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ORIGINAL PAPER

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CONTACT WITH HEALTH-CARE SERVICE EXPECTATION AND REALITY OF SITUATION EXPERIENCED BY IMMIGRANTS SEEKING SWEDISH HEALTH-CARE

Ferid Krupic¹, Sahmir Sadic², and Nabi Fatahi³

¹Department of Orthopaedics, Institute of Clinical Sciences, Sahlgrenska Academy, University of Gothenburg, Sweden.

²Orthopaedic and Traumatology Clinic, University Clinical Centre Tuzla, Bosnia and Herzegovina.

³Institute of health and care sciences, Sahlgrenska Academy, University of Gothenburg, Sweden

Corresponding author: Ferid Krupic, MD, PhD. Department of Orthopaedics, Institute of Clinical Sciences, Sahlgrenska Academy, University of Gothenburg, Sweden. ORCID ID: www.orcid.org/0000-0002-6648-4939. Tel: +46-31-342 82 42
Mobile: +46-739-337488. E-mail: ferid.krupic@gu.se

ABSTRACT

Aim: The aim of the study was to investigate how immigrants from Bosnia and Herzegovina, Somalia and Kosovo experienced contact with Swedish health-care regarding meeting with health-care professionals. **Material and Methods:** Eighteen participants, nine men and nine women from Bosnia and Herzegovina, Somalia and Kosovo participated in focus group interviews (FGI). Data were collected from April 2013 to April 2014 through three group interviews using open-ended questions. A qualitative approach, incorporating a critical incident technique (CIT) was used. **Results:** The findings highlighted patient's negative experiences regarding the Swedish health care system. Their main complaints concerned delayed ambulances, lack of doctors in outpatient clinics, long journeys to the hospital and long waiting time at the emergency department. Lack of information about the disease, difficulties seeing a doctor in the department, poor language skills and insufficient interpreters were some of other difficulties that mentioned by participants. **Conclusions:** In order to provide satisfactory health care to patient with different ethnic backgrounds, it is important to be aware of their vulnerable situation and their limit capacity to express their needs. This research could be a starting point in developing strategies for reducing ethnicity-based misunderstandings and inequalities in the health-care system.

Key words: Immigrants, health-care system, experiences, expectations, trans cultural health care.

1. INTRODUCTION

There are now nearly 230 million people living outside their country of birth (1, 2). With a growing population of immigrants in a country, an increased use of the health-care sector at different levels will be unavoidable and this process poses a major challenge to health-care professionals to provide individualized, holistic care based on each individual's needs and to address the need to respect individual autonomy (3-6). All humans, immigrants or not, do carry their socio-cultural heritage regarding beliefs and practices in both health and illness which has to be taken into consideration. To guarantee basic rights and freedom, health care interventions should be guided by the value of benefiting others and individuals should be treated fairly, equally and impartially (7, 8). The main

aim for Swedish health-care is the delivery of high-quality care, accessible to all (7). According to Swedish official statistics in 2013, 23.3% of the Swedish population of 9.7 million had a foreign background and 15.4% were born outside the country (9). According to the Swedish Health and Medical Services Act, the Swedish health-care system is expected to provide equal health care opportunities for all patients (7, 10). There are documented many differences in health and in many medical disciplines between native patients and these born abroad (11-13). Research conducted in Sweden has demonstrated an association between ethnicity and poor self-reported health [14-16] and mental health disorders (17). One study from Sweden about immigrants coming from Burundi, Colombia, Iraq, Kazakhstan, Poland, Kosovo and Syria, showed that

