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ABSTRACT Increase and diversification of the migrant population can have significant implications for the Norwegian Health Plan’s commitment towards equitable access. Despite the generous nature of the welfare state in Norway and emphasis on culturally sensitive care, it is important to consider the various impediments that some migrants may experience in accessing and consuming healthcare services. We conducted a scoping review aimed to shed light on the extent of healthcare utilization and the socioeconomics barriers experienced by migrants. Our review illustrates that migrants’ overall consumption of different forms of healthcare services is lower than that of the general population but varies between different migrant groups. Financial affordability has been found to influence use of services that more or less fall out of the publicly covered healthcare benefits, such as dental care, physiotherapy and private specialists’ care. However, there is lack of information on how affordability influences use of primary healthcare, somatic specialist care, nursing homes and mental healthcare. While there is evidence of socioeconomic barriers at the patient level for utilization of primary healthcare services, including both pre-migration aspects and factors in the host country, the question of affordability often becomes subordinate in the context of the welfare state. Our review suggests further examination of pro-rich inequity in healthcare services, given the rising income inequality in Norway, and with migrants usually having lower incomes than the rest of the population. Furthermore, research needs to take into account different groups of migrants such as undocumented refugees, migrants awaiting residency and labour migrants in order to examine barriers encountered both in everyday experiences as well as structural barriers to healthcare consumption.

KEYWORDS: migrant | healthcare | consumption | barriers | access | Norway

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4.1 INTRODUCTION

As a consequence of global migration, the Norwegian population has become increasingly multicultural (Ruud, Aga, Natvig, & Hjortdahl, 2015). Migrants in Norway are heterogeneous in many respects; they vary in reasons for migration, cultural, ethnic and socio-economic background, education, as well as length of stay in Norway (Diaz, Kumar, & Engedal, 2015). Studies show that migrants are at a higher risk for health issues for a number of reasons (Rechel, Mladovsky, Ingleby, Mackenbach, & McKee, 2013), and several factors influence their utilization of health services. Of importance are the expectations based on earlier experiences from their country of origin as well as lack of culturally sensitive health services and negative experiences with these services in the resettlement country (Kalich, Heinemann, & Ghahari, 2016). Depending on the nature and extent of health insurance coverage in a country, financial aspects may also hinder access to healthcare (Scheppers, van Dongen, Dekker, Geertzen, & Dekker, 2006). These features may undermine migrants’ consumption of the health care services. The term ‘healthy migrant effect’ is often used to describe how migrants who succeed in reaching their destinations will generally be the healthiest. Nevertheless, some studies suggest an ‘exhausted migrant effect,’ which is in line with the social and economic inequalities that have been shown to play a large role in the declining health profile of populations, both in Norway and internationally (Dahl, Bergli, & Wel, 2014; Marmot & Wilkinson, 2006; Rognerud, Naess, & Strand, 2007). This way, ethnicity and socioeconomic status may intertwine with and influence the process of migration and healthcare consumption.

A defining facet of the Scandinavian public policies is the extensive and universal coverage of public goods and services (Esping-Andersen, 1990). Hence, healthcare is predominantly state-funded in Norway. Public sources account for over 85% of total health expenditure, mostly comprising financing from the central and local governments and from the National Insurance Scheme (NIS) (around 12% of total health expenditure). Services are available to all citizens and residents, covering regular medical consultations (subject to a small fee), emergency treatment and hospitalization. Regional boards are responsible for management of hospitals and the municipalities for community-based health care (Haarman, 2018). While hospitals are mainly responsible for acute and specialized health care services, the municipalities provide health care suitable for early identification and follow-up of somatic and mental health (Helsedirektoratet, 2009, 2015). The vast majority of the 15% of health expenditure that is privately financed comes from households’ out-of-pocket payments. Moreover, various mechanisms, such as exemptions and ceilings on out-of-pocket payments, limit
the financial burden of care on individuals. However, the level of protection is much lower for certain types of care such as dental care (Ringard, Sagan, Saunes, & Lindahl, 2014).

The Norwegian authority’s ambition is that public services should contribute to the levelling of social and economic differences, and that all citizens should be offered equal quality health care services (Helse og omsorgsdepartementet, 2013b). At the same time, developing accessible, appropriate, and effective services for the migrant population poses a challenge for health care systems in host countries (Czapka & Sagbakken, 2016). Knowing more about the factors that influence migrants’ use of health care services can help aid health care delivery and policy planning. In view of the increasing proportion of migrants and refugees, health planners need to consider how migration influences demand for health care services (Elstad, 2016).

