Ethnic boundary-making in health care: Experiences of older Pakistani immigrant women in Norway

Abstract

Older immigrant women experience several barriers in accessing health care. In this study, we explored how older Pakistani women are met with, and respond to, barriers to health care in Norway, using an ethnic boundary-making and intersectionality approach. Our data included interviews with 23 older Pakistani women and 10 caregivers. We found that ethnic boundaries were constructed in healthcare interactions and were influenced by participants' social positions. At the micro level, the interplay of language barriers and being an immigrant fuelled the making of ethnic boundaries. At the macro level, ethnicised cultural discourse in the public sphere fuelled the making of ethnic boundaries in health care. Having encountered ethnic boundaries in health care, older Pakistani women actively coped through compensatory, de-stigmatising and boundary-modifying strategies.

Highlights

- This is the first study exploring ethnic boundary-making in health care in Norway
- Ethnic boundaries are constructed in immigrant women's encounters with healthcare
- Ethnic boundary-making is contingent on the intersection of social positions
- Ethnic boundaries from public discourse spill into health care and create barriers
- Ethnic boundary-making may undermine ambitions of equitable health care in Norway

Keywords

Norway; ethnicity; health care; immigrants; barriers; older age; women's health; intersectionality

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Introduction

With an increasing number of immigrants in Western Europe and continued population ageing, recent research has focussed on barriers to health care among older immigrants. Immigrant populations face a number of challenges when accessing health care in their host country, such as language barriers, unfamiliarity with the health system and differing cultural practices (Goth and Berg, 2011; Oglak and Hussein, 2016; Suurmond et al., 2016). Older age may heighten these barriers (Khan et al., 2013). According to a thematic synthesis, the barriers facing older immigrants stem from three main areas: a) a different understanding of health, health care and the role of healthcare professionals; b) the traditional discourse of care influencing healthcare-seeking behaviour among immigrants; and c) the predisposed vulnerabilities of older immigrants, such as language barriers, low literacy and a lack of information (Arora et. al., 2018). Other studies have shown that the intersections of old age, ethnicity, socioeconomic factors and gender have further implications for health and access to healthcare services (Brenner and Clark, 2018; Northwood et al., 2018; Gee et al., 2003; Goth and Berg, 2011; Villatoro et al., 2017). For example, the multiple roles of women, including caregiving responsibilities, can reduce their ability to make decisions regarding their own health and limit their access to, and use of, healthcare services (Gee et al., 2003). Further, immigrant women of non-Western origin may not be aware of their right to, for instance, request a female doctor (Goth and Berg, 2011).Overcoming barriers to health care is important from a social justice perspective. However, this perspective is largely absent in the literature on ageing and ethnicity, perhaps because an ethno-gerontological understanding of ethnicity relies on either essentialist or structuralist assumptions or a combination of the two (Torres, 2019).

Health and social literature often presumes that ethnicity leads to inequalities without exploring how these inequalities are created or maintained (Torres, 2019). A social constructionist perspective of ethnicity, as originally developed by Barth (1969), may help to show ethnicity

48 as the product of social processes rather than a cultural given and how ethnic boundaries are
49 maintained in our lives (Torres, 2019).

50 In the current study, we applied the ethnic boundary-making perspective to explore how older
51 Pakistani women experience their healthcare interactions in Norway. We discuss how
52 experiencing barriers to healthcare services promotes boundary work by the women. We also
53 use an intersectionality perspective to show how ethnic boundary-making is moderated by
54 social contexts regarding gender, age and class. Our study contributes to knowledge of ethnic
55 boundary making in healthcare and potentially undermines commitment towards equity in
56 health care.