the main problems were related to lack of information and the immigrants being sent to various levels of care. This was shown to result in a lack of trust of health-care professionals and feeling that no one from health-care professionals took overall responsibility (18). The Statistics Central Boards study showed that 21% of immigrant women reported needing health care, but not seeking it compared with 12% of women born in Sweden. The same study showed that the rate of preventable mortality (death due to illnesses that the health care sector is equipped to address through the application of preventative or targeted medical treatment) is higher among immigrants. Immigrants are treated unequally within several areas of the Swedish health-care sector including the use of well-documented medical treatments for heart attack, heart failure, stroke and chronic obstructive pulmonary disease compared with patients born in Sweden (9). Despite that correlation between ethnicity and health is less studied and that we have scarce knowledge about this, there are only a few studies focusing on challenges in cross-cultural health-care (19-21). Therefore, the present study is presented to fill this gap and the aim was to investigate how immigrants from Bosnia and Herzegovina, Somalia and Kosovo experienced contact with Swedish health-care regarding meeting with health-care professionals.

2. METHODOLOGY

Design

The present study is based on a qualitative, descriptive approach, incorporating a critical incident technique (CIT). CIT is a method described by Flanagan (22), utilized to obtain records of specific behaviors from those in the best position to define an incident. It is a systematic, inductive, highly flexible method, giving concrete, actual descriptions of events and intended to solve practical problems (23). Flanagan's requirements for CIT are that the activity investigated should have a well-defined aim and that both the positive and negative aspects and the problems of the activity, such as in the present study about informants' experiences in seeking health-care are taken into account. For a critical incident report to be effective and useful, three important pieces of information must be included:—a description of a situation that led to the incident,—the actions or behaviors of the focal person in the incident and — the results and outcomes of the behavioral actions. The number of incidents needed depends on the nature of the problem. An analysis of 100 incidents is considered sufficient for qualitative analysis. Critical incident methodology has been effectively used by health services researchers to identify the responses and behaviors of patients in studies of health-care quality (22).

Participants

The study was designed as a prospective, qualitative study. The inclusion criteria to participate in the study were: participants coming from Bosnia and Herzegovina, Somalia and Kosovo, who were more than 30 years old, and had lived in Sweden more than 5 years. Twenty-four participants were invited to participate in the study, of which 18 agreed to participate. Four of the participants declined without explanation and two participants be-

came sick during the study period. The participants were nine women and nine men, aged 38 -75 years (mean 61.5 years). The men were aged 47-75 (mean 62.8 years) and the women 38-72 (mean 60.2 years). All participants had lived in Sweden for 8–20 years, and all of them were unemployed. The first author of the study made appointments for all interviews and interviewed all the participants.

Data collection

Data were collected through focus group interviews (24) with six participants in every group (three of each gender) using open-ended questions. The interviews were performed from April 2013 to April 2014. Group interviews of six participants in Bosnian and Swedish were conducted by the first author, who is bilingual. In the group interviews with Somalia or Albanian participants who did not speak Swedish (four from Somalia and two from Kosovo), the author was assisted by a native Somalia or Albanian professional interpreter, respectively. Information concerning the aim and background of the study was translated into Swedish, printed and distributed to the informants, and repeated to them orally before the interview. Participants were encouraged to speak freely using their own words and the interviewer encouraged the informants to respond to questions as comprehensively as possible. All interviews were translated first into Swedish by the first author, and a professional translator checked the translation. The interviews lasted between 90 and 180 minutes and were tape-recorded and transcribed verbatim.

Data analysis

After reading each transcribed interview carefully and systematically, a description of the difficult situations in the participants' statements was identified. A decisive incident was considered to be a specific experience (critical incident) described by the informants as positive or negative in relation to their experience of the situation in which they experienced health-care system and health-care professionals. A total of 257 critical incidents were identified and the number of reported incidents varied between seven and 24 incidents per participant. To categorise the incidents, they were first abstracted from the interview text, given labels, and then sorted into groups. The groups were classified in terms of different kinds of behavior, which resulted in one theme, and three categories. These were regrouped into eight subcategories as finer similarities and differences became apparent. The process was continued until all critical incidents have been appropriately classified.

Ethical considerations

As there was no physical intervention and as no information on individual health issues were involved in the study, there was no need to involve the ethical board according to Swedish law (25). The World Medical Association Declaration of Helsinki (26) was, however, considered carefully.