The objective of this chapter is to explore how and to what extent the migrant population in Norway uses healthcare services. Based on a scoping review of the literature on health access and barriers, we explore features of health care utilization for the migrant population in Norway.

First, we assess whether or how the migrant population’s use of healthcare differs from the majority population in the area of primary healthcare, specialist somatic healthcare and mental healthcare. We then discuss how migrants’ current pattern of healthcare consumption is compatible with the expected increase of an aging migrant population with health deterioration, and rising income inequality in Norway.

4.2 METHODOLOGY

To explore the consumption of health care services among the migrant population in Norway, we conducted a scoping review. According to Arksey and O’Malley (2005), a scoping review focuses on mapping out a topic based on a research question and relies on different study designs. The emphasis in scoping reviews is the inclusion of studies on the merits of relevance and is less likely to exclude studies only on the basis of relatively lower quality. This research method gives a rapid and descriptive review of a research field where it is difficult to anticipate the range of the material available. The method entails a comprehensive search for primary studies and reviews from different sources, including electronic databases, reference lists and handsearching of key journals (Arksey & O’Malley, 2005). Thus, a comprehensive scoping review of published academic articles and grey literature was conducted to answer the following questions:
a. How and to what extent do immigrants use healthcare services in Norway?
b. What are the barriers and facilitators for using healthcare services?

We conducted the review in Medline, Cinhal and Embase, Psych Info, SocIndex, Norart and Svemed using combinations of keywords obtained from our research questions.

The keywords were as follows (with MESH headings): (MH ‘Transients and Migrants’) OR (MH ‘Emigration and Immigration’) OR ‘migrant or immigrant’ OR (MH ‘Ethnic Groups’) OR ‘or ethnic minorit* AND (MH ‘Primary Health Care’) OR (MH ‘Health Services Needs and Demand’) OR (MH ‘Health Care Delivery’) OR (MH ‘Health Services Accessibility’) OR (MH ‘Healthcare Disparities’) OR (MH ‘Secondary Health Care’) OR (MH ‘Emergency Care’) OR (MH ‘Community Health Nursing’) OR (MH ‘Community Health Services’) OR (MH ‘Hospitals, Community’) OR (MH ‘Nursing Homes’) OR ‘Consumption or use or usage or utilization or primary care or community care or home care or nursing care or nursing home or hospital or healthcare or health care or access or barrier or facilitator’ AND Norway.

The database search was done in February-March 2018. To obtain most of the relevant sources, we did not exclude the search based on language, timeframe or methodology. After the first screening of article titles and abstracts, we shortlisted 72 studies. We utilized additional grey literature based on reference lists and the search included journal articles and scientific reports.

4.3 RESULTS

In Norway, statistics on the utilization or consumption of health care services are obtained according to some of the characteristics of the population, such as sex, age, state of health, education and income. Ethnicity or country background is not registered in official statistics (Lunde, Otnes, & Ramm, 2017). Many of the studies and reports we have tracked have analysed healthcare consumption among the migrant population by conducting separate inquiries or by connecting various official registers. Nonetheless, a growing body of literature suggests that migrants’ patterns of health care utilization differ to that of natives (Straiton, Reneflot, & Diaz, 2014). Health data from Statistics Norway’s living conditions survey show that migrants evaluate their health more negatively with increasing age than other populations, and generally report poorer health (Blom, 2016). Such diverging patterns of healthcare utilization might have to do with poor income development and necessitate a closer investigation of access to and consumption
of different parts of the healthcare services, such as the primary health care, the
specialist care, and mental healthcare.