57 **Pakistani immigrants in Norway and their utilisation of healthcare services**

58 Ethnic boundary-making is contingent and feeds on contemporary and historical discourse and
59 images of the 'other' (Wimmer, 2013). It is therefore useful to provide a short overview of the
60 'othering' processes of immigrants in Norway, especially for Pakistani immigrants. Older
61 Pakistani immigrants are one of the largest groups of older immigrants in Norway (Ingebretsen
62 et al., 2015). The first Pakistani immigrants arrived in the late 1960s and 1970s as labour
63 immigrants, with more following through family reunification and marriage. The resulting
64 strain on the labour and housing market led to a general perception that such problems were
65 caused by 'a Pakistani problem' (Brochmann and Kjeldstadli, 2008).

66 Recently, scholars have argued that the use of categories such as 'ethnic minority' and
67 'Pakistani' sets immigrants and ethnic minorities in opposition to Norwegians (Thun, 2012).
68 Discourse about 'Norwegianness' prevails through the use of the categories of 'us' and 'the
69 others', which maintain (perceived) borders between the two and the concept of a homogeneous
70 society (Lane, 2009). This suggests that ethnic boundaries are continually constructed in public
71 discourse.

72 Ethnic boundaries in public discourse have material consequences (Wimmer, 2013). A recent
73 study demonstrates that more than a third of Pakistani immigrants report perceived
74 discrimination in the labour market (Hamre, 2017). Among descendants of immigrants, young
75 applicants with Pakistani names are severely disadvantaged in the labour market compared to
76 equally qualified majority applicants (Midtbøen and Rogstad, 2012). In addition, stereotypes
77 are prevalent across generations, and the children of immigrants encounter attitudes and
78 prejudices attached to their parents' generation when entering the labour market (Midtbøen,
79 2014).

80 Apart from the public discourse and its consequences, healthcare utilisation patterns suggest
81 the need to explore barriers to health care among Pakistanis in Norway. Health care is
82 predominantly state-funded in Norway and is available to all registered residents (Haarmann,
83 2018). While immigrants have, in general, been found to use primary health care (PHC) less
84 than "native" Norwegians do, Pakistani women have an average of five consultations with a
85 GP per year, one of the highest rates among the surveyed immigrant groups (Lunde and
86 Texmon, 2013). High utilisation may indicate non-effective contact, implying that older
87 Pakistani women struggle to access appropriate care services suited to their needs. In addition,
88 despite the high utilisation of health care, Pakistanis also report a higher prevalence of poor
89 self-reported health—54.7%, as opposed to 22.1% in ethnic Norwegians (Syed et al., 2006).
90 Immigrant women in higher age groups also report greater distress, as age influences the ability
91 to learn and use a new language, to socialise and to cope with stressful environments (Thapa
92 and Hauff, 2005). Furthermore, Pakistani women are less likely to have higher education or to
93 be employed than Pakistani men (Kumar et al., 2008). Thus, Pakistani women are socially
94 disadvantaged when compared with their male counterparts, which can impact both their health
95 and their access to healthcare services.

96 Equity in health care provision is an important policy goal (Meld. St. 13., 2018–2019). In
97 Norwegian society, a strong emphasis on ‘similarity’ and ‘sameness’ has led to conflict
98 avoidance (i.e., the avoidance not only of ideas but also of people who are deemed too different)
99 (Gullestad, 2002). Such an emphasis on ‘imagined sameness’ has blurred social class divisions
100 among Norwegians but has also made the differences between Norwegians and immigrants
101 discursively salient (Gullestad, 2002). Given this seemingly egalitarian social context and
102 equitable healthcare system in Norway, the country makes for a unique context in which to
103 study this topic.

104 **The ethnic boundary-making approach**

105 The ethnic boundary-making approach explores the making and unmaking of ethnic boundaries
106 (Barth, 1969). In line with Wimmer (2008), we conceptualise ‘race’ as a subtype of ‘ethnicity’,
107 although they are hard to separate. The term ‘ethnicity’ is more common in the Norwegian
108 public and social scientific research sphere, perhaps due to an absence of a history of race-based
109 slavery and Norway never having been a colonial power. However, this does not imply that
110 Norwegian society is colour-blind, as ‘skin-color and external physical features invoke notions
111 about ancestry, identity and belonging’ (Kyllingstad, 2017, p.326).