3. RESULTS

The analysis of the text in the present study resulted in two main categories and five subcategories and is based on how the participants described their situation in Swe-

Theme: The patient between expectations and reality of situation	
Categories	Subcategories
Participant expectation	Expectations from ambulance professionals
	Expectations in the emergency room
The reality of the situation	The situation in the emergency ward
	The situation with health-care professionals
	Health-care Organization
	Language barriers

Table 1. Overviews of Categories and subcategories

den. The categories, together with the subcategories, are presented in Table 1. The categories were "Participant expectations" and "The reality of the situation".

3.1. Participant expectations

The condition for immigrants living in other countries is influenced not only by experiences of health and illness, but also by other changes related to migration. Immigrants already have problems such as: language barriers, lack of employment, and culture shock to deal with as well as the problems following them from their native countries. The participants in this study stated that they expected to return to their homeland due to the difficulties they are facing in Sweden. The participants in the present study have even expectations when they seek health-care. The expectations went all the way—from the participant's call the ambulance to they was leaving at home from the hospital. They are living in Sweden because they must and explained that their thoughts are in their homeland, though their bodies are in Sweden.

Expectations from ambulance professionals

Despite the suffering that the patients felt because of, loss of family, property, neighbors, language and culture, the majority of patients in this study still had expectations. Notwithstanding acute circumstances; situations of stress, pain and severe disease, for example, most patients in this study recalled their expectations of the Swedish health-care. As described by the patients, their expectations were sometimes justified, but sometimes they were disappointed and dissatisfied.

One participant described his expectation as follow:

"I expected that the ambulance would come quickly and I would meet a doctor as quickly. But it was not so". "I often have chest pain. Most often when you call an ambulance, they are either delayed several hours or do not come at all. I'm afraid of what might happen."

About the ambulance help, one participant said:

"The professionals from ambulance are often late and do not come on time. Last time I had severe pain in the hip and I thought I was going to die. I called them at 17:00 and they showed up at 20:00. First we went to Sahlgrenska, then Östra, and then after a few hours we were in Mölndal. But then the problems start.....Waiting."

Expectations about the emergency ward

The journey to the hospital was usually longer than participants expected. Because of hospital policies, the ambulance professionals had to pick up other people

on route to the participants in the study. Following this, the participants undergo triage. Depending on when the participants arrive to the Hospital and the severity of their problems they are assigned a number. The patients expected that the waiting time in the emergency room would be short and that they would go home after the examination. However, the entire process could last several hours.

Another participant had the following expectations like this:

"I thought that if I came to the hospital to get help I would be going home soon. But my problems had just begun in the hospital. I got help from a nurse, I had been waiting ten hours, I did not sleep, I did not eat, I had pain. Disaster."

One patient had this experience of the waiting time:

"Waiting in the hospital for me is worse than the pain and illness".

3.2. The reality of the situation

The current situation in Sweden, experiencing a high standard of health-care and service, was contrasted against the situation in the countries of origin, with descriptions of insufficient care and poor conditions being common. The majority of patients described how high their expectations were regarding Swedish health-care. However, these expectations were lowered when the patients came to the hospital and received medical help. The reality of the Swedish health-care did not meet the expectations of the patients in this study.

The situation in the emergency ward

Patients described the situation in the acute ward as very stressful. They had the feeling that the health-care professionals were very busy and these circumstances made the participants nervous. Despite the current situation in Sweden, experiencing a high standard of health-care and service, the reality the participants in the present study experienced was different from their expectations.

About the situation, one participant said:

"I went with my son who had been beaten. We first met many nurses and then after a couple of hours, the doctor. During this time we waited, my son could have died. What is the health system?"

One patient was critical of the prioritizing of the health-care:

"I had severe pain in my spine and I asked for the help of a doctor. I had severe pain and I thought I'd die, but the personnel did not priorities me as if I could wait. When I started to vomit from the pain, then it was my turn. Very strange."

