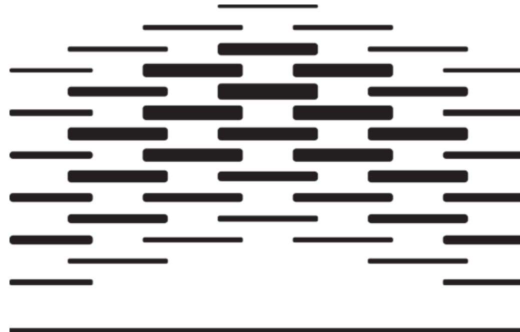
A study to observe the health care satisfaction among Pakistani immigrants in Norway

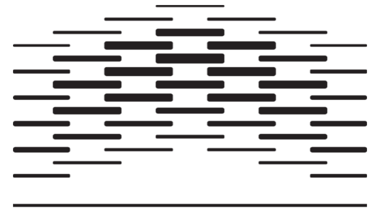


Farhan Mohsin

Master Thesis of International Social Welfare and Health Policy

Oslo and Akershus University College of applied sciences

Faculty of Social Sciences



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Farhan Mohsin

(s300734)

November 2017

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Oslo and Akershus University College of applied sciences

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The work done with this thesis has helped me a lot to learn more about the lifestyle of Pakistani immigrants in Norway. As it is difficult to understand the health conditions of individuals living alone and with the family. Some vital values are invisible in the Norwegian society and this thesis has helped me to go through the hidden health care values. I feel happy and motivated to help Pakistani immigrant's problems they are facing, in access to health care, to the higher health authorities. All the credit goes to the participants of my study who helped me in sharing their views, knowledge and experiences to achieve my goals of knowledge and understanding about patient health care satisfaction in Norway. There are many people who supported me in this thesis and I want to express my special gratefulness to Dawit Shawel Abebe who has supported, encouraged and inspired me for achieving this challenge. I am thankful to Dawit Shawel Abebe forever for having him as my supervisor. He took special time to help me out in this thesis by sharing his own experiences with me and I salute him for his help. Furthermore, I am thankful to the administration of the mosques in Oslo for helping me in completion of my questionnaire and providing me the respondents. Moreover, I want to express my gratitude to all my colleagues in the data collection process. Special thanks to my brother Farhad Mohsin for guiding me as how to initiate the thesis, collect data and helping in my thesis. I am not forgetting my family members in this occasion who have supported me in every step of my life. My cousin Waseem Shahzad from England also helped me in completion of my thesis. The support from friends and classmates are not to be forgotten. I say thanks to my classmates for helping and listening to my thesis and giving their useful information for my thesis.

Thank you

Farhan Mohsin

1. Abstract.

Title

A study to observe the health care satisfaction among Pakistani immigrants in Norway.

Background

A number of studies in the past have assessed health care satisfaction among various groups of patients in Norway. However, very little is known about health care satisfaction among Pakistani immigrants residing in Norway. The basic aim and purpose of this study is to understand if Pakistani immigrants are satisfied with the health services being provided to them in Norway by different health care institutions.

There are two main research questions.

i) Are Pakistani immigrants satisfied with the health care system especially primary health care (PHC) including services from Regular General Practitioners, Psychologist and Physiotherapist?
ii) What do the Pakistani immigrants think about the barriers and facilitators to health care satisfaction?

Methods

In this research, I have used quantitative research methods including descriptive statistics, one way Anova and correlation analysis.

Cross sectional research was conducted with interview based questionnaire. Convenience sampling was used and a total of 140 respondents participated in this study. The data was collected from Pakistani immigrants in different Pakistani gatherings such as mosques, shops, homes and public gathering among others in Oslo, Norway.

This research is based on a pragmatic model of patient satisfaction and theory of post positivism.

Results

Pakistani immigrants reported adequate satisfaction with the services of GP, Physiotherapist and Psychologist. They did not face discrimination and their confidentiality is ensured. Culture, language and structure of health are not barriers in access to health care. Medicines, ambulatory care and nursing care are good facilitators of health care. Appointment time is perceived to be a barrier.

Discussion

The main findings of this study show that majority of the participants were satisfied with the services of the GP. These findings are similar to that reported by Rajan Madhok in United Kingdom about Pakistani immigrant's satisfaction level with primary health care services in 1998. In terms of appointment time, the study found that participants were generally satisfied with appointment times. This finding is in contrast to that of Ursula and Berg (2011). Additionally, communication and language barriers were not considered as barriers by the participants. These findings are also in contrast with those presented by Ursula & Berg (2011)

When considering Psychologist services, this study found a statistically significant difference across age, job status, immigration and religious offering for the level of Psychologist satisfaction. This could suggest that religious interpretations and cultural influence can play a role in impacting patient satisfaction among the Pakistani immigrant community in Norway. Furthermore, the results of this study indicate that half of the participants remained neutral or they had never visited the Psychologists. The low use of psychologist services was also reported in in the study by Diaz & Larrañaga (2015).

Key Terms and Concepts.

Patient Satisfaction can be defined as the judgement made by the patient receiving health care as whether his desired expectation about health care services has been met or not (Palmer 1991)

Immigrants can be defined as those who are born by two foreign-born parents, and that are registered residents of Norway (Statistics Norway and UDI).

Norwegian-born to immigrant parents is defined as those individuals who are born in Norway with the two immigrant parents (Statistics Norway and UDI).

Asylum seeker – An individual who requests the local authorities for his protection due to war, fight, conflicts etc. in his country (Statistics Norway and UDI).

Ethnic minority is defined as immigrant minority population in a country and their offspring's (Statistics Norway and UDI).

Norwegian-born is defined as individuals which are born in Norway and their parents which are also born in Norway (Statistics Norway and UDI).

Health care system- there are different health care systems in different countries but mainly all those activities, actions and plans which main aim or purpose is to promote, restore or maintain health of an individual, or to the society as a whole, is health system or health care system (WHO 2000).

Barrier in access to health care is defined as anything that restricts the use of health services by the individuals and making it more difficult to use and to get benefit from it (Caulford 2014).

Facilitator in health care is defined as someone who helps forward to the patients and by his experience gives direction to the patients to sort his problem (Ewan 1985).

Universal coverage **-**Universal health coverage (UHC) can be defined as all those people who can use sufficient quality of the promotive, preventive, curative, rehabilitative and palliative health services they need, but it also ensures that the use of such health services does not affect the user to financial crisis (WHO 2016).

2. Introduction

Pakistani immigrants in Norway mostly came in the late 1960s, mainly to undertake un-skilled work which was required by Norway at the time. Pakistani immigrants were part of the first generation of migrants in Norway, which also included immigrants from Turkey and Morocco. The first generation of migrants were trained by the local Norwegian skilled workforce. After the initial influx of migrants, migration to Norway further continued until 1975. Once the shortage of workers were fulfilled, in 1975, Norway introduced a ban on migration. Immigrants moving to Norway after this time were mainly family members and spouses of those already settled in the country, and as asylum seekers. The Norwegian government is appreciative of the work undertaken by the migrants in the country and the contribution they have made to the country's economy. Moving to Norway has also been beneficial for Pakistani migrants as they enjoy better living conditions and healthcare here compared to that in Pakistan. This thesis focusses on the first, second and third generation of Pakistani immigrants in Norway. The first generation includes those that migrated to Norway during late 1960s. The second generation consists of children of migrant parents and were born in Norway, whilst the third generation consists of those born in Norway, whose parents were also Norwegian born (Berge et al 2010).

Pakistani immigrants form the largest ethnic minority group residing in Norway. It is for this reason that this thesis focuses on Pakistani immigrants as opposed to other ethnic minorities in Norway. Additionally, being Pakistani myself, I know about the health background and health conditions in Pakistan and how they differ in comparison with Norway. Based on my experience, people are generally not satisfied with the health care services in Pakistan, therefore, it would be good to learn the experience of Pakistani migrants regarding the healthcare system in Norway and assess how the satisfaction levels among Pakistani migrants. The satisfaction level with health care services is very important and currently there is very limited data available regarding Pakistani immigrants' satisfaction with health care in Norway. Norway provides universal health care system to its citizens irrespective of their cast, religion or socio economic status and ethnic background (Helsedirektoratet 2015).

2.1) Migration

Migration is a process in which people move from one society or culture to another new location with a different culture and society. It is broadly associated with the change of residence for the purpose of seeking higher standards and better opportunities for living. There are two main types of migration; internal migration and external migration. Internal migration is one that takes place within a country whereas external migration is one that takes place between countries. External migration is also refered to as international migration. Migration is also among the three main elements responsible for changes in population; the other two being mortality and fertility.

Migration can take place for a number of reasons. For example, people would want to migrate in times of war to protect their lives, to take shelter in another country during times of natural disasters like earthquakes, storm, and tsunamis. Migration can also be undertaken for economic purposes, such as to search for job opportunities, to get better and high paid jobs. Another reason for migration can be discrimination. If one feels discriminated in their own country or own town then he or she would want to migrate to another town or another country. Other reasons for migration can include political conflicts like political victimization and poverty (Thet, 2014).

According to the World Migration Report it is expected that in the near future, patterns of migration will change mainly due to a number of changing social and demographic factors. The social changes, environmental effects, new changing global economics and politics, and advancement in recent technology are likely to have a strong impact on migration. These transformations are expected to have a strong cumulative effect on economic growth and reduction in poverty. There are also likely to be new challenges as well, such as illegal migration and illegal immigrant’s protection of human rights. The global economic crisis has also affected migration processes in many parts of the world. If migration continues to increase at the current rate that is today then it is expected that in 2050 the number of the migrants world wide would be higher than 405 Million.The number of migrants working in the foreign countries illegally are increasing day by day. Many countries have failed to manage the problem of the migration (World Migration Report 2010).

According to the International Migration Report about two third of the migrants (66%) are living in Europe that is almost 76 million and 76 million in Asia and 21 million in Africa. Women constitute 48% of all migrant population worldwide. The median age of migrants is about 39 years. Migration can have positive impacts in both the host and the home country. It can contribute to cumulative economic growth in both host and home country. However, the International Migration Report (2015) does argue that the international community must pay close attention to the human rights of migrants in host countries and ensure these that must be the same as human rights protection received by citizens of the host country (International Migrant Report, 2015).

2.2) Migration and health.

There is a complex relationship between migration and health. There are a number of diseases that can be caused during the migration process. For example, the spread disease plague, which is also known as Black Death which occurred in Europe. Many people fled from this disease to other countries, however, since those fleeing were also carrying the germs of the disease, it infected people in countries where the migrants has fled to. In addition, Europeans were exposed to new diseases, such as tuberculosis and malaria, when they moved to Asian countries where these diseases were widespread. Tuberculosis was also spread when migrants from Asia and Africa moved to Europe for work. HIV is another disease that the potential to spread due to migration (Attanapola, 2013).

According to the World Health Organization (2016), approximately 214 million people were residing outside of their respective countries, while 740 million are considered internally displaced persons (IDP) or local migrants. The WHO has therefore stressed the need to manage health problem of migrant people effectively and urgently (WHO 2016).