112 Ethnic boundaries are the result of negotiations between actors whose strategies are shaped by
113 the characteristics of their social field (Wimmer, 2008). The concept of ethnic boundary-making
114 has both subjective and objective dimensions and applies when a symbolic, social and material
115 element is present (Wimmer, 2008). The symbolic element occurs when ethnic salience is
116 asserted by constructing subjective distinctions between ethnic in-groups and out-groups. When
117 people act upon these ethnic distinctions, by preferring interaction with ethnic in-group
118 members and avoiding or getting into conflicts with out-group members, the social element of
119 ethnic boundaries emerges. A material element emerges when the re-distribution of resources

120 occurs through people favouring or privileging fellow ethnic in-group members, resulting in
121 inequality or exclusion (Wimmer, 2013).

122 Boundary work is relational; individuals from both the ethnic majority and the ethnic minority
123 may be involved in the social construction of ethnic boundaries. One response to meeting with
124 boundaries is the use of 'boundary-modifying strategies'. These do not aim to change a
125 boundary but rather to modify its meaning or implications (Wimmer, 2013, p. 56). Such
126 strategies may include boundary-blurring, where individuals are seen as members of the groups
127 on either side of the boundary simultaneously or at different times (Alba, 2005). Another
128 boundary-modifying strategy is 'boundary crossing', which implies that someone moves from
129 one group to another, without any real change to the boundary itself (Alba, 2005). 'Normative
130 inversion' is another boundary-modifying strategy, which occurs when members of stigmatised
131 groups react to stigmatisation through a broad range of responses (Lamont and Mizrachi, 2012).
132 Through reverse stigmatisation and reinterpreting their identity positively, these groups can
133 challenge inequality, stereotypes and discrimination (Wimmer, 2013).

134 The factors that contribute to the making or unmaking of ethnic boundaries can best be
135 identified in institutional settings where ethnicity is presumably insignificant and where
136 interaction takes place according to non-ethnic principles (Wimmer, 2013). Considering
137 healthcare interactions through the boundary-making approach may shed more light on how
138 barriers in health care are experienced and coped with.

139 **Ethnic boundary-making and Intersectionality**

140 Because the literature related to ethnic boundary-making does not account for different social
141 positions within ethnicity, such as gender (Werbner, 2018; Duemmler et al., 2010), we use an
142 intersectionality approach to add analytical value to our study. The term intersectionality was
143 coined by Kimberle Crenshaw to highlight the importance of simultaneous categories of

144 oppression that constitute differences in power (Crenshaw, 1997). Intersectionality describes
145 'the entanglement of identity categories that make up an individual, the differential attributions
146 of power that result from such varied configurations, and the need to view intersectional beings
147 holistically rather than try to tease apart different strands of identity' (Hulko 2009, 48). Thus,
148 intersectionality is concerned with how different social locations such as gender, age, ethnicity
149 and class interact to shape experiences. Both ethnic boundary-making theory and
150 intersectionality have the potential to inform each other. The boundary-making literature
151 focuses on how ethnicity contributes to the making or unmaking of boundaries, whereas
152 intersectionality highlights the complex social locations within these boundaries (Korteweg and
153 Triadafilopoulos, 2013). These complex interwoven social locations (Crenshaw, 1991), can not
154 only give rise to different subjective experiences in healthcare interactions but also different
155 structures of power and inequality in accessing and utilising healthcare services. Thus, even
156 though ethnicity is the underlying premise of the boundary making process, it is moderated by
157 other social locations of gender, age and class.