The situation with health-care professionals

Expectations of patients were lower when they were relocated to the department of medicine, geriatrics, intensive care, obstetrics, and surgery. Because of earlier dissatisfactions in Swedish health-care, the majority of the participants even had low expectations at the others wards in hospital. When there the participants often compared their experiences to the health-care in their homelands, expecting them to be the same. The participants experienced disappointment with nurses, doctors who came late or not at all, interpreters who translated poorly or arrived

late, and that stressed health-care professionals who did not have time for questions.

About the nurses and doctors in the ward a participant said:

"I asked the nurse many times to explain more about my disease, and she always said that would come later. Later, I asked for a doctor, but he was always busy".

About the information in the surgery a participant said:

"I operated on the hip and I was in orthopedics. One doctor operated on me, the other was in the ward, I was treated by the third and a fourth doctor sent me home after a few days. I have not received information about my surgery and what to do afterwards. I do not know Swedish. It's very difficult".

Health Care Organization

According to the result a majority of the participants in the present study were unsatisfied regarding health care organization. Organization of transport from their residence to hospital was mentioned as an obvious difficulty by participants. Furthermore the length of the waiting times at the emergency room that almost was another issue that highlighted. One participant mentioned that sometimes one must wait many hours to get help from personal.

The following citations have been added by other participants:

"Once I called an ambulance to drive me to emergency department at the Sahlgrenska hospital. They drive me first to Mölndal hospital and then continued to Östra hospital and finally to Sahlgrenska hospital. I do not understand how my transport has been organized?"

Participants wondered why authorities do not improve organization and they think it is quite easy to do it.

"I think it is more practical to wait at my residence than drive me through all part of the town and wait several hours at the emergency room".

Language barriers

Communication in health-care with both the nurses and other health-care professionals was limited by language difficulties at times. They often consulted an interpreter when visiting the hospital, either from the municipality or a family member, to receive sufficient information. Some of the patients were dissatisfied with the interpreters help because they did not speak the same language, missed the appointment, did not translate correctly or took a long time. Even problems with different languages and dialects were noted.

One woman said:

"I waited to see a doctor for five months. My daughter was at the meeting, and the interpreter was translating. He did not understand everything the doctor said; he translated around 50 percent".

One patient from Kosovo said:

"I ordered an interpreter who speaks Albanian and the interpreter who came spoke Serbian. It's not the same language I do not understand that language".

4. DISCUSSION

A primary goal for Swedish health-care policy is that applicable care should be offered to the entire population

on equal terms. Reports and statistics show, however, that participants born outside are not satisfied with Swedish health-care (9, 27). The majority of the participants in the present study have been enforced to leave their homelands. In this context immigrants had neither the opportunity to choose their escape route, nor to plan their resettlement country. However, by coming to another country a person doesn't lose their religious, cultural and ethnic affiliation. These factors might contribute to dissatisfaction, a sense of lack of control, and the feeling of not belonging in the resettlement country, which in instances resulted in disaffection for the immigrant. Previous studies have indicated that health-care should be based on respect for autonomy and privacy and promote a sound relationship between patients and health-care providers, while simultaneously being adapted to the patient's situation and capabilities (7, 10, 28). The majority of the participant in the present study had high expectations from health-care and health-care professionals. The participant had expectations from the moment they called an ambulance until they came home from the hospital. Reasons for this may be found in that the majority of participants compared Swedish health-care with that of their home countries. Different expectations between participants and health-care professionals, negative events in relation to inadequate information exchange with health-care professionals and prejudicial behavior from the care providers were also found in the study of Suurmond et al. (29). The authors in this study described that the participants had expectations, yet they were disappointed about medical procedures, waiting times in the emergency room of more than five hours, different medical complications, and a doctor who made a medical error and left the participant the day after surgery. Negative experiences could be due to different expectations of the encounter even between women and men. The importance of expectation in health-care as a predictor of satisfaction is unclear. Some differences are also found in women's and men's experiences of health-care received. Women with various diagnoses reported more experiences of negative treatment, such as being treated with indifference or disrespect. Health-care professionals did not take time, did not listen, and did not believe or doubted the female patients' complaints (30, 31). Language barriers and insufficient interpreters were additional hindrances stated by participants. The fact that language barriers limit the possibility of dissemination of information might in turn affect the content of the help received. Consequently there is a risk that, when seeking health-care, immigrants have a reduced capacity to define their needs and feelings, which affects the content as well as the amount of care they receive. The findings in the present study are in line with another study made by Akhavan (14), where the author interviewed ten midwives who treated immigrant women and showed that the interpreters' help was very important to all of the women because of language difficulties. This issue was also confirmed by previous studies (32, 33). However, the present study has some limitations. One may be that in the group of participants from Somalia, the interview was held in a group with women and men together. These