Since the late 20th century there have been several factors responsible for the increase in the migration process. The governments in many countries have opened their country's border for the purpose of trade of goods, movement of capitals and free movement of labour. Examples of such arrangements include the EEA and NAFTA. Other factors includes the reduction in the cost and time of travel. Economic stability in one country also affects other countries as their instability in economic growth causes many people migrating to more stable countries. Mostly labour migrants

from low income countries move to high income countries for better livelihood. Some parts of the world are facing conflicts such as wars, which has resulted in an increase in the number of IDPs (Internally displaced persons). Migration forced as a result of these problems have also caused increased inequality and discrimination. Consequently, challenges such as health and protection of human rights are increasing (IOM 2010).

The migration process results in a number of hardships for the migrant, which can result in an increase in their health risk. The exposure to health risks starts from the point when their journey begins, for example leaving their home country, and then continues to increase during their journey and thereafter in the host countries. Considering the start and duration of the migrant's journey, they are likely to experience loss of relatives, very long stays in refugee camps, torture, anxiety, depression, imprisonment, and other socioeconomic problems. The problems and hardships after arriving in the host country include language barriers, lack of social support, marginalization, inequality, discrimination, lack of knowledge about the health care system of the host country, belief in the orthodox health care and healing, imprisonment, and the lengthy asylum seeking processes. Additionally, long stays in refugee camps can cause additional problems such as insecurity, stress and fear which can have a negative effect on the health of the migrants. Such negative health influences include high blood pressure, diabetes and other health problems which are caused by indirect factors of unhealthy behavior, for example consumption of alcohol, drug abuse, and lack of resources to prevent diseases, and poor compliance with medical advice. The adaptation process also affects the mental health of migrants and it depends on the age, gender, social support, language capabilities, religious beliefs, education level and reasons for migration (Bull 2007).

Migration also has a very negative influence on the migrant's risk behavior and risk perception such as identity processes, lack of social support and their migrant status or minority status can influence their health behavior. The number of factors which are important here are for example the migrants may focus on their past due to experienced losses. They focus on their past country of origin instead of their future host country. The psychological issues which are attached with migrants such as minority status, lower social status, and lack of job may lead to coping with these issues instead of focusing on future health behavior (Bull 2007).

Figure 1 below provides an illustration of the migration process as discussed above.

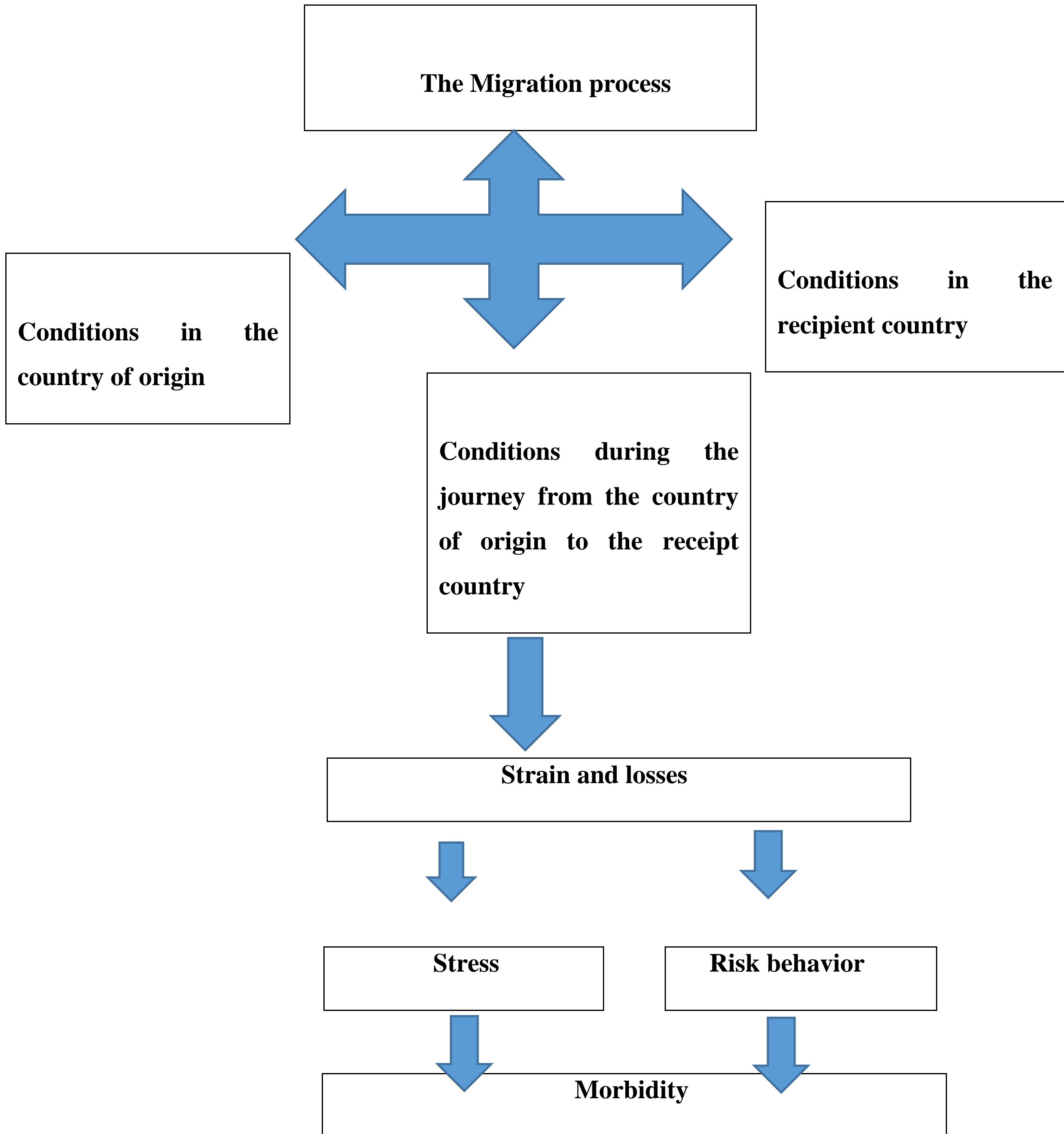

Figure 1- The influence of the migration process on migrant's morbidity (Bull 2007).

Healthy migrant effect

There are a number of hypothesis discussing healthy migrant effect. Among these the most important one is health selection hypothesis which gives us a possible explanation about this effect. This hypothesis suggests that immigrants who migrate are different from the ones who do not migrate to other countries. Immigrants are more educated, braver, exposure to risk is very low among them, and they can withstand more stressful circumstances as compared to the ones who do not migrate. The decision to migrate depends on the costs and benefits of migration. The benefits can include higher incomes in host countries when compared with the home country. On the other hand, the costs can include the expenditure which would be required for migrating, loss of family and social support. The people who migrate are often in good health, which in turn depends on a number of factors such as age, good education, self-motivation and determination to bring about social and economic change in the family. Thus, the healthier worker effect mainly focusses on healthier migrants as generally it is them that migrate for purpose of better jobs. Selective migration explains that migrants who are less healthy often return to their native country. Many countries have health screening systems in which only migrants who have good health are being welcomed in their country. So, migrants have good health as compared to the countries from where they immigrate (Domnich 2012).

A number of useful literature explains the “healthy migrant effect”. According to literature, the first generation immigrants were healthier than the second generation immigrants in United Sates of America among similar ethnicity and background. It is interesting to note that over time this effect reduces radically. The immigrant men and women had relatively very low risks of mortality as compared to the U.S born and foreign born residents in the United States of America. Thus, it was concluded that the immigrants were generally healthier and they have longer life expectancies compared to the natives. A comparison between foreign born immigrants or residents with the native U.S born residents showed that immigrants had better health and did well on certain health scores such as breast and cervical cancer, heart diseases, diabetes, teen pregnancy, infant mortality, tobacco and alcohol use and suicide (Fennelly 2005).

There was also a study conducted in 2011 by (Blue and Fenelon 2011) in the United States which indicates that in many developed countries, immigrants live longer that is, they have lower death

rates or mortality rates at most or all ages than native-born residents and a high life expectancy (Blue and Fenelon 2011).

According to the Abebe report on public health challenges of immigrants in Norway there were different factors which affected migrants such as personal factors, pre-migration factors, post-migration factors and health outcomes. Figure 2 below summarizes these factors:

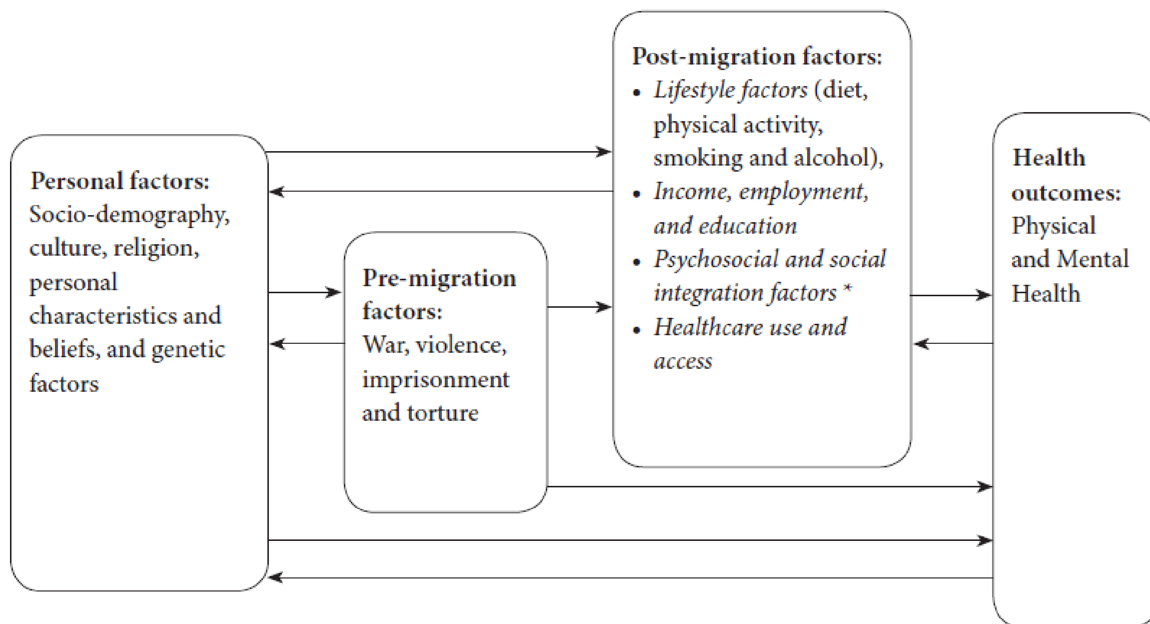

Figure 2 – A model for migration and health research (Abebe 2010).

The average health of migrants is better than the average health of the respective native population. The reason for migrant's good health can be that only the healthiest people are able to migrate in the first place as they have strength and are resilient when faced with hardships. This makes it is easy for them to migrate compared to the rest of the family members. Afterwards the rest of the family members migrate during the second phase such as family reunions and marriages. The main point to note here is that if migrants generally have better health compared to the local native population, why is there a need to address satisfaction with health care services and provision among migrants. When migrants do suffer from health problems, there are number of factors that interfere with migrants receiving the best possible care, for example, cultural and religious beliefs.