4.3.1 PRIMARY HEALTHCARE

Primary healthcare (PHC) includes general practitioner (GP) and emergency pri-
mary care (EPC) services, which are the only ways of access to secondary care ser-
vices and hospital admissions. Only very acute diseases, such as heart attack, are
directly admitted at the hospital without a previous consultation at the EPC (Diaz
& Kumar, 2014). In 2001, the Regular General Practitioner (RGP) scheme was
implemented. Except for emergencies, the scheme requires patients to access the
health system through their assigned GP. In the RGP scheme, the GP provides pri-
mary medical care and is gatekeeper to secondary care, and coordinates various
health and social services (Goth, Berg, & Akman, 2010). Obtaining information
about migrant’s use of PHC is important because this part of healthcare is the first
level of care where people present their health complaints and where the majority
of health needs are satisfied (Diaz & Kumar, 2014; Diaz et al., 2015). Diaz and
Kumar (2014) conducted a registry-based study of migrants’ use of PHC using
merged data from the National Population Register and the Norwegian Health
Economics Administration database in 2008. Migrants in general have been found
to use PHC less than Norwegians. Overall utilization of PHC has been found to be
positively associated with length of stay and to vary with reason for migration.
Rates are typically higher for refugees but lower for labour migrants as compared
to those migrating for family reunification (Diaz & Kumar, 2014). The study found
that although migrants from high-income countries presented a similar number of
diagnoses when in contact with PHC, they used PHC less than Norwegians did.
Among migrants from other income countries, however, those 50 to 65 years old
used PHC services more often than Norwegians used them and had higher comor-
bidity levels. This pattern was reversed for older adults and indicated lesser use of
PHC. For all immigrants, utilization of PHC increased with longer stay in Norway.
It is worth noting that the longer immigrants live in Norway, the more they tend to
earn (Sandnes, 2017). Although Diaz and Kumar (2014) found that socioeconomic
variables did not completely explain disparities in utilization of services, there
were substantial differences between migrants depending on the wealth of their
country of origin. In addition, the inclusion of income and education levels in the
analyses contributed to a decrease in differences in utilization between migrants
and Norwegians. Thus, their results point to socioeconomic barriers at the patient
level, including both pre-migration aspects and factors at the host country.
Except for labour migrants with contracts shorter than six months and migrants without a legal residency permit, everyone in Norway, including migrants, is entitled to the RGP scheme. Refugees are served by a GP at the refugee centre. The situation is however different for undocumented migrants and migrants awaiting their residency. Undocumented migrants in Norway have limited access to health services and, with a few exceptions, their entitlement is restricted to emergency healthcare. According to Norwegian regulations, migrants with no legal residence permit are only entitled to receive ‘immediate medical assistance if intervention cannot wait without risk of imminent death, permanent severe disability, serious injury or acute pain’.

Some groups, such as children and pregnant women, have access to services beyond this minimum (Ringard et al., 2014).

Nursing homes constitute an essential part of PHC, but due to the proportion of older migrants in the Nordic countries still being low, relatively few use them (Pleijert, Jansson, & Yazdanpanah, 2014; Sagbakken, Spilker, & Ingebretsen, 2018). Long-term institutional care for older or disabled people requires high cost-sharing and co-payment levels are income tested (Ringard et al., 2014). Although it is difficult to estimate the future use of nursing homes and home healthcare services, some studies suggest that Norwegian municipalities need to prepare for increased demand for care services from elderly migrants (Helse og omsorgsdepartementet, 2013b; Ingebretsen, 2011; Nergård, 2009). Furthermore, a report from 2008 on migrants’ use of care services reveals that, compared to the entire older population, only 2.5 percent receives practical assistance and 3 percent home healthcare. Those with the longest stay in Norway used the service more frequently and came from Pakistan, Iran, Vietnam and Morocco (Nergård, 2008). This could be due to greater affordability as the longer immigrants live in Norway, the more they tend to earn, according to (Sandnes, 2017). However, there is lack of research on financial affordability for this type of care.

Of particular importance within the PHC is the use of dental care services. Although universal coverage and public financing is very high in Norway, dental care is an exception and private participation in cost is high (Ringard et al., 2014). Migrants’ visits to the dentist are higher among migrants from Poland, 80 percent, while migrants from Eritrea and Somalia show lower rates, less than 50 percent. The latter are refugee groups with short residence time and low employment rates (Blom, 2016), and the groups with two of the lowest median incomes in Norway (Sandnes, 2017). This is compatible with findings that show the importance of having high income in order to afford more use of PHC services such as dental care or physiotherapy (Lunde et al., 2017).
4.3.2 SPECIALIST SOMATIC HEALTHCARE