circumstances may have affected the answers and discussion and may have made the participants less open, more nervous and therefore caused greater challenges describing their experiences. Another limitation of the present study may be that the interviews held during a time many other people present which may make the participants nervous and it could have been difficult to concentrate to the interview and discussion.

5. CONCLUSION

In order to provide satisfactory health care to patient with different ethnic backgrounds, it is important to be aware of their vulnerable situation and their limit capacity to express their needs. This research could be a starting point in developing strategies for reducing ethnicity-based misunderstandings and inequalities in the health-care system. Immigrants need to be educated and informed about the Swedish health-care system; something which should be undertaken early, under the responsibility of the migration board for example. Satisfactory and fundamental information to immigrants concerning health-care system would result to improvement of patient knowledge about health-care system and more reality wives regarding meeting between patients and health-care professionals.

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REFERENCES

1. IOM (International Organization for Migration) 2012. [hq@iom.int](http://iom.int). Retrieved on 30 October 2013.
2. UNHCR (United Nation High Commissioner for Refugees). Global Refugees trends. Statistics/Statistical Yearbook 12th September 2013 Available from <http://www.unhcr.org>.
3. Taylor G. Migration and refugees. In: Papadopoulos I (ed). *Transcultural health and social care: development of culturally competent practitioners*. Churchill Livingstone Elsevier Publishing. London. 2006: 45-63.
4. Purnell LD, Paulanka BJ. *Transcultural health care: a culturally competent approach*. 2nd ed. FA Davis Publishing. Philadelphia. 2003.
5. Fishman J. Ethnicity as being, doing and knowing. In: Hutchinson J, Smith A D (eds). *Ethnicity*. Oxford University Press. New York. 1996: 62-68.
6. Taylor G, Papadopoulos I, Dudau V, Maerten M, Peltegora A, Ziegler M. Intercultural education of nurses and health professionals in Europa (IENE). *Int. Nurs Rev* 2011; 58(2): 188-95.
7. Wilow K. *Författningshandbok*. Liber. Stockholm. 2003. (In Swedish).
8. WHO. *Basic documents*, 43rd ed. World Health Organization. Geneva. 2001.
9. Statistics Sweden. *Description of the population in Sweden 2013*. <http://www.scb.se>
10. The Swedish National Board of Health and Welfare: In Volume SOSFS 2011: 11 The Swedish National Board of Health and Welfare; 2011.
11. Krupic F, Määttä S, Garellick G, Lyckhage ED, Kärrholm J. Preoperative information provided to Swedish and immigrant patients before total hip replacement. *Med Arch*. 2012; 66(6): 399-404.
12. Krupic F, Eisler T, Garellick G, Kärrholm J. Influence of ethnicity and socioeconomic factors on outcome after total hip replacement. *Scand J Caring Sci*. 2013; 27(1): 139-46.
13. Krupic F, Eisler T, Eliasson T, Garellick G, Gordon M, Kärrholm J. No influence of immigrant background on the outcome of total hip arthroplasty. 140,299 patients born in Sweden and 11,539 immigrants in the Swedish Hip Arthroplasty Register. *Acta Orthop*. 2013; 84(1): 18-24.
14. Akhavan S. Midwives views on factors that contribute to health care inequalities among immigrants in Sweden: a qualitative study. *International Journal for Equity in Health*. 2012; 11: 47. doi: 10.1186/1475-9276-11-47.