It is important to understand such beliefs among migrants in order for health care professionals to establish treatment accordingly (Goldin 2012).

With regards access to health care, equity is a fundamental objective in many European health systems regardless of migration status and ethnic group. The main focus in many European countries is equity so that everyone has the same rights and access to the health care system. Equity is concerned with the fairness of the services, the allocation of resources and access to health services regardless of gender, ethic group, religion and other such important factors (Oliver 2004).

Important strategies for improving the health of migrants

It is very important for host countries to improve the health of migrants and they should implement and practice justice while giving equal resources to the migrants. Examples of important strategies for improving the health of migrants by the host countries can be:

- Develop a policy and highlight the sensitive health areas that must correspond to the principles of the public health approach. The aim is to improve health of migrants, their rights, eliminating discrimination, enhancement of social protection, and development of partnerships with international organization like IMO.
- Doing assessment and research on migrants health is also an important strategy. Key gaps in health care provisions can be identified and improved, thereby reducing discrimination by age, gender, and socioeconomic status. Doing both qualitative and quantitative studies on migrant's health gives important feedback about and from the migrants.
- Capacity building is also another strategy in which the stakeholders and policy makers of the host countries are involved with the migrant's health. Thus, they promote the social, cultural, and religious matters associated with the migrant's health. The training of health professionals about different diseases and pathologies are also advocated in the host countries.
- The delivery of different services like migrant friendly health services and delivery methods of these services are important as they strengthen and promote the health of migrants and reduce their diseases as a whole (WHO 2007).

2.3 Migration in Norway

If we look at the historical aspects of Norway's immigration process, it is evident that they had solid customs in the past. Whilst the process of immigration is a relatively recent phenomenon, it sped up in the 1960s when Norway became a very rich country because of oil discovery in the Northern areas of sea. Since then, there have been three waves of immigrants that came into Norway. The first wave of immigrants started with migrant workers, especially low skilled workers, from Pakistan, Morocco and Turkey. These immigrants undertook work that the local Norwegian population was reluctant to take. In 1975, the Norwegian government stopped the immigration process due to an excess of workers and the need to hire more labor was reduced. The second wave of immigrants came between 1980-2000 as asylum seekers, refugees, family reunion and family marriages. The second wave immigrants were mainly from Iran, Iraq, Somalia, Sri Lanka, Chile, Vietnam and other war –torn countries. The third wave of migrants came after Norway Became part of EEA. This included migrants from countries such as Poland, Bulgaria, Albania, Bosnia, Greece, Romania, Croatia and Italy (Berge et al 2010).

Immigrant population in Norway

In Norway the net migration is 26 076 in 2017. The immigrant population in Norway constitutes about 13.8% of the total population. The ratio of Immigrants in Norway is increasing dramatically. The largest group of immigrants in Norway are Polish, followed by Lithuanians in second place, while Swedish are the third largest migrant population and fourth largest are from Somalia. In the beginning of the year 2017 there were almost 724 987 immigrants and 158 764 of these were Norwegian-born to immigrant parents. Oslo has the highest number of immigrants. It is estimated that Norway is home to migrants from 221 countries (Statistics Norway 2017).

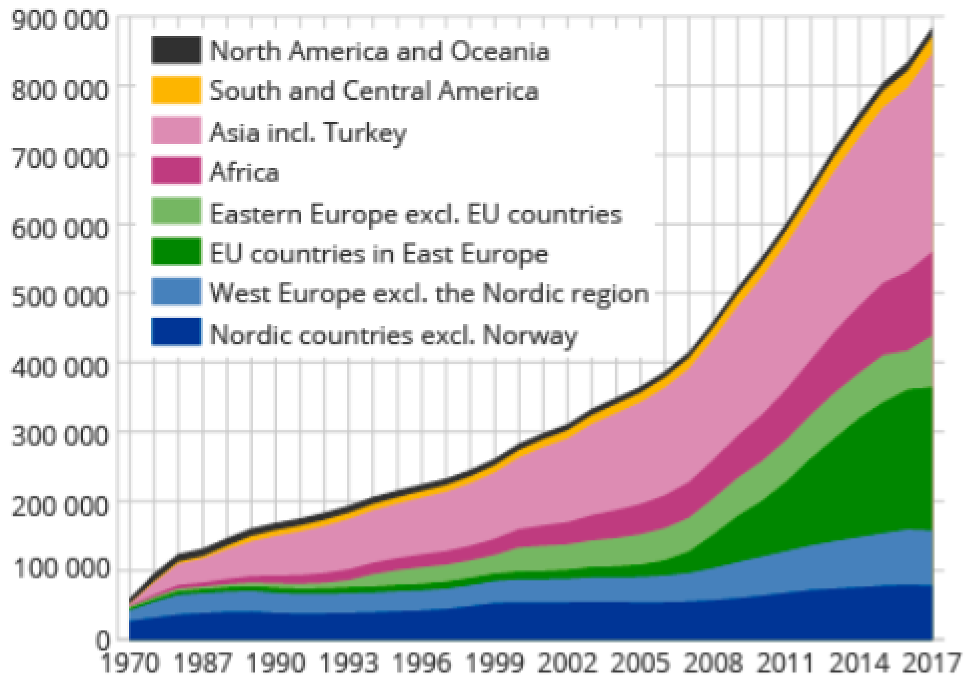

Figure 3: Growth in numbers of Immigrants and Norwegian-born to immigrant parents, by country background, 1970–2017 (Source: Statistics Norway)

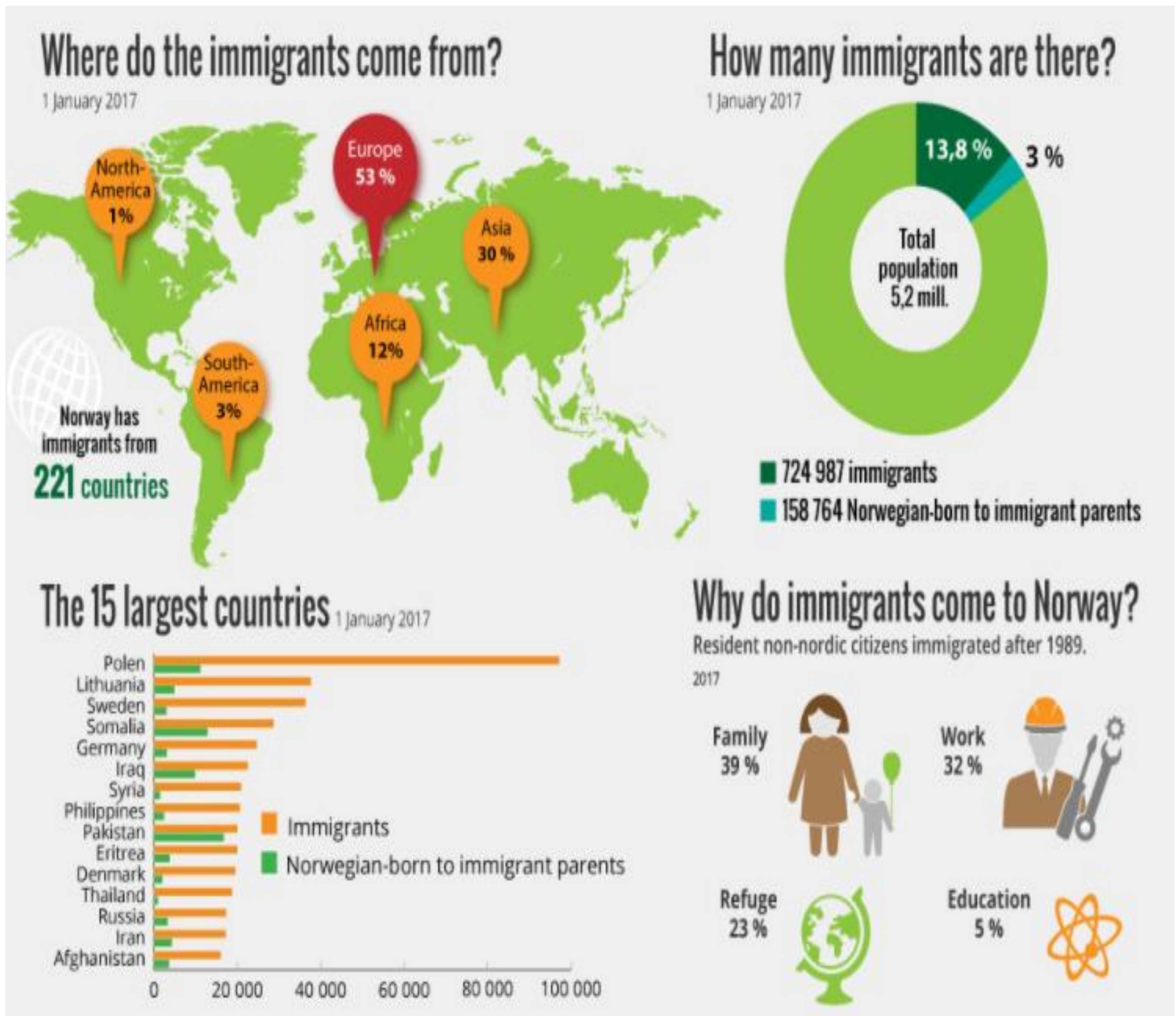

Figure 4: The numbers of Immigrants, reasons for immigration and Norwegian-born to immigrant parents, by country background, and the 15 largest groups 1 January, 2017 (Source: Statistics Norway).

Among the migrants from Asia, Pakistani immigrants were the first to arrive in Norway during the late 1960s. At that time, Norway was in need of low skilled workers to complete projects such as construction and other developmental projects. Therefore, the initial migration from Pakistan to Norway consisted of labor migrants looking for un-skilled jobs. Norwegian economy was

dependent on the immigrants from Pakistan, Morocco and Turkey. Following the initial migration, the Pakistani community in Norway has grown rapidly. After 1975, the main reason for growth in population was due to internal reproduction and family reunions as at that time the Norwegian government had imposed a ban on labor migration (Eriksen 1997).

Pakistani migrants in Norway

Recent statistics show that the population of Pakistani immigrants is above 35,000 consisting of the following subdivisions:

- Born in Norway to Norwegian-born parent's accounts for 1,342 individuals.
- Immigrants accounts for 19,973 individuals.
- Norwegian- Born to immigrant parents make up the largest group, with 16,727 individuals.
- Foreign- born with one Norwegian- born parent accounts for 144 individuals.
- Norwegian-born with one foreign-born parent accounts for 5,734 individuals.
- Foreign-born to Norwegian-born parents accounts for 21 individuals (Statistics Norway 2017).

2.4 Migration and health in Norway.

Migrants in Norway face a number of challenges towards their health status. These include access to the health care system, reproductive health, mental health problems, infectious diseases and health problems related with diet and lifestyle. The diet and lifestyle problems includes diabetes, obesity, cardiovascular disease and vitamin D deficiency. Mental health problems include lack of socioeconomic and social support, stress, effect of migration discrimination and negative life events. Infectious diseases include tuberculosis, HIV/AIDS and malaria (Hjelde 2012).