158 **Methods**

159 Our study used a qualitative research design based on semi-structured in-depth interviews with
160 older Pakistani women and informal caregivers. All participants were recruited using 'snowball
161 sampling' (Robinson, 2013) through key informants, a local mosque and an activity centre. We
162 recruited older immigrant women and caregivers who were not related to each other to ensure
163 that both groups of participants felt free to discuss sensitive topics. In addition, a focus group
164 discussion (FGD) was conducted with older Pakistani women to explore group dynamics and
165 perceptions. The study was conducted in the municipality of Oslo, where the largest number of
166 older Pakistanis in Norway reside. The recruitment criteria for older Pakistani women were:
167 being a Pakistani immigrant woman aged 45 years or older, being permanently settled as a legal
168 resident in the municipality, and having lived in Norway for at least 10 years. Caregivers were

169 recruited if they perceived themselves to be the primary provider of care for an older female
170 relative or if they were primarily involved in facilitating access to formal health care by
171 accompanying an older female relative to appointments. Although we contacted both male and
172 female key informants in the community to refer us to caregivers willing to participate, we
173 found only women who associated themselves with the role of primary caregiver.

174 We conducted 16 interviews with older Pakistani women and one FGD with seven older
175 Pakistani women. Older participants were aged between 48 and 81 years old and had been living
176 in Norway for 26 to 46 years. Twelve participants described their Norwegian language skills as
177 'good', eight participants as 'average' and three participants as 'limited' (i.e., able to understand
178 nothing beyond a few simple sentences). Ten informal caregivers were recruited; eight were
179 daughters and two were daughters-in-law, aged between 23 and 40 years old. All but two of the
180 caregivers were born in Norway.

181 Interviews with older Pakistani women revolved around their perceptions of their own health,
182 their experiences with healthcare services in Norway and Pakistan, their knowledge of
183 healthcare services, their coping strategies and the involvement of others in their health care.
184 The interviews focused mainly on their experience with GPs, the main providers of primary
185 health care in Norway and the gatekeepers to more specialised care. Caregivers were asked
186 about their caregiving responsibilities and experiences, the involvement of other family
187 members, their perception of their older relative's experiences in using healthcare services and
188 their knowledge of healthcare services. Interviews lasted between 45 minutes and 1.5 hours and
189 took place at participants' homes or public settings, such as cafes and parks. Data collection
190 took place from 2017 to 2018.

191 The interviews were conducted by the first author in the participants' own language (i.e., Urdu
192 and/or Punjabi). This allowed them to express themselves well, without the difficult dynamics
193 of involving an interpreter. The interviewer, an immigrant from India, was an insider by proxy

194 (Carling et al., 2014), sharing similar cultural elements and language. This helped create a sense
195 of commonality with the insider group, aiding the interviewer's ability to gain access and
196 making participants less reluctant to share their experiences. However, a high degree of
197 closeness can create an illusion of friendship and lead the participants to say more than they
198 intend (Kvale and Brinkmann, 2009). To reduce this risk, the interviewer was sensitive to the
199 participants' needs and vigilant in observing discomfort during the interview. While her role as
200 a researcher helped her to maintain a professional distance, her younger age helped rebalance
201 the power between the interviewer and the participants.

202 The interviews were audio-recorded with permission, transcribed verbatim and translated into
203 English. All interviews were anonymised upon transcription. Participants' names reported in
204 this study are pseudonyms. Ethical approval for the study was obtained from the Norwegian
205 Centre for Research Data.

206 We analysed the data through thematic analysis, using Braun and Clarke's (2006) six-phase
207 guide. We then examined the ideas, conceptualisations and assumptions behind what was said
208 at a semantic level (Braun and Clarke, 2006). After familiarising ourselves with the data, we
209 engaged with the themes of ethnicity, gender, socioeconomic status and the historical
210 immigration context to develop our codes and patterns of meaning into higher ordered themes.
211 NVivo was used to aid in coding.

212 Findings

213 In our interviews, older Pakistani women reported that their health problems were often not
214 taken seriously by their GPs. They specifically compared GPs on the basis of whether they took
215 the initiative or an active interest in their health and prescribed medicines or treatment quickly
216 enough. The final analysis resulted in five main themes, outlined in the following sections.