15. Krupic F, Rolfson O, Nemes S, Kärrholm J. Poor patient-reported outcome after hip replacement, related to poor perception of perioperative information, commoner in immigrants than in non-immigrants. *Acta Orthop*. 2016; 87(2): 1-7.
16. Krupic F, Garellick G, Gordon M, Kärrholm J. Different patient-reported outcomes in immigrants and patients born in Sweden: 18,791 patients with 1 year follow-up in the Swedish Hip Arthroplasty Registry. *Acta Orthop*. 2014; 85(3): 221-8.
17. Blight K J, Ekblad S, Persson J O, Ekberg J. Mental health, employment and gender. Cross-sectional evidence in a sample of refugees from Bosnia-Herzegovina living in two Swedish regions. *Soc Sci Med* 2006; 62(7): 1697-1709.
18. Razavi MF, Falk L, Bjorn A, Wilhelmsson S. Experiences of the Swedish Healthcare system: an interview study with refugees in need of long-term health care. *Scand J of Publ Health*. 2011; 39(2): 319-25.
19. Akhavan S, Karlsen S: Practitioner and Client Explanations for Disparities in Health Care Use Between Migrant and Non-migrant Groups in Sweden: A Qualitative Study. *J Immigr Minor Health*. 2013; 15(1): 188-97.
20. Hadziabdic E, Heikkilä K, Albin B, Hjelm K: Problems and consequences in the use of professional interpreters: qualitative analysis of incidents from primary healthcare. *Nurs Inq*. 2011; 18(3): 253-61.
21. Seffo N, Krupic F, Grbic K, Fatahi N. From immigrant to patient: Experiences of Bosnian immigrants in the Swedish Healthcare System. *Materia Sociomed*. 2014; 26(2): 84-9.
22. Flanagan JC. The critical incident technique. *Psychol Bull* 1954; 51(4): 327-58.
23. Bradbury-Jones C, Tranter S. Inconsistent use of the critical incident technique in nursing research. *J Adv Nurs*. 2008; 64(4): 399-407.
24. McLafferty I. Focus group interviews as a data collecting strategy. *J Adv Nurs*. 2004; 48(2): 187-94.
25. Swedish Health Care Act. The Act concerning the Ethical Review of Research Involving Humans. http://www.epn.se/eng/start/2003_460.aspx (last accessed Juni 2008).
26. The World Medical Association Declaration of Helsinki. Code of Ethics 1964 (Revised). 2005. World Medical Association, Edinburgh.
27. Swedish National Board of Health and Welfare. *Socialstyrelsen*, 2013.
28. Löfvander M, Dyhe L. Transcultural general practice in Scandinavia. *Scand J Prim Health Care*. 2002; 20(1): 6-9.
29. Suurmond J, Uiters E, de Bruijne M C, Stronks K, Essink-Bot ML. Negative health care experiences of immigrant patients: a qualitative study. *BMC Health Services Research*. 2011; 11: 10.
30. Peck B, Ubel P, Roter D, Goold S, Asch D, Jeffreys A. Do unmet expectations for specific tests, referrals, and new medications reduce patients' satisfaction? *J Gen Intern Med*. 2004; 19(11): 1080-87.
31. Upmark M, Borg K, Alexanderson K. Gender differences in experiencing negative encounters with healthcare: a study of long-term sickness absentees. *Scand J Public Health*. 2007; 35(6): 577-84.
32. Björk Brämberg E, Nyström M, Dahlberg K. Patient participation: a qualitative study of immigrant women and their experiences. *Int J Qual Stud HealthWell-being*. 2010; 5(1): 46-50.
33. Gerrish K. The nature and effect of communication difficulties arising from interactions between district nurses and South Asian patients and their carers. *J Adv Nurs*. 2001; 33 (5): 566-74.