The health of migrants is very important in Norway as it provides equal opportunities to every individual irrespective of the ethnic origin. A study was conducted in Norway to assess migrant's participation in the Norwegian health care system based on data collected on migrants from 13 major countries. The results of the study showed that mental health issues faced by migrants were

mainly among those migrants that were refugees and had faced issue in the past. The study also found evidence of substance abuse among migrants that had experienced trauma in their life. Migrants that had been resident in Norway for a longer period of time were found to mainly suffer from diseases related with lifestyle, such as diabetes and obesity. Additionally, the study found that the incidence of musculoskeletal diseases was higher among labour migrants. Finally, the study also concluded that those migrants that had moved to Norway from neighbouring countries were more satisfied with the GP scheme compared with migrants that move to Norway from countries further away (Ursula & Berg 2011).

When looking at the satisfaction rates, the study by Ursula and Berg (2011) found that the main problem associated with lower satisfaction rates was the appointment time with the GPs. Another problem associated with satisfaction level was language barriers. Migrants and GPs often found that it is difficult to communicate effectively, and the use of translators have caused confidentiality issues. The study also found that female migrants from non-western countries did not consult with male doctors in certain matters, especially in gynecological examinations (Ursula & Berg 2011).

A register based study in Norway found that there was a lower percentage of immigrants who utilised primary health care services, especially the GPs, in comparison with native residence. However, migrants that did visit the GP, visited 2-15% more than the natives. GP use was found to be lower among older immigrants compared with the younger ones. GP visits were also low among migrants from high income countries compared with migrants from low and middle income countries. However, migrants from low and middle income countries had a higher percentage of visits to emergency departments as compared to high income countries and native residence. The study found a number of reasons for low use of primary care services; it was either due to good health in a number of cases, or due to a number of barriers such as culture, language, and personal reasons (Diaz & Larrañaga 2015).

In a separate study looking at mental health problems associated with migrants in Norway, it was found that older immigrants from low and middle income countries have higher mental health problems compared with the native population. An important factor found to be linked with mental health issues was deprivation of socioeconomic situations, and lack of support in the host country, that the migrant would otherwise have enjoyed in their home country. Other factors included

accumulated stress, effects of the migration process, especially in cases where the migrants faced trauma during migration, discrimination and events having a negative impact on their lives (Abebe 2012).

Pakistani immigrants in Norway have a high prevalence of psychological distress compared to the ethnic Norwegians. The socioeconomic situation can help to explain the inequalities in health of the Pakistani immigrants versus ethnic Norwegians. Unemployment rate is four times higher among Pakistani immigrants compared with ethnic Norwegians, and this can possibly explain the disparity in health inequality and psychological distress among Pakistani immigrants. Unemployment can lead to considerable amounts of stress and depression and can have a negative impact on the psychological health of migrants. Education levels have a strong impact on the health status of Pakistani immigrants. However, even with a higher level of education among Pakistani immigrants, unemployment remains high which can be a likely cause of increasing mental illness among the group. Inequality in health care was found to be higher among Pakistani low education and low income migrants. It was also found that 54.7 per cent of Pakistani immigrants in a study reported higher degree of bad self-rated health care compared to the ethnic Norwegians (22.1 per cent) (Raza 2006).

Ahlberg and Duckert have found that ethnic Norwegians and the minority patients have quite different views and understanding of diseases and treatment. This is due to a lack of shared understanding of disease pattern and knowledge (Ahlberg & Duckert 2006).

2.5 Health care system in Norway.

The health care system of Norway is very advanced. It has Nordic welfare system, which gives same benefits to its citizens irrespective of income, job, gender, religion, and ethnicity. There are both, public and private health care centers, however the private health care centers are limited in number. Life expectancy in Norway is 81.53 years which is above the average life expectancy in Europe. The Norwegian health care system is mainly semi-decentralized. The primary health care is mainly the responsibility of the Municipalities. Norway spends about 9.4 per cent of its GDP on health care expenditure. The number of physicians and nurses have increased in the past few decades and the number of health care personnel per person is higher in comparison with the other EU countries. The primary care including the emergency services is provided by the GPs.

Physiotherapist and Occupational therapist have the role of rehabilitative services which are under primary health care. Overall people enjoy a good health care system in Norway when compared with other European Countries (Rigard & Sagan 2013). In Norway people who are entitled to regular GP are: Any person that is registered with Norwegian National Registry and has an address in Norway, and immigrants and asylum seekers who have been assigned a D-number (Helsenorge, 2016).

Norway provides a universal health care system to its people irrespective of their economic and cultural backgrounds. Norway´s primary healthcare system's main divisions include the prevention and promotion of health, minority health and rehabilitation, physiotherapy, nursing homes, emergency care, community health and social care services and mental health and substance Abuse. All these primary health care beneficiaries are insured by the Norwegian Social Insurance Scheme (NSIS). The main purpose of the primary health care is the improvement in general health of the public so they do require hospitalization and are treated for their respective diseases (Helsedirektoratet, 2012).

The Regular General Practitioners (RGPs) scheme (*fastlegeordnign*) was introduced in 2001. According to this scheme, Norwegian residents have access to GPs and have the right to have their own GP. The immigrants who arrived newly often visited the emergency centers for very low level medical need. The reason might be due to a lack of health education and that they considered their health problem and emergency. A study conducted in Oslo in 2008 reported that immigrants visited their GPs and other specialist two to three times more than Norwegians. Among migrants, women and those with basic education of less than 10 years made the most visits. Iranians and Turkish migrants visited the psychologist or psychiatrist more than any other immigrants group in Norway due to having high prevalence of mental illness among the group. Despite visiting health professionals more frequently, satisfaction levels were low among this group. Reasons for this include poor communication between health professional and migrants due to language barriers and cultural perception. It is therefore important to consider the barriers that lead to dissatisfaction with health service among migrants (Kumar 2008).

2.6 Health care satisfaction

Patient Satisfaction can be defined as the judgement made by a patient receiving health care as to whether his desired expectation about health care services has been met (Palmer 1991).

Client satisfaction is also used to in place of patient satisfaction, and Davis and Hobbs defined it as the extent to which the expectation and treatment of the client is fulfilled. The different components of client satisfaction are access to health care health services, physical environment of the place and the care received by the clients (Davis and Hobbs 1989).

In 2008, research was published about non-western immigrants' satisfaction with the general practitioners' services in Oslo. The result shows that non-western immigrants including Pakistan immigrants were less satisfied than ethnic Norwegians. The reasons for dissatisfaction could be due to feelings of loneliness or feeling of not having good health, young age and coming from outside Norway (Lien 2008).

In a different study regarding patient satisfaction, Lurås found that reduced patient lists were positively related with higher patient satisfaction. This finding was based on data collected of 2326 patients who had visited their GPs during a six-month period. It is interesting to note that the results were not related to the ethnic background of the patients (Lurås 2007).

Mjaaland & Finset have found in their study that the Norwegian GPs were not using effective strategies in order to manage their daily workload effectively. Only 2% of GPs were using coping and resource strategies that are said to be coping and solution oriented. These strategies are very much important for patient satisfaction especially for the migrant patients (Mjaaland & Finset 2009).

So far very little is known about Pakistani immigrant's satisfaction with health care in Norway. There have been a number of studies in relation to immigrant's health and their satisfaction but not specifically about the Pakistani community which is the third largest ethnic group in Norway. Research conducted in United Kingdom to assess the satisfaction of Pakistani immigrants with the health care services showed that the satisfaction level was high among the community. About 94 % were satisfied with the services from General Practitioners, 93 % were satisfied with the help provided by GP receptionist and 97 % were satisfied with the care provided by hospital doctors.

Only 19 percent of the Pakistani immigrants in the study were found to be dissatisfied with Accidents and Emergency services. Therefore, the study concluded that Pakistani immigrants in England were very satisfied with primary health care services like GPs and Physiotherapists (Madhok 1998).

Another study related to satisfaction and utilization of health care was carried out in Maryland, USA among Pakistani immigrants. The results showed that higher levels of education, prolonged stay in hospitals, men and people with high income had a higher utilization of the primary health care services. There was also dissatisfaction with long appointment time for treatments, and some patients felt that there was a communication problem due to language barriers. Some patients could not speak English properly and therefore were unable to communicate effectively with their doctors. A number of migrants also reported difficulty in availing health care services due to job commitments. The problems in this regard stemmed from having to find someone that would cover their absence at the workplace. As a result, utilization and satisfaction levels with health care services among this group were low. Low income immigrants in USA have very low health insurance so they have to pay out of pocket payments for their treatment which leads to increased dissatisfaction and utilization of health care services (Ali 2014).

It has been found that immigrants often face problems and challenges when accessing to health care in Norway. For example, immigrants who do not speak good Norwegian language. In such a situation, communication acts a hurdle for the immigrant and therefore they are left dissatisfied with the information about their particular health problem and treatment. Additionally, immigrant can also lack information about the available health care services and facilities, and therefore, this could also lead to low levels of satisfaction among immigrants. Furthermore, the immigrants' economic conditions can also act as a hurdle in their access to health care services, and have an impact on their satisfaction levels (Forland 2009).

The regular GPs serve as gatekeepers for patient's access to secondary care. GPs act as the first point of contact for the patient in the primary health care environment. If the regular GP feels that a more specialized appointment, such as skin specialist, ENT, cardio specialist or Physiotherapist, is required by the patient, the GP will then refer the patients to the specialists. Once referred, the GPs are also responsible for follow up checkups of the patient. Patients referred by GPs in

Europeans countries, have generally been found to have a higher level of satisfaction with the services, and this was also found to be the case in Norway (Kroneman 2006).

2.7 Barriers and Facilitators of Health Care Satisfaction.

An important barrier found to be higher satisfactions is communication problems between doctors and their patients. Communication that is not effective can lead to misunderstanding and subsequently, unsatisfactory treatment results. Different treatment approaches used by doctors, such as psychological, biological and social can also act as barriers that affect doctor-patient communication. Children are often used as interpreters in such situations, and where there is a lack of interpreters it results in stress (Bischoff 2003 and 2010).

There is also a problem of stigmatization which can result in increased levels of fear and shyness among patients. Patients facing certain health conditions, especially related to mental health, worry about what others may think about their problem. Patients also fear that the doctors may not take their problems seriously and fear being judged. Most immigrants do not visit psychologists for mental health problems because of stigma related to the health problems and also their respective established culture that affects their decision. For example, if a patient has anxiety or another psychological related problem, and the patient's culture is such that disclosing the problem would lead to shame for the rest of the family members, that patient is likely to keep that stigma in mind and may not visit the doctor because of this (Wieringen 2002).

Similar findings were also observed in a study by Ahlberg and Duckert. According to their study, culture and language can act as major barriers in patient satisfaction and can also have a negative impact on patient treatment and compliance with their GP (Ahlberg and Duckert 2006).

A Dutch study showed that GP communicated differently with immigrants and non-immigrants. The study showed that consultations with migrants were shorter compared to consultations with non-migrants, GPs were more dominant verbally, and the immigrants were less demanding as compared with the non-immigrants (Meeuwesen 2006).