The use of specialist healthcare is another issue that might give a more complete picture of the healthcare utilization of migrants. Elstad (2015) has conducted a survey on the use of hospitals and specialist healthcare services among Norwegians and migrants in the period of 2008–2011. Overall, the migrant population in total had a lower use of somatic hospitals and mental health services than their proportion in the entire population. However, there was variation in consumption among different migrant groups. It appears that Pakistani men and women, but also men from Sri Lanka, had a higher consumption of specialist health services. This was especially true for cardiovascular disorders and endocrine disorders, such as diabetes. Somali women had also a relatively higher consumption, mostly related to conditions of birth and pregnancy. On the other hand, migrants from Vietnam had the lowest amount of admissions and less than native Norwegians. Since specialist healthcare is fully state-funded, differences in individual financial issues will mainly appear in the use of private clinics and medical specialists. It has been found that for use of private specialists’ care and the use of outpatient services, there exists an inverse socioeconomic gradient in Norway. This indicates that given the same medical need the use is higher among the better off (Finnvold, 2009). However, although there is a rise in demand for private specialist healthcare, the market for such services is still quite limited compared to public healthcare (Facto, 2017). When it comes to migrants, there seems to be a paucity of research on their consumption of services from privately funded healthcare.

4.3.3 MENTAL HEALTHCARE

Blom (2016) reports that a larger proportion of migrants report mental health problems compared to the entire population, but few visit psychologists or psychiatrists. Migrants from Iran were those of the country groups most in contact with psychologists or psychiatrists (14 percent), while migrants from Eritrea had the least share of contact (4 percent) (Blom, 2016). Straiton et al. (2014) also found that except from Iraqi men, all migrants groups had lower consultation rates for mental health problems at PHC than their Norwegian counterparts. In addition, a study by Abebe, Lien, and Elstad (2017) examined the use of specialist mental healthcare services among ethnic Norwegians and specific migrant groups. Their results showed that migrant children and adolescents had significantly lower use of specialist mental healthcare than Norwegians of the same age did. However, a distinct exception was the high utilization rate among children and youth from Iran. This particular finding is interesting in a generational aspect, considering the studies of
Elstad et al. (2015) and Blom (2016) indicating that adult Iranian women and men had a relatively higher proportion of psychiatric health care services. Similarly, studies on Filipina women, the biggest group of migrant women from outside EU, have shown that they are far less likely to have had a primary care consultation for a mental health problem than Norwegian women (Straiton, Powell, Reneflot, & Diaz, 2016). Although migrant or refugee status generally seem to be a predisposing factor for mental health problems (Kamperman, Komproe, Jong, & Kaplan, 2007), there seems to be a dearth of research specifically investigating financial consideration as to the use or avoidance of psychiatric consultations in Norway.

4.4 DISCUSSION

Health care consumption in Norway varies considerably within different migrant groups and compared to the general population. However, migrants’ use of health care services must be considered within the context of the large and systematic social inequalities in health that have been established in Norway as well as internationally (Dahl et al., 2014). Recent comparative evidence even shows that health inequalities are larger in Norway compared to countries with less developed welfare states (Mackenbach et al., 2016; Murtin, Mackenbach, Jasilionis, & Mira D’ercole, 2017). To the extent that differences in utilization produce and reinforce exclusionary structures and practices, it may pose a challenge to the authorities’ stated goal of equitable healthcare (Helse- og omsorgsdepartementet, 2013a). Studies have previously shown that service use is likely to vary depending on the health care system and service availability, the health issue under scrutiny and the migrant population being studied (Straiton et al., 2014). Our findings show that the migrant population’s consumption of healthcare services differs from that of the majority population. However, in line with other studies (Van Doorslaer & Masseria, 2005), there seems to be less evident inequity when it comes to utilization of primary healthcare, especially GP. Even though Van Doorslaer and Masseria (2005) OECD report shows pro-rich inequity with respect to consultations of medical specialists, we have not found Norwegian literature that testifies to such differences among the migrant population in Norway. This lack of focus on migrants’ consumption of private healthcare may have to do with the fact that fully private funded healthcare services are still marginal compared to the public sector, although there are increasingly new start-ups of such services (Facto, 2017).

Nevertheless, migrants’ consumption of health care services is expected to increase. International literature shows that migrants in general have worse health than the native population, and that a growing number of migrants and ageing
migrant population may therefore be indicative of more health problems and demand for healthcare services (Solé-Auró & Crimmins, 2008). In a survey of healthcare use in Europe, migrants showed higher rates of consumption than native-born across countries. This was true for both physician visits and hospital stays, which is compatible with an aging migrant population with health deterioration (Solé-Auró, Guillén, & Crimmins, 2012). Similar migrant healthcare consumption trajectories seem probable in Norway. Still, with rising income inequality in Norway, and with migrants typically having lower incomes than the rest of the population (Sandnes, 2017), their consumption of healthcare services might be negatively affected. There is therefore a strong need to study the presence of socio-economic barriers in access to healthcare.