217 **Salience of ethnicity and the blurring of ethnic boundaries in meetings with GPs**

218 Some older participants attributed a lack of initiative and delays in prescribing medicines and
219 treatment to the GP's ethnicity. Thus, ethnicity was brought to the centre of the discussion in
220 the interviews, with participants comparing the perceived quality of care from Norwegian and
221 Pakistani GPs: '[Norwegian GPs] wouldn't care in the beginning; then, when an illness
222 becomes very serious, they start to give treatment' (Fatima, older participant). The same
223 participant went on to point out the difference in the way Norwegian GPs approach health care
224 as compared with Pakistani GPs: '[T]hey are not in favour of giving medicines; they don't give
225 medicine for the sake of satisfaction.…now many of our Pakistani boys and girls…those who
226 are doctors..so we ask them to prescribe medicine..I mean i[I]f there is a Norwegian doctor,
227 then he/she is not going to care' (Fatima, older participant).

228 In the narratives of caregivers, the ethnicity of the GP also became salient. Some caregivers,
229 who preferred Pakistani GPs for their mother/mother-in-law, perceived Norwegian GPs as less
230 concerned with their older relative's care than were Pakistani GPs. Bushra, a caregiver whose
231 mother now had a Pakistani GP, constructed 'them' and 'us' categories of distinction:

232 Right now, [my mother] has a Pakistani [doctor]. Earlier, she has had Norwegian
233 doctors mostly. The Pakistani doctor whom she has now, he follows up nicely. The
234 Norwegians, they are a bit sluggish…. I am not saying that they do not care, but
235 they think of their work more as work … that they have to just see their patients
236 and whatever help they can give at that time … that's it. Get done with them and
237 send them home! But our doctors … maybe they know patients through some other
238 network … so they know about each other and care more. (Bushra, caregiver)

239 A few participants had fluctuating preferences between Pakistani and Norwegian GPs. For
240 example, Mariam, a caregiver who reported finding it easier to consult with the GP now that
241 her mother had a Pakistani GP, made a contradicting account later in the interview:

242 Norway [is] the top; the best health care is in Norway. But if we talk about our own
243 people—the Indians, Pakistanis, Bangladeshis, I mean 'desi' people—I think it's
244 like … they just brush off people. (Mariam, caregiver)

245 Mariam's initial stated preference for a Pakistani GP for her mother could be interpreted as
246 simply a case of homophily for reasons of language compatibility. However, Mariam also
247 perceived the delay in an ambulance arriving for her father to be due to her mother speaking in
248 English with a distinct accent that made her recognisable as an immigrant, highlighting the
249 perceived ethnic boundaries.

250 Another caregiver, Asia, asserted her preference to seek health care for her mother from a
251 Norwegian GP, noting the following:

252 Pakistanis and Norwegians think differently. Mostly, Pakistanis get poor treatment
253 from Pakistanis; they don't do a full check-up because the relationship becomes
254 friendly …. 'Ger mulkis' [foreigners] think that old people's lives are over now.
255 Norwegians consider a person as a person. (Asia, caregiver)

256 However, Asia later spoke about her own experience with the Norwegian GP, whom she felt
257 would 'put off the matter' and not take her seriously, due to her being 'young'. She attributed
258 such poor experience as the reason for switching to a Pakistani GP.

Although caregivers also pointed out boundaries of ‘them’ and ‘us’, their preferences of seeking care from Pakistani or Norwegian GP were indeterminate, rendering ethnic boundaries blurred.

Ethnic boundary-making and gendered health issues

Most participants cited their preference to visit a female healthcare professional or GP for matters requiring physical touch, physical examination or the discussion of sensitive issues. Although they also reported flexibility in emergencies, they nevertheless expressed their preference to seek health care from female healthcare professionals for non-emergency care. When the participants recognised their health problems as ‘gendered’, they observed gender relations among Pakistanis as different from those among Norwegians.