A longitudinal study conducted among 610 individuals assessed the effects of stigma on the psychological well-being and patient life satisfaction related to mental illness showed that there was a negative effect of stigma on health satisfaction and that the stigma has adverse effect on the patient's life satisfaction. The most important stigma was associated with psychological aspects of

health such as depression and anxiety.. Those with mental health problems are more likely to be unemployed, have lower incomes, work less, have low motivation levels, and lack self-interest. As a result, they eventually also end up receiving no social support which only adds to their stressful life. The study concluded that social support was an important tool to help in building motivation to fight against mental health related problems (Fred 1998).

Among other barriers to satisfaction are culture and ‘newness’ in society. Being new in the society means that there will be a certain level of difficulty when initially accessing health care services, such as making GP appointments. This can initially result in low levels of satisfaction among patients. In Norway, the waiting list for appointment time has been considered long, which can also lead to dissatisfied patients (Ursula & Berg 2011).

Culture can also act as a significant barrier to access and satisfaction with health care services. Migrants will initially not be used to the culture of the host country, therefore, may have a different understanding on certain aspects. Different cultural interpretation can also mean that the expectations from the health care service are also different, and as a result, satisfactions levels are impacted. For example, in the gynecological problems, migrant women may prefer to only speak with female doctors and not discuss such issues with male doctors. Where language barriers are easier to detect, cultural barriers are difficult. Health care professional often lack the knowledge required to deal with patients of a varied cultural background, which can give rise high levels of dissatisfaction with health care services (Kale et al 2010).

Facilitators are factors that help increase patient satisfaction with health care services. Facilitators can act as a catalyst for change and can help patient receive a better health care service. For example, there are various facilitators in health care such as medicines, good nursing care, ambulatory services and good communication between doctors and patients which can lead to a better understanding of the problems being faced by the patient and by the doctor, and the patient responding well to precautionary measures (Fullard 1987).

In a study to understand the barriers and facilitators in healthcare, in addition to language and communication, patient engagement with their GPs was also highlighted. If patients have a poor relationship with their GPs, this can lead to lower satisfaction levels with health care providers. Conversely, if the relationship is good, this will lead to higher levels of patient satisfaction. Among

other barriers noted by the study included uncaring and disrespectful behavior of the health care provider. In addition, the study noted that a lack of strong evidence of the effectiveness of standard care practices was considered a barrier, and so were shortage of health care professionals, non-availability of drugs, high cost of treatment, poor quality of care and lack of necessary equipment. The study found that continuity of care and active engagement with health care providers in the decision making process was consider a facilitator, in addition to regular supervision and feedback, and the provision of effective training to health care providers through a needs based and solution oriented training with high supervision and different courses (Nair &Yoshida 2014).

Another barrier to patient satisfaction identified is financial. This includes the cost of different services which the patient has received. Although Norway has a universal health care system which is free at the point of use, there are however other costs that must be considered, for example, transportation costs, over the counter medicine costs and other such expenses. These can act a barrier in accessing effective health care, especially for patients that do not have a good socioeconomic standing (Hauger 2011).

The different problems of the Pakistani immigrants related to health care satisfaction can be highlighted by this research. This knowledge will be important in order to have an understanding of problems and challenges they are facing in Norway. For example, if there is a problem that confidentiality is not ensured by the medical professionals or appointment times with health care professionals are too long or they discriminate while treating, these factors can be very useful to the Pakistani immigrants in Norway. Their point of view can be conveyed to the health authorities accordingly.

3. Theoretical perspectives

The theoretical perspective of this research is based on theory of post-positivism which represents our thinking and behavior after positivism. It is based on empirical observation and measurement. Post positivists recognized that while studying human behavior and actions we cannot be positive about our claims of knowledge. Post positivists believe that knowledge is valued and biased, and comes from many realities rather than one. There is a relationship between cause and effect. The problems which are studied by post positivists show the need to find the causes which influence

its outcomes. The cause and effect relationship exists together so we cannot separate cause from effect (John 2013).

There are not many theories about patient's satisfaction but one of the important theory is the **Pragmatic model of patient satisfaction**. The model is called pragmatic because it is links available empirical evidence about patient satisfaction with general social or psychological theories of behavior and defines the term satisfaction as an attitude. The attitude of satisfaction was defined as an evaluative judgement and reaction to care received by the patients (Linder 1982).

This pragmatic model serves as a base for future research on patient satisfaction. It can also serve as a stimulus for investigating the linkage between different components of the model and behavioral theories. Different observations, their respective and predicted results can be explained by the help of this theory as it is tested in empirical research. For patient satisfaction, the theory is helpful as it highlights possible results for which treatments may be helpful as far as patients are concerned. Thus, this theory can explain observations and suggest new hypothesis (Richard 1997).

According to the Figure-5 (shown below) the characteristics of patients influence their respective behavior or attitude towards heath care. The importance they give to different elements of care and their characteristics influence different priorities they give to various elements of health care. After their interaction with elements of health care, they assign their level of satisfaction accordingly. Many patients are highly satisfied while some are satisfied only with quick appointment. The patients' characteristics like age, sex, past experience of the care, mood and cultural factors etc. can influence their treatment. If patients are satisfied, they comply with advice they receive, but, if not, they change their doctors. This model has been assessed with different questionnaires like consultation satisfaction questionnaires (CSQ) and Surgical Satisfaction Questionnaires (SSQ). (Richard 1997).

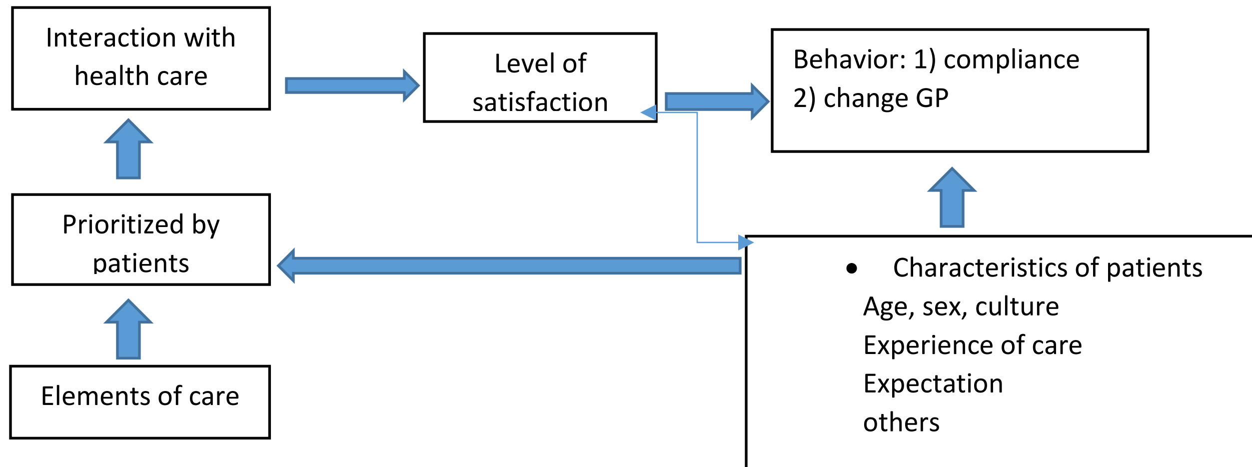

Figure 5: initial model of patient satisfaction in general practice.

This model also argues patient behavior can also influence the level of satisfaction as well. In one study looking at patient behavior, it was found that a patient that changed their GP without changing their address, were not happy with their new GP compared with their previous GP (Richard 1992).

This model was subsequently revised. The previous model did not attach any importance to personal care. This model is shown in Figure 6 below. Continuity and relation with the consultants are key features of the revised model as some patients regard personal care as important while some may not. The infrequent consulters and the people who change their addresses may affect the level of satisfaction as it is an important element of the satisfaction care (Richard 1992).

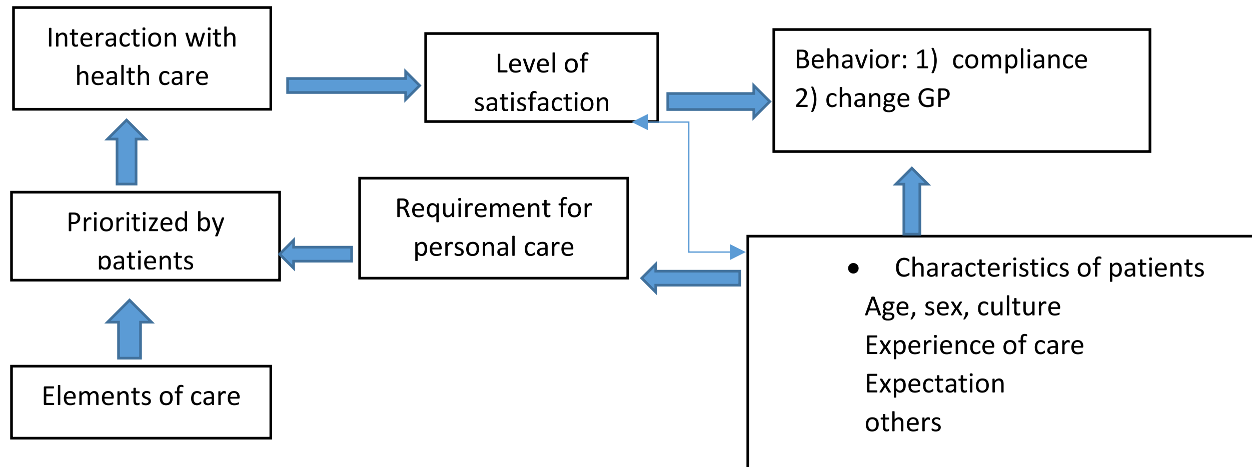

Figure 6: revised model of patient satisfaction in general practice.

How to evaluate patient satisfaction is an important debate for policy makers. Questionnaires are used widely to evaluate the level of satisfaction among the patients in health care system. For the assessment of patient satisfaction, the widespread use of questionnaires is helpful as it can show the doctor patient relationship and democratization of health. For evaluation of patient satisfaction heterogeneous questionnaires are used that can explore different areas of health care satisfaction (Kurti 2015).

The different types of questionnaire are:

Patient Satisfaction Questionnaire – PSQ, PSQ-II, PSQ-III and Client Satisfaction Questionnaire – CSQ. The Patient satisfaction questionnaire developed by Ware et al in 1976 is a general tool used in medical care to access patient's satisfaction and it consists of 18 different questions and takes approximately 3-4 minutes to complete (Ware et al 1976).

From PSQ which were later developed to PSQ-II and later it was shaped to the PSQ-III. The PSQ-II consists of mainly 55 items that give rise to the 18 subscales which is one of general satisfaction. The items on a scale can be rated as of 5 points (1 = completely agree, 5 = strongly disagree, 2= agree, 3= uncertain and 4=disagree) (Ware et al 1983).

The PSQ-III, is an instrument of 50 items and in addition to the general satisfaction, it also measures six specific aspects like technical quality, interpersonal manner, communication,

economic aspects of health care, time spent with the doctor, and accessibility of care (Marshall et al 1993).