Moreover, despite evidence from many studies that the migrant population is underutilizing certain healthcare services, there is reason to believe that their demand for healthcare services will adjust to the host countries’ level of consumption. Of course, the demand for healthcare does not necessarily have to be translated into supply and will depend heavily on how the services are financed. However, there is lack of information on affordability of various types of care (Ringard et al., 2014), and only a few qualitative studies exist which hint towards the possibility of financial barriers as well. A recent qualitative study on Filipina immigrant women found that few participants did report finding the GP consultation fee as a barrier, given that they also had responsibility for sending money back to their families. This shows that while healthcare is largely publicly funded and carries low out of pocket expenses for individuals, it might carry high opportunity cost for those migrants with low socioeconomic status as they struggle to prioritize their healthcare amid responsibility of sending remittances back home (Straiton, Ledesma, & Donnelly, 2018). Elstad et al. (2015) suggest that factors such as economy and travel length, can also affect the usage rates of health services. This reiterates the need to study the impact of invisible costs such as cost of transportation or over-the-counter medicines, which may also be a barrier to using healthcare services for some migrants.

In Norway, the relatively low out of pocket expenses might also undermine the relevance of conducting affordability studies in health care. For example, given that a GP visit requires a small flat co-payment, generally around 180 kroner with a ceiling of around 2,000 kroner, after which an exemption card is issued, entitling patient to free treatment for the rest of the year, it is hardly surprising that questions of financial affordability have not been the focus of research. However, findings from countries based on universal health care systems such as Canada indicate that economic barriers to care still exist. For example, a qualitative study showed that
despite existence of the Ontario Health Insurance Plan, 1 approximately two thirds of the focus group participants did not have extended health insurance to cover pharmaceuticals, eye care, dentistry, and other essential services. In such cases, the elderly migrant population is the most vulnerable as they generally lack financial means and employment-related insurance (Wang & Kwak, 2015). Another study in Canada reported similar financial barriers for unemployed immigrants for accessing prescription medication, uncovered under employment health insurance plans. As immigrants (especially newcomers) experience higher rates of unemployment than the Canadian-born population, they are outside the insurance coverage for such health services. The lack of extended health benefits also hinders access to alternative or supplementary health care services (e.g., chiropractic, massage therapy, physiotherapy) (Asanin & Wilson, 2008). Since these studies were conducted in Canada, they may be limited in the extent to which the results can be applied in the Norwegian context. Still, they are relevant to consider, given the similarity of low employment levels among migrants and high cost of using supplementary healthcare services in Norway, and their possible impact on access to care. For services such as dental care in Norway, Blom (2016) points out that an important reason why many migrants do not seek dental treatment is that clients themselves have to pay dental care services. This is consistent with a study that found consistent pro-rich inequity in dental care utilization among men and women in all age groups in the Norwegian population (Vikum, Krokstad, Holst, & Westin, 2012). Therefore, there is a need for research on financial barriers to care for migrants, often with high unemployment rates, low income and financial responsibilities at home, in a universal healthcare system such as Norway.

Studies have also pointed to the possibility that migrants from nearby countries might be travelling abroad to see a physician which might explain differences between migrants and Norwegians, as well as remigration without registration (Diaz & Kumar, 2014). A study (Wang & Kwak, 2015) on migrants in Canada also found that with decline in health status and with the presence of sociocultural, economic and geographic barriers in accessing healthcare, migrants adopted transnational strategies such as traveling to their home country for medical examinations or treatment. They also imported medications from the home country to Canada and consulted health resources by phone or email in their home country. More research needs to be done on whether transnational care is adopted by migrants in Norway as a way to cope with financial or cultural barriers in healthcare.

1. Ontario Health Insurance Plan ensures that every Canadian citizen and permanent immigrant living in the province of Ontario has prepaid public health insurance for all medically necessary physician and hospital services.
Health promotion and preventing health problems in the population is a major task for health authorities and professionals. It is therefore important to include information about migrants’ access to preventive health services. For example, a study among Somali women in Norway shows that despite the women’s good knowledge of diabetes and risk factors such as sedentary lifestyle and unhealthy diet, they faced barriers to being physically active, such as time pressure, a lack of financial affordability for training facilities, and an absence of a tailored physical activity environment, such as training facilities not being gender-exclusive (Gele, Torheim, Pettersen, & Kumar, 2015). A similar study on barriers to outdoor physical activity among Somali youth, pointed out financial barriers such as expensive outdoor clothing, lack of time because of parents’ work and children having after-school jobs (Rothe et al., 2010). In light of this, to gain a fuller picture of migrants’ healthcare consumption, financial barriers should include consideration of both direct and indirect costs that prevent access to healthcare.