For example, one caregiver, during an appointment for an endoscopy for her mother-in-law, described the difficulties they encountered after requesting a female healthcare professional:

> [T]he [male] doctor said, ‘I have a colleague, she is doing someone else’s test, so when she gets free, she can come’. However, when she came, she was also a bit irritated. It’s obvious because this wasn’t supposed to be her work…. [T]hese people are not very concerned that we think like this. [S]ometimes, they say that, ‘here we have Norwegian laws…. a doctor is a doctor … you people consider them to be a man or a woman’. I did not like that. (Zeenat, caregiver)

Gender relations were thus highly relevant for participants when identifying themselves as an ethnic group. They subjectively mobilised their own ethnic gender relations as those related to the concept of ‘lihaaj’ (i.e., ‘shame/consideration’) in interacting with male healthcare professionals, whereas no such concept was perceived to exist in Norwegian gender relations. This was noted, for example, by caregiver Shazia:

> [T]he doctors do not try, because the doctors from here do not have that concept…. [T]hey just say that, ‘to us, you are a patient; there is no ‘purdah’ [veil or curtain]’… For us, our

283 culture comes in between … shame, 'lihaaj' [consideration], comes in between…. [H]ow
284 can I tell a man that I have this gynaecological problem, or that I have a wart at this place?
285 (Shazia, caregiver)

286 Thus, the construction of gender relations amongst the participants reinforces ethnic
287 boundaries, as they struggled to find validation for their concept of 'lihaaj' while navigating
288 healthcare services.

289 However, the intersection of gender and ethnicity has also led to ethnic boundary-crossing.
290 Some participants stated that they found it easier to seek health care from a male Norwegian
291 GP than from a male Pakistani GP, noting the different ethnicised gender relations within their
292 own group. For example, one older participant, Suraiya, believed that, although she may not
293 feel uncomfortable, a Pakistani male doctor would, since such issues are taboo between
294 Pakistani men and women. Thus, she felt that gendered health issues were less problematic to
295 discuss with a male Norwegian doctor. Another older participant had asked her homecare
296 professional to write to her Pakistani GP for adult diapers on her behalf. When the homecare
297 professional asked her if she needed another letter for more adult diapers, she said, 'No, I won't
298 ask him again' [laughs]…. [I]f it's a Norwegian doctor … it's a different case then' (Tahira,
299 older participant).

300 It seems that when gender became salient in health care (i.e., when health problems required
301 physical examinations or concerned sensitive health issues), some participants preferred
302 seeking care from male Norwegian GPs than male Pakistani GPs. We also found that in other
303 cases, some participants, despite having sensitive health concerns, preferred seeking care from
304 male Pakistani GPs. This was exemplified by an older participant, Tahira, who, despite
305 acknowledging her hesitancy and embarrassment when discussing sensitive matters with her
306 male Pakistani GP, decided she still felt she received better care through her Pakistani GP than
307 through a Norwegian GP. She had access to his personal contact number to arrange

308 appointments more quickly and received longer consultations— something she felt would be
309 impossible with a Norwegian GP. The older age of the participant compared to her GP might
310 also have helped to reduce her hesitancy and embarrassment. For example, while imitating her
311 conversation with the GP during the interview, Tahira often referred to her GP as 'son' and
312 spoke about her relief in learning that he was far younger than she was: 'When I went for the
313 first time, I was wondering how old he would be [in a worrying tone]…. [W]hen I saw him, I
314 thought, "he is even younger than my son!" [laughs]' (Tahira, older participant).

315 **Language and being an immigrant as a barrier to health care**

316 One caregiver, Saima, spoke about how her mother-in-law's lack of Norwegian language skills
317 hindered access to health care in ways beyond communication barriers in consultations:

> 318 [M]y mother-in-law's eye doctor … didn't provide a very good service…. [S]he
> 319 got an operation. So, he never asked if she needed an interpreter, a taxi or something
> 320 like that….they would think, 'this is their own problem; they didn't learn the
> 321 language'. They would criticise her: 'You've been here many years and you haven't
> 322 learnt anything'…. They would say this a lot in hospitals: 'Why didn't you learn?'
> 323 (Saima, caregiver)

324 From the above account, we see that the experience of being criticised by healthcare
325 professionals for not having learnt Norwegian rendered language a site for ethnic boundary
326 construction. While language barriers make ethnicity salient in health care, ethnic boundaries
327 are reinforced when they lead to inequality in the distribution of or power to access resources.