The CSQ allows to get measurements related to user satisfaction and family satisfaction in different types of health care services. The reliability and validity is very good. The original version consists of 31 items covering nine different areas such as express satisfaction of the patient, overall satisfaction, different procedures, supportive staff, quality of health services, therapeutic staff, outcome of service and the duration or amount of health service. The wide CSQ is the one with 8 items (CSQ-8) (Larsen 1979). The questionnaire used for this study was developed using various questions from patient safety questionnaires (Appendix 1).

4. Study aim and research questions

Currently, very little is known about health care satisfaction among Pakistani immigrants residing in Norway. The basic aim and purpose of this study is to understand if Pakistani immigrants are satisfied with the health services being provided to them in Norway by different health care institutions.

The main research questions are as follows:

i) Are Pakistani immigrants satisfied with the health care system especially primary health care (PHC) including services from Regular General Practitioners, Psychologist and Physiotherapist?

ii) What do the Pakistani immigrants think about the barriers and facilitators of health care satisfaction?

There are different barriers in access to health care as have been discussed in the background section. The section also highlighted if the barriers are in the individual level, structural level, and cultural level or at system level. Satisfaction from facilitators is also an important research question as facilitators are health care providers which help patients to overcome their barriers.

It’s very important to know about the barriers and facilitators of health care satisfaction because by knowing the different barriers of primary health care, health care providers can provide better facilities and will try to remove the hurdles and barriers in access to health care.

5. Methodology

5.1. Study design and population

This study used quantitative research methods based on a convenience sample. Initially, the research was meant to use a sample of 200 participants consisting of 100 male and 100 females to maintain an equal ratio. The sample size was selected because of time and resources limitation.

5.2. Sampling strategies and size

The data was collected using interview-based questionnaires. Questionnaires were given to the respondents, and they were also interviewed to mark their response on the questionnaire. Participant names were not written on the questionnaire to provide them anonymity, and prior to filling the questionnaire and taking the interview, consent was obtained from the participants. Due to limited time, only 80 questionnaires from male and 60 from females were collected.

Data collection took place by visiting different gatherings of the Pakistani immigrants like religious gathering, Mosques, marriage ceremonies, festival in August like Mela and by going into different shops of Pakistani immigrants in Norway. The data was also collected by going in few homes of Pakistani families in Oslo.

The questionnaire used for this study is based on PSQ II questionnaire which consist of 18 points of patient satisfaction and it is easy to complete in a short amount of time (Marshall 1993). The questionnaires was about satisfaction with GPs, Physiotherapists, Psychologists, and different barriers and facilitators of health services satisfaction. Socio-demographic information is also included in the questionnaire.

5.3. Study variables

5.3.1. Outcome (dependent variables)

The dependent variables of this study were satisfaction from GPs, Physiotherapist, and Psychologist. Barriers and facilitators of satisfaction were appointment time, discrimination,

confidentiality, treatment plan, proper time and behavior of health care professionals, and quality of services.

5.3.2. Independent variables

The independent variables of this study were age, gender, income, job, education, reasons for coming to Norway, language skills, health status, marital status, religious practice, physical exercise, family size and time of stay in Norway.

5.4 Statistical analysis

Data was analysed using descriptive statistics. This describes the basic data features in a study population and gives simple summaries of the data. It allows to present given quantitative data in a suitable form. There are different types of analysis in descriptive statistics like univariate analysis, bivariate analysis and multivariate analysis. It gives different frequencies so that data can be arranged in different pattern like charts, graphs and histogram. Cross tabulation is also possible with the help of descriptive statistics (Trochim 2006).

The study also used one-way Anova test for collected data. It is an important tool to measure if there is any statistically significant difference between two or more than two independent variables. It also checks if there is any significance difference between two groups of study (Lund Statistics 2013). Using one way Anova test, this study will measure the statistical significance in satisfaction levels among Pakistani immigrants in Norway for GP, Psychologists and Physiotherapy services. Therefore, this test will be helpful in answering the first research questions set for this study.

6. Ethical considerations

Prior to completion of questionnaires, complete explanation was given to the participants about the purpose of the questionnaires and the purpose of this research. Everyone was free to express their views and if any participants refused to answer any questions, their decision was respected in this regard. Participant names were not recorded in the questionnaire and confidentiality was maintained. Participant were not forced into answering the questions and if they were busy and another participant was sought. In some cases, I had to wait for the participant to be free to respond. Ethics approval for this research was also obtained from the Regional Committees for Medical and Health Research Ethics (REC) to conduct research in Norway.

7. Results

7.1. Descriptive summary of the study population

Table 1 below provides the descriptive statistics obtained for the data. 80 participants were males and 60 were females which constitutes about 57.14% and 42.86% of the sample respectively. Almost two third of the participants in this were above the age 30 years. Most participants were married and were earning an income money above 300000 NOK per year. Majority of participants (52.9%) were working full time. Similarly, majority of the participants (62.85%) had obtained higher education and 85.7% of the participants considered themselves to be in good health. Most of the participants came to Norway after marriage (41.43%), and almost 70% of the participants had been resident in Norway for more than 15 years. Majority of the participants (50.7%) also undertook weekly exercise routines. 68.6% of the participants undertook daily religious offering, and almost 63% of the participant's belonged to larger families consisting of more than 4 family members. Only 35.75% of participants were native Norwegian speakers, however, almost 48% of the participants considered their Norwegian language to be of advanced level.

Table 1. Descriptive summary of the study population (N=140)

Variables	**N**	**%**
Age		
18-25	24	17.1
25-30	25	17.9
30-40	40	28.6
Above 40	51	36.4
Gender		
Male	80	57.14
Female	60	42.86
Marital status		
Single	37	26.43
Married	92	65.71
Divorced+Seperated	11	7.86
Income Level		
<200000 NOK	54	38.6
200000-300000 NOK	23	16.4
>300000 NOK	63	45
Job status		
Student+Part time	35	25
Employed Full time	74	52.9
Unemployed + pensioner	31	22.1

Education		
Primary+Secondary	52	37.1
College+University	88	62.85
Health Status		
Very good	42	30
Good	78	55.7
Fair+Bad	20	14.3
Reasons for Norway		
Study	16	11.43
Work	26	18.57
Family Marriage	58	41.43
Born in Norway	40	28.57
Residence Status		
< 5 Years	21	15
5-15 Years	22	15.7
>15 Years	97	69.3
Physical Activity		
Daily	39	27.9
Weekly	71	50.7
Monthly	14	10.0
None	16	11.4
Religious offerings		
Daily	96	68.6

Weekly	36	25.7
Monthly+ None	8	5.7
Family Size		
1-2	11	7.86
3-4	41	29.29
>4	88	62.9
Language skills		
Beginner+Intermediate	23	16.4
Advance	67	47.9
Native	50	35.75

The response options regarding dependent variables for satisfaction levels were measured on a likert scale of 1 to 5, where 1 was strongly agree, 2 agree, 3 uncertain, 4 disagree and 5 strongly disagree. Look at the mean and standard deviation of the different dependent variables, the mean score for GP satisfaction (3.9) was found to be higher than that for Physiotherapist (3.51) and Psychological (3.46) satisfaction. This means that on average, the participants were more satisfied with the GP services than they were with Physiotherapist and Psychologists. The highest mean score was obtained for ensuring confidentiality (4.31). Therefore, on average, the participants agreed that confidentiality was maintained by health care professionals. Additionally, participants also agreed that treatment plans and medicines were a good facilitator for their satisfaction with the services. The results of the questionnaire are summarized in Table 2 below.

Table 2. Detailed descriptive response rate of the dependent variables

Variables	**Mean**	**SD**
GP Satisfaction	3.90	0.924
Psychologist Satisfaction	3.46	0.781
Physiotherapist Satisfaction	3.51	0.809
Appointment time satisfaction	3.41	1.187
Treatment behaviour	3.78	0.890
Discrimination	2.11	1.188
Quality of services	3.82	0.931
Treatment plan	3.65	0.944
Confidentiality	4.31	0.750
Communication and language barrier	2.75	1.224
Structure of health and cultural barriers	2.61	1.11
Ambulatory service and nursing care good facilitator	3.93	0.895
Treatment plan and medicines good facilitator	4.04	0.897

Table 3 provides detailed description of the response rate for dependent variables. Satisfaction levels were found to be highest for services received from GPs, where almost 70% of the participants reported being satisfied with their GP services. This was followed by satisfaction with services received from physiotherapists (about 50%) and services received from psychologists (about 40%). About 50% of the participants were satisfied with appointment time at their services, whereas, about 70% participants reported being satisfied with the treatment and behavior they experienced. About 69% of the population said they were not discriminated. Almost 84% of the population felt that confidentiality was ensured by the health care professionals and about 45% of the participants said there were no communication and language barriers in access to the health care. Almost half the participants (50%) said that that the structure of health care and culture were not considered as barriers to accessing healthcare. Almost 75% of the population said that ambulatory service and nursing care are good facilitators of health care and 77% said that treatment plan and medicines are good facilitators of health care.

Detailed responses are provided in Table 3 below.

Table 3. Description of the response rate for dependent variables

	Response options				
Dependent variables	Strongly Agree N (%)	Agree N (%)	Uncertain N (%)	Disagree N (%)	Strongly Disagree N (%)
GP Satisfaction	39(27.9)	60(42.9)	31(22.1)	8(5.7)	2(1.4)
Psychologist Satisfaction	16(11.4)	41(29.3)	74(52.9)	9(6.4)	0(0.0)
Physiotherapist Satisfaction	15(10.7)	54(38.6)	60(42.9)	10(7.1)	1(0.7)
Appointment time satisfaction	31(22.1)	39(27.9)	32(22.9)	32(22.9)	6(4.3)

Treatment behaviour	26(18.6)	73(52.1)	26(18.6)	14(10.0)	1(0.7)
Discrimination	7(5.0)	14(10.0)	23(16.4)	40(28.6)	56(40.0)
Quality of health services are very good	32(22.9)	66(47.1)	30(21.4)	9(6.4)	3(2.1)
Same treatment plan	24(17.1)	64(45.7)	32(22.9)	19(13.6)	1(0.7)
Confidentiality	67(47.9)	51(36.4)	21(15.0)	1(0.7)	0(0.0)
Communication and language barrier	13(9.3)	27(19.3)	37(26.4)	38(27.1)	25(17.9)
Structure of health and cultural barriers	4(2.9)	33(23.6)	32(22.9)	47(33.6)	24(17.1)
Ambulatory service and nursing care good facilitator	37(26.4)	68(48.6)	25(17.9)	8(5.7)	2(1.4)
Treatment plan and medicines good facilitator	48(34.3)	60(42.9)	23(16.4)	8(5.7)	1(0.7)

Table 3.1 below provides the difference in the mean level of satisfaction with GP between groups highlighted in the descriptive statistic Table 1. Table 3.1 also provides the results of the ANOVA analysis undertaken for this study to assess the level of statistical significance. Based on the results

obtained, there is a statistically significant difference only across religious offering group for the level of GP satisfaction i.e. those who had monthly or none religious offerings have a significantly high level of satisfaction followed by daily and weekly offerings. There is no statistically significant difference across age, gender, marital status, income level, job status, education, health, immigration, residence status, physical activity, family size and language skills for the level of satisfaction with the GP. For more detailed information see the table below:

Table 3.1. Differences in the mean level of satisfaction from GP

Independent variables	**GP Satisfaction** (1-5) M(S.D)	**Anova** **F (P-Value)**
Age		
18-25	3.92(0.974)	
25-30	4.04(0.889)	1.471(0.225)
30-40	3.65(0.975)	
Above 40	4.02(0.860)	
Gender		
Male	3.83(0.991)	1.233(0.269)
Female	4.00(0.823)	
Marital status		
Single	4.00(0.850)	0.424(0.655)
Married	3.85(0.971)	
Divorced+Seperated	4.00(0.775)	
Income Level		
<200000 NOK	3.96(1.063)	
200000-300000 NOK	3.78(1.043)	0.313(0.732)
>300000 NOK	3.89(0.743)	

Job status		
Student+Part time	4.09(0.951)	
Employed Full time	3.80(0.827)	1.191(0.307)
Unemployed + pensoner	3.94(1.093)	
Education		
Primary+Secondary	3.96(0.949)	0.365(0.546)
College+University	3.86(0.912)	
Health Status		
Very good	3.81(1.042)	0.340(0.713)
Good	3.92(0.849)	
Fair+Bad	4.00(0.973)	
Reasons for Norway		
Study	3.81(1.167)	0.317(0.813)
Work	4.04(0.958)	
Family Marriage	3.84(0.875)	
Born in Norway	3.93(0.888)	
Residence Status		
< 5 Years	3.62(1.244)	
5-15 Years	3.86(0.710)	1.264(0.286)
>15 Years	3.97(0.883)	

Physical Activity		
Daily	3.85(0.988)	
Weekly	3.83(0.910)	0.812(0.489)
Monthly	4.14(0.864)	
None	4.13(0.885)	
Religious offerings		
Daily	3.97(0.923)	3.181(0.045)
Weekly	3.61(0.903)	
Monthly+ None	4.38(0.744)	
Family Size		
1-2	3.82(1.168)	
3-4	3.88(0.842)	0.075(0.928)
Above 4	3.92(0.850)	
Language skills		
Beginner+Intermediate	3.65(1.027)	1.236(0.294)
Advance	4.00(0.937)	
Native	3.88(0.849)	

Similar to the analysis carried out for GP satisfaction, table 3.2 provides the ANOVA results for participant's satisfaction levels with Psychologist services. The results obtained show that there is a statistically significant difference across age, job status, Immigration and religious offering for the level of Psychologist satisfaction. The age group 18-25, student or working part time, born in Norway and monthly or none religious offerings have higher satisfaction level with the Psychologists as compared to the rest of the group. There is no statistically significant difference across gender, marital status, income level, education, health, residence status, physical activity,

family size and language skills for the level of satisfaction with the Psychologist. Detailed results are provided in Table 3.2 below:

Table 3.2 Differences in the mean level of satisfaction from Psychologist

Independent variables	**Psychologist Satisfaction** (1-5) M(S.D)	**Anova** **F (P-Value)**
Age		
18-25	3.83(0.816)	
25-30	3.44(0.768)	2.701(0.048)
30-40	3.28(0.784)	
Above 40	3.43(0.728)	
Gender		
Male	3.41(0.741)	0.608(0.437)
Female	3.52(0.833)	
Marital status		
Single	3.68(0.818)	2.116(0.124)
Married	3.39(0.770)	
Divorced+Seperated	3.27(0.647)	
Income Level		
<200000 NOK	3.50(0.818)	
200000-300000 NOK	3.48(0.790)	0.190(0.828)
>300000 NOK	3.41(0.754)	

Job status		
Student+Part time	3.77(0.770)	
Employed Full time	3.42(0.759)	4.958(0.008)
Unemployed + pensoner	3.19(0.749)	
Education		
Primary+Secondary	3.56(0.777)	1.376(0.243)
College+University	3.40(0.781)	
Health Status		
Very good	3.45(0.803)	2.00(0.139)
Good	3.54(0.801)	
Fair+Bad	3.15(0.587)	
Reasons for Norway		
Study	3.38(0.719)	3.281(0.023)
Work	3.35(0.936)	
Family Marriage	3.31(0.627)	
Born in Norway	3.78(0.832)	
Residence Status		
< 5 Years	3.33(0.796)	
5-15 Years	3.27(0.883)	1.257(0.288)
>15 Years	3.53(0.751)	
Physical Activity		
Daily	3.51(0.756)	
Weekly	3.44(0.823)	0.090(0.965)
Monthly	3.43(0.646)	
None	3.44(0.814)	

Religious offerings		
Daily	3.51(0.795)	3.089(0.049)
Weekly	3.22(0.681)	
Monthly+ None	3.88(0.835)	
Family Size		
1-2	3.27(0.786)	
3-4	3.51(0.840)	0.406(0.667)
Above 4	3.45(0.757)	
Language skills		
Beginner+Intermediate (23)	3.22(0.736)	1.726(0.182)
Advance	3.45(0.822)	
Native	3.58(0.731)	

Table 3.3 provides individual group means and standard deviations related to satisfaction with the Physiotherapist services and the ANOVA results obtained. Similar to GP satisfaction, there is a statistically significant difference only across religious offering for the level of Physiotherapist satisfaction. Those who had monthly or none religious offerings have a significantly high level of satisfaction followed by daily and weekly offerings. There is no statistically significance difference across other variables. Detailed results are provided in Table 3.3 below:

Table 3.3 Differences in the mean level of satisfaction from Physiotherapist

Independent variables	**Physiotherapist Satisfaction** (1-5) M(S.D)	**Anova F (P-Value)**
Age		
18-25	3.63(0.924)	
25-30	3.44(0.651)	0.221(0.882)
30-40	3.50(0.784)	
Above 40	3.51(0.857)	
Gender		
Male	3.50(0.796)	0.058(0.810)
Female	3.53(0.833)	
Marital status		
Single	3.68(0.818)	1.077(0.344)
Married	3.45(0.803)	
Divorced+Seperated	3.55(0.820)	
Income Level		
<200000 NOK	3.65(0.756)	
200000-300000 NOK	3.30(0.974)	1.597(0.206)
>300000 NOK	3.48(0.780)	

Job status Student+Part time Employed Full time Unemployed + pensoner	 3.71(0.860) 3.49(0.798) 3.35(0.755)	 1.733(0.181)
Education Primary+Secondary College+University	 3.63(0.841) 3.44(0.786)	 1.841(0.177)
Health Status Very good Good Fair+Bad	 3.57(0.887) 3.51(0.785) 3.40(0.754)	 0.301(0.740)
Reasons for Norway Study Work Family Marriage Born in Norway	 3.44(0.629) 3.46(0.859) 3.53(0.754) 3.55(0.932)	 0.121(0.948)
Residence Status < 5 Years 5-15 Years >15 Years	 3.38(0.590) 3.59(0.666) 3.53(0.879)	 0.390(0.678)
Physical Activity Daily Weekly Monthly None	 3.69(0.766) 3.38(0.763) 3.36(1.082) 3.81(0.750)	 2.238(0.087)

Religious offerings		
Daily	3.55(0.866)	4.098(0.019)
Weekly	3.28(0.779)	
Monthly+ None	4.13(0.641)	
Family Size		
1-2	3.18(0.982)	
3-4	3.46(0.778)	1.302(0.275)
Above 4	3.58(0.798)	
Language skills		
Beginner+Intermediate	3.39(0.499)	0.413(0.662)
Advance	3.57(0.821)	
Native	3.50(0.909)	

4. Correlation

Correlation between the main dependent variables (GP satisfaction, Psychologist and Physiotherapist satisfaction) with the other dependent variables such as appointment time satisfaction, behavior of the health care professionals, discrimination, quality of health care services, same treatment plan, confidentiality, was also analyzed.

Higher GP satisfaction levels were found to be significantly positively correlated with satisfaction with appointment time, the treatment and behavior experienced from health care professionals, the quality of health care services, and good treatment plans and medicines. In terms of satisfaction with Psychologist services, significant positive, but weak correlation was found with appointment time satisfaction, quality of health services provided and ensuring confidentiality. Satisfaction with Psychologist services was found to be significantly negatively correlated with discrimination. In

the case of satisfaction with services received from Physiotherapists, statistically significant positive correlation was found with treatment and behavior by health professionals and ensuring confidentiality.

Table 4: Correlations between Satisfaction with GP, Psychologist and Physiotherapist and the facilitators and barriers of health care satisfaction

	GP Correlation coefficient	**Psychologist Correlation coefficient**	**Physiotherapist Correlation coefficient**
Appointment time satisfaction	0.367**	0.170*	0.143
Treatment behaviour	0.443**	0.342	0.372**
Discrimination	-0.005	-0.183*	0.016
Quality of health services are very good	0.225**	0.216*	0.113
Same treatment plan	0.044	0.077	0.121
Confidentiality	0.079	0.274**	0.218**
Communication and language barrier	0.064	0.112	0.034
Structure of health and cultural barriers	-1.16	-0.33	-0.79
Ambulatory service and nursing care good facilitator	0.148	0.049	0.068

Treatment plan and medicines good facilitator	0.203*	0.126	0.078

****.Correlation is significant at 0.01 level (2-tailed)**

***. Correlation is significant at 0.05 level (2-tailed)**

8. Discussion

8.1. Summary of main findings and Comparison with Previous Studies

The main findings of this study show that almost two thirds of the participants were satisfied with the services of the GP. Almost 41% of the population were satisfied with the services of Psychologist and almost half of the population were satisfied with the services of the Physiotherapist. Majority of the population said they were not discriminated during treatment and most of the participants felt that confidentiality was ensured by health care professionals. Less than half of the population said there were no communication and language barriers in access to the health care. Half of the population said that culture and structure of health care were not a barrier in access to health care. Majority of the participants said that ambulatory service and nursing care are good facilitators of health care, and most of the participants said that treatment plan and medicines were good facilitators of health care satisfaction.

In terms of satisfaction with GP services, this study found that majority of the participants had a high level of satisfaction. This finding is similar to that reported by Rajan Madhok in United Kingdom about Pakistani immigrants satisfaction level with primary health care services such as GP in 1998.

Communication and language barriers were not considered as barriers by the participants. Reflecting back on the descriptive statistics obtained for participants, over 80 per cent of the participants were advanced or native Norwegian language speakers. Therefore, it is not surprising that language and

communication were not considered as barriers to health care access. These findings are in contrast with those presented by Ursula & Berg (2011) who found not only low levels of satisfaction among participants in relation to GP services, but also that language and communication were considered as barriers. There are number of reasons for these different results. Firstly, this study only focuses on the Pakistani immigrant community, whereas in the study by Ursula and Berg (2011), participants were from a mixture of ethnic backgrounds. Secondly, Pakistani immigrants came to Norway as part of the first wave of Migrants in the late 1960s. Having been an established community in Norway for a while, it would be expected that the community would have obtained advanced language skills. This is also evident from the descriptive statistics presented in Table 1, which shows that almost 70% of the participants in this study had been in Norway for more than 15 years. These findings are also in contrast to a study conducted by Shehzad in Maryland, USA, who found that communication and language acted as a barrier for the Pakistani immigrant community when accessing health care.

