og øvrig dokumentasjon, finner vi at prosjektet ikke medfører merkeplikt eller konsekvensplikt etter personopplysninglovens §§ 31 og 33.


 Vedlagt følger vår begrunnelse for hvorfor prosjektet ikke er meldepliktig.

Vennlig hilsen

Vigdis Nøtvedt Kvalheim

Kontaktperson: Linn-Merethe Rød tlf: 55 38 89 11

VEDLEGG: Prosjektvurdering

Kopi: Olena Ponomarina, Olav M. Troviks vei 48, H0406, 0864 OSLO
APPENDIX II: Permission from the Agency for nursing home services in Oslo municipality

Oslo kommune
Sykehjemsetaten
Administrasjonen

Olena Ponařina
olena.ponařina@studmed.uio.no

Dater: 22.03.2012

Tillatelse i forbindelse med forskningsprosjekt på sykehjem, og

Viser til søknad mottatt pr. e-post 08.03.12. Du søker om tillatelse til å foreta en kvalitativ undersøkelse i forbindelse med din masteroppgave. Prosjektet heter "Likeverdigehelsetjenester for eldre innvandrere" og handler om utfordringer som helsepersonell på sykehjem står overfor når de skal yte likeverdige tjenester for eldre innvandrere.

Sykehjemsetaten vil med dette gi deg tillatelse til å foreta forskningsintervjuer med sykepleiere, hjelpere og assistenter på sykehjem, sykehjem, og

Du bør om å ta kontakt med institusjonssjef ved disse sykehjemmene for å gjøre avtale om tid og sted for intervjuene.

Venlig hilsen
Sør Førts
Områdedirektør I

Anne Berger Sørl
Områdedirektør II

Kopi:

Sykehjemsetaten
Administrasjonen
Besøksadresse: Nedre Slotsg. 3
Postadresse: Postboks 435, Sentrum
0103 Oslo
Internett: www.oslo.kommune.no
E-post: postnothkr@syv.oslo.kommune.no
Telefon: 0210
Telefaks: 23 43 30 09
Bankkonto: 6034.06.50219
Org.nr.: 990812498
APPENDIX III: Request for participation in the research

Forespørsel om deltakelse i forskningsprosjektet

"Likeverdige helsetjenester for eldre innvandrere"
Oslo, 2012

Jeg heter Lena Ponarina, jeg er en masterstudent ved Institutt for Helseledelse og Helseøkonomi, ved Universitetet i Oslo. Jeg er i gang med en kvalitativ undersøkelse i forbindelse med masteroppgaven. Oppgaven handler om utfordringer som helsepersonell på sykehjem står overfor når de skal yte likeverdige helsetjenester for eldre innvandrere. I den forbindelse vil jeg se på hvilke eventuelle barrierer og hindringer helsepersonell opplever mot å yte likeverdig helsetjenester som innebærer like god kvalitet, tilgjengelighet, og individuell tilpasning av tjenestene.


Konfidensialt: Informanten, samt arbeidssted er anonym. Ingen av overordnete, veiledere, medarbeidere eller andre personer vil få tilgang på hvilken informant som har svart hva, de vil kun få tilgang til de endelige resultatene av prosjektet og den endelige rapporten. Intervjuene vil ikke bli publisert i sin helhet. Jeg vil kun trekke ut deler av intervjuene i rapporten, uten referanse til informant eller arbeidssted. Opptak av intervjuene vil være tilgjengelig kun for meg mens prosjektet pågår. All informasjon vil behandles konfidensielt og ikke kunne føres tilbake til konkrete enkeltpersoner.


Tilbakemelding til informanter: Informanten vil få tilbakemelding på min oppfatning av hovedtrekk fra intervjuet, slik at det er mulig å gi tilbakemelding på om jeg har oppfattet rett.

Samtykke: Dersom du samtykker til å delta på intervjuet under disse retningslinjene ønskes det at du sender meg en mail eller ringer for å bekrefte dette før jeg utfører intervjuet. Om du har noen spørsmål eller noe du vil klargjøre før du gir ditt samtykke er jeg glad om du tar kontakt med meg eller en av mine veiledere.

Skulle du ønske nærmere opplysninger om masteroppgave, kan du ta kontakt med min hovedveileder, seniorforsker Anne Sigfrid Grønseth ved Nasjonal Kompetanseenhet for Minoritetshelse, Oslo Universitetssykehus, på tlf. __________, e-post: __________ eller min biveileder Trond Tjerbo ved Institutt for Helseledelse og Helseøkonomi på tlf. __________, e-post:

Med vennlig hilsen,

Lena Ponarina

Telefon:
E-post:
APPENDIX IV: Interview guide

INTERVJUGUIDE

1. Hva legger du i begrepene ”likeverd”, ”likeverdige helsetjenester”?
2. Brukes disse begrepene på deres arbeidsplass?
3. Kan dere beskrive dagens situasjon i forhold til arbeid med eldre innvandrere på din arbeidsplass?
4. Fortell om din egen erfaring med eldre innvandrere. Hvilke utfordringer har du?
5. Har du utfordringer knyttet til de individuelle behovene pasientene med innvandrerbakgrunn har?
6. Hvordan tilpasser dere tjenestene for å møte pasientenes individuelle behov?
7. Hvilke forhold og hvordan kan forbedres?