The discussion on financial barriers for migrants becomes more pertinent when undocumented migrants’ situation is taken into account. In Norway, undocumented migrants (people who do not have legal residence in Norway, e.g. members of the Roma people) have been found to be severely underserved in terms of access to health services (Ringard et al., 2014). Because undocumented migrants are not members of the Norwegian National Insurance Scheme, they have no right to an assigned general practitioner. They are required to pay the full cost for treatments. Exceptions are made for prenatal care, forced admission for psychiatric treatment, treatments for contagious diseases, and vaccinations, all of which are free of charge. Lack of information, fear of deportation and inability of healthcare professionals to determine which case falls under ‘immediate medical assistance’ under Norwegian regulation are some of the barriers that such groups face. Undocumented migrants in Norway have been found to put off seeking healthcare due to a lack of funds (Hjelde, 2010; Kvamme & Ytrehus, 2015).

In addition to undocumented migrants, financial barriers to primary healthcare can also exist for migrants awaiting their residency status, as they are not covered by the Norwegian Insurance Scheme. Straiton and colleagues discuss that though entitled to emergency care, migrants may feel unsure of how to access primary healthcare before being assigned a GP. However, more research is needed to substantiate the evidence that financial reasons are in play (Straiton et al., 2018). Research done in Canada found that participants indicated cost of purchasing private insurance or paying directly for health care as a significant deterrent to seeking medical care during their first three months in Canada. In the absence of private health insurance, migrants were found to be left with the choice of paying for
health services out of pocket or forgoing treatment. This could be a particularly significant barrier for families with children (Asanin & Wilson, 2008). Similar mechanisms might be at play for migrants that have not yet been assigned a GP.

According to Debesay, Harsløf, Rechel, and Vike (2014) the healthcare policies implemented to tackle challenges stemming from migration often fail to keep pace with social change because the structural dimension of everyday experience is not recognized. Moreover, according to Elstad (2016), the world region origin, reason for migration and duration of residence are important sources for variations in migrants’ utilization of healthcare services. Solé-Auró et al. (2012) suggest that the observed differences on migrants’ access to and use of healthcare across countries requires further exploration of the cultural, political and financial features affecting the propensity for use of healthcare consumption. Therefore, migrant patients’ experience of inclusion or exclusion from healthcare consumption needs to be addressed. Usually, patients have to navigate among different sources of information, taking into consideration traditional values, experiences and habits from living in Norway, and affordability of the various healthcare services (Wandel et al., 2016). There seems to be a need for evidence-based knowledge about the different migrant groups’ propensity to use healthcare services based on cultural and socioeconomic background, but we also need to know about the quality of healthcare individual persons with migrant backgrounds receive. For example, there is evidence of longer waiting times for hospital treatment for patients with low levels of education and/or income than for groups higher up the socioeconomic scale (Monstad, Engesæter, & Espehaug, 2014; Ringard & Hagen, 2011). All the same, although many of the newly arrived migrants from non-Western countries fit the general description, there is need for a differentiated research on various groups of migrants — from labour migrants to refugees and ‘illegal’ migrants. Research needs to take into account migrants’ personal experiences of barriers to healthcare access, but also to explore structural barriers to healthcare consumption. Specifically, there is a need of qualitative studies to contextualize barriers, intersectionality perspectives to explore the interplay of socio-economic barriers at patient level (financial/poverty, age, gender, class) as well as barriers at the institutional and provider level.

4.5 CONCLUSION

In this chapter, we have attempted to highlight the migrant population’s consumption of healthcare services. We have addressed the migrant population’s use of primary health care, specialist health care and mental healthcare. Although health
care services are fully funded by the state, there is reason to believe that differences in consumption exist despite equal needs. Although some of these features are slightly emerging in the general population, there is lack of research on migrants’ use of public or private healthcare. Understanding the patterns of migrants’ health-seeking behaviour due to cultural and socioeconomic factors may be essential when designing health and social services. It is therefore of great importance to assess migrants’ healthcare consumption in order to achieve equity across social groups in Norway.

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