In this study, it was found that participants were generally satisfied with the appointment times. This finding was similarly reported by Ursula & Berg (2011) related to appointment time satisfaction with the GP.

There was a statistically significant difference only across religious offering group for the level of GP and Physiotherapist satisfaction. Those who had monthly or none religious offerings had a significantly high level of satisfaction followed by daily and weekly offerings. This could suggest that religious interpretations and cultural influence can play a role in impacting patient satisfaction among the Pakistani immigrant community in Norway.

There was a statistically significant difference across age, job status, immigration and religious offering for the level of Psychologist satisfaction. The age group 18-25, student or working part time, born in Norway and monthly or none religious offerings have higher satisfaction level with the Psychologists as compared to the rest of the group. The findings with regards to age group can suggest that the younger generation of Pakistani immigrants are more open to attending psychologist services. Maintaining traditional and cultural beliefs, especially in regards to mental health issues as discussed in the literature, can lead to having low levels of satisfactions with the psychologist's services. Older Pakistani immigrants may be more reluctant in using psychologist service to begin with and hence

could report lower levels of satisfaction. Similarly, students who fall in the same age group may have similar views about using psychologist services. This is further evidence by the fact that the study found that those born in Norway had a higher level of satisfaction with psychologist services compares with those that were not. Furthermore, the results of this study indicate that half of the participants remained neutral or they had never visited the Psychologists. The low use of psychologist services was also reported in the study by Diaz & Larrañaga (2015).

In addition, the significant negative correlation between discrimination and levels of satisfaction with psychologist could signal the effects of stigmatization. If patients feel that they will be stigmatized or judged by health care professionals, their levels of satisfaction will be low. This can also explain why confidentiality was positively correlated with Psychologist and Physiotherapist services. It would follow, based on the results obtained, that if patients felt that the services were ensuring confidentiality, they were more likely to access that service and have higher levels of satisfaction with that services. Confidentiality was not a significantly related with satisfaction levels in GP services, suggesting that participants were perhaps more concerned about confidentiality in Psychologist and Physiotherapist services.

However, overall, this study found that culture and language were not considered a barrier in accessing health care. This finding is in contract with that reported by Diaz & Larrañaga (2015), who argued that lower usage of primary health care services was linked with having good health, and barriers such as culture, language and personal reasons. Given the time that majority of the participants had been in Norway for (15 years and above), it can be said that the Pakistani immigrant community has embedded well with the local culture, and therefore, do not consider culture as a barrier to accessing health care.

9. Strengths and Limitation

This study has a number of limitations that must be highlighted. First, the study population is limited to only those above 18- years of age, and Pakistani immigrants in Oslo, Norway. Second, data collection was a difficult process due to time and resource constraints. Initially the study had planned to use a sample of 200 participants (100 male and 100 female) however, only 140 participants were recruited (80 males and 60 females). The main problems faced were during data collection from female

participants as due to their religious point of view, female participants were reluctant in being approached directly. Furthermore, they were reluctant in providing feedback to the interview questionnaire. Third, I have tried to avoid memory bias while just generally focusing on my study population. Fourth, I have employed cross sectional study design in which data was collected at once without getting feedback again from the respondents. Where this method saved substantial research time, it also has its limitations. Using a cross sectional study design, it is difficult to make causal inferences. This is mainly because the data collected is done at one particular time, and hence, the results could change if the same data was collected at a different time and a different place (Bland 2001).

10. Implications to policy makers and health authorities

Regarding implications to policy makers and health authorities there are few things that need to be addressed by policy makers such as satisfaction from Psychologist and Physiotherapist. The satisfaction level with Psychologist and Physiotherapist was much lower than GP satisfaction. More than half of the participants remained neutral when reporting satisfaction levels with Psychologist and less than half of the population for Physiotherapist satisfaction level. While asked about being neutral participants said that they had never visited nor utilized these services. To a lesser extent they are neither satisfied nor dissatisfied with these services, however, this does provide a good point for future research among the Pakistani immigrant community. Secondly, the appointment time with these primary health care professionals also needs to be addressed as to some extent appointment time is also related to lesser satisfaction. Although half of the population was satisfied with the appointment time, there is a need for measures to be taken to increase its percentage. Almost one third of the population said that there are language and communication barriers in access and satisfaction with the health care. Although this was not an explicit barrier, it should be monitored by authorities.

11. Conclusion

The study found that mostly people were satisfied with services provided by their GPs, Psychologist and the Physiotherapist. The satisfaction level of GP was higher when compared with those of Psychologist and Physiotherapist. People were satisfied with the quality of services and confidentiality being insured by the health care professionals. Discrimination was not a major barrier in accessing health care, however it was negatively correlated with satisfaction levels with Psychologist services.

Structure of health and culture were not barriers in access to health care, and language and communication were also not considered as barriers in accessing health care. Nursing care, ambulatory service, treatment plan and medicines were found to be good facilitators of the health care.

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Appendix 1

Questionnaire

Please select the following suitable options.

1) What is your gender? A) Male b)Female

2) What is your age?………...years.

3) What is your marital status?

a) Married b) single c) divorced d) widow

4) What is your current status of job?

a) Employed full time b) Employed part time c) Unemployed d) Student e) other …………

5) What is your profession?......................................

6) What is your level of your education?

a) Primary b) secondary c) bachelors d) masters e) doctorate f) other……………

7) How is your health in general?

a) 5 = "very good" b) 4 = "good" c) 3 = "fair" d) 2 = "bad" e) 1 = "very bad".

8) What are the reasons for coming to Norway?

a) Work b) family marriage c) study d) asylum e) Born in Norway e) other……………….

9) How long you have been living in Norway?…………....years.

10) How is your skills in Norwegian language?

a) 5 = "very good" b) 4 = "good" c) 3 = "fair" d) 2 = "bad" e) 1 = "very bad".

11) What about your family size?

a) Large b) Medium c) Small d) no family

12) How often do you practice religious offerings?

a) Daily b) Once or twice a week c) Weekly d) Monthly e) No practice

13) How often you do physical activity?

a) Daily b) Once or twice a week c) Weekly d) Monthly e) No practice

Related to satisfaction from primary health care professionals i.e. General practitioners, Physiotherapist and Psychologist how strongly do you agree or disagree with the following statements.

	Strongly Agree	Agree	Uncertain	Disagree	Strongly disagree
1) Are you satisfied with the services receiving from General practitioners?	1	2	3	4	5
2) Are you satisfied with the services receiving from physiotherapists?	1	2	3	4	5
3) Are you satisfied with the services receiving from psychologists?	1	2	3	4	5
4) Are you satisfied from the appointment Time with your health care professionals?	1	2	3	4	5
5) They treat,behave,give proper time,and I can easily access health care. Above treat very well to us	1	2	3	4	5
6) They usually discriminate while Treating me as to other people.	1	2	3	4	5
7) The quality of health services are Very good	1	2	3	4	5

8) They always follow the same 1 2 3 4 5
Treatment plan whenever I visited them.

9) Confidentiality is insured by the 1 2 3 4 5
Health professionals

10) There is a communication and
Language barrier in access to health care 1 2 3 4 5

11) Structure of health system is not good
and Culture is a barrier for satisfaction to 1 2 3 4 5
health care

12) Ambulatory service and Nursing care 1 2 3 4 5
Are good Facilitator for satisfaction to health care.

13) Treatment plan and Medicines 1 2 3 4 5
are good facilitator for
satisfaction.

Appendix 2.

Decision from REK

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst	Hege Holde Andersson	22845514	14.09.2016	2016/1282/REK sør-øst B
			Deres dato:	**Deres referanse:**
			14.06.2016	

Vår referanse må oppgis ved alle henvendelser

Dawit Abebe
HiOA

2016/1282 Helsetjenester tilfredshet blant pakistanske innvandrere i Oslo: En tverrsnittstudie

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK sør-øst) i møtet 17.08.2016. Vurderingen er gjort med hjemmel i helseforskningsloven § 10, jf. forskningsetikkloven § 4.

Forskningsansvarlig: Høgskolen i Oslo og Akershus
Prosjektleder: Dawit Abebe

Prosjektomtale:
Jeg vil gjennomføre kvantitativ studie. Min viktigste spørsmålene er som under: i) Gjør pakistanske innvandrere er fornøyd med helsevesenet spesielt primærhelsetjenesten (PHC) inkludert tjenester fra fastlegene, psykolog og fysioterapeut? ii) Hva gjør de pakistanske innvandrere mener om barrierer og tilretteleggere av helsevesenet tilfredshet? Det finnes ulike barrierer i tilgang til helsetjenester som jeg har diskutert i bakgrunnen delen og jeg vil prøve å finne ut om barrierene er i individnivå, strukturelt nivå, kulturell eller på systemnivå. Tilfredshet fra tilretteleggere er også viktig problemstilling som tilretteleggere er helsepersonell som hjelper pasienter til å overvinne sine barrierer. Det er veldig viktig å vite om barrierer og tilretteleggere av helsevesenet tilfredshet fordi ved å kjenne de ulike barrierer av primærhelsetjenesten de helsepersonell kan gi anleggene bedre og vil prøve å fjerne hindringer og barrierer i tilgangen til helsetjenester.

Komiteens vurdering
Det er oppgitt i søknaden at forskningsspørsmålene i studien er:

- Om pakistanske innvandrere er fornøyd med helsevesenet spesielt primærhelsetjenesten (PHC) inkludert tjenester fra fastlegene, psykolog og fysioterapeut?

- Hva pakistanske innvandrere mener om barrierer og tilretteleggere av helsevesenet tilfredshet.

Slik komiteen forstår prosjektet er hensikten med studien å finne ut om pakistanske innvandrere er fornøyd med helsevesenet, spesielt primærhelsetjenesten inkludert tjenester fra fastlegene, psykolog og fysioterapeut.

Helseforskningsloven gjelder for medisinsk og helsefaglig forskning, det vil si «virksomhet som utføres med vitenskapelig metodikk for å skaffe til veie ny kunnskap om helse og sykdom», jf. helseforskningsloven § 2, jf. § 4. Komiteen anser dermed at prosjektet ikke omfattes av helseforskningslovens virkeområde. Det kreves ingen forhåndsgodkjenning fra REK for å gjennomføre prosjektet.

Vedtak

Etter søknaden fremstår prosjektet ikke som medisinsk eller helsefaglig forskning, og det faller derfor utenfor helseforskningslovens virkeområde, jf. § 2.

Klageadgang
Du kan klage på komiteens vedtak, jf. forvaltningslovens § 28 flg. Klagen sendes til REK sør-øst B. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK sør-øst B, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Komiteens avgjørelse var enstemmig.

Med vennlig hilsen

Grete Dyb
professor, dr. med.
leder REK sør-øst B

Hege Holde Andersson
komitésekretær

Kopi til:
postmottak@hioa.no
rune.halvorsen@hioa.no