328 When some participants reported instances in which they or their older relatives were treated
329 differently, they contemplated whether language barriers or their identity as a Pakistani or an
330 immigrant was the underlying cause .Some felt there was a 'fine line between having a language
331 barrier and being an immigrant', as noted by Samaira, a caregiver who believed that her mother

332 would have had a 'different experience' had she gone alone instead of being accompanied.
333 When asked if her mother's 'different experience' was due to her being an immigrant or her
334 lack of language skills, Samaira suggested that it was a combination of the two and that
335 immigrants who speak the language well are often treated better.

336 Another caregiver, Shazia, who spoke about her mother's poor experience with a Norwegian
337 GP, reported that her mother felt that the 'GP must have thought that she is an immigrant: "if I
338 give her my time or not, it won't matter to her". They don't think that she will complain or tell
339 anyone' (Shazia, caregiver).

340 When other caregivers were asked about how their mothers/mother-in-laws perceived being
341 treated differently, some emphasised that their 'parents did not wish to think bad about anyone'.
342 Thus, it is not surprising that when older women did not perceive they were treated differently
343 on account of language, ethnicity or being an immigrant, when asked during the interview. This
344 illustrates how the intersection between ethnicity and age influences experiences of being
345 treated differently in healthcare.

346 **Insecurity in accessing health care due to ethnicised discourse**

347 We found that some participants felt a sense of insecurity when accessing health care generated
348 by the macro-discourse about Pakistani immigrants. This was reflected by a participant, Anum,
349 who interpreted her poor experience with GPs was due to the negative image of Pakistanis as
350 recipients of welfare in public discourse in Norway. Anum felt this resulted in her GP doubting
351 her health complaints and not giving her the care she expected:

352 I don't know why they have this thing in their mind … for the women, foreigners
353 … Asian women like us… we come here, [they think that] these women do drama,
354 based on what I have seen. Because whenever I would go, she [the GP] would
355 'behlana' [talk in circles around] me. (Anum, older participant)

356 In Anum's case, the ethnicised discourse surrounding Pakistanis as wrongfully claiming
357 welfare benefits and as exaggerators in health care led to insecurity, contributing to ethnic
358 boundaries in health care. Anum spoke about having a poor relationship with her Norwegian
359 GP until she decided to switch to another. We found similar findings from caregivers'
360 narratives, highlighting that women from both generations experienced the influence of
361 ethnicised discourse in healthcare interactions. For example, Zeenat, a caregiver, recounted the
362 following:

> 363 [T]here are many Pakistanis, so doctors have the perception… that this is how
> 364 things are in their culture. So, it's possible that when my mother-in-law is telling
> 365 about her problems, they may not take her very seriously. Because they say that the
> 366 people from foreign countries, they exaggerate their problems, and they visit
> 367 doctors for minor issues. (Zeenat, caregiver)

368 From the above accounts, we see that discourse in health care, and in the public sphere,
369 generated insecurity about being identified as a Pakistani, Asian or an ethnic other, thus
370 reinforcing ethnic boundaries between Norwegian GPs and older Pakistani women. However,
371 some participants also spoke about similar experiences with Pakistani GPs. At the beginning of
372 the FGD, women started narrating their experiences of health care by comparing GPs according
373 to their ethnicity. Later in the FGD, a participant mentioned a 'negative stereotypical discourse
374 surrounding Pakistanis as abusers of sick leave benefits in public and health care' as the reason
375 for Pakistanis GPs' inconsiderate and strict behaviour, specifically towards 'their own'. All
376 participants agreed with this, irrespective of their preference for Norwegian or Pakistani GPs.
377 Thus, participants perceived that boundary work was also done by minority GPs who are part
378 of the healthcare system, highlighting the power relationship between minority patients and the
379 healthcare system, irrespective of the ethnicity of the GPs.

Compensatory and de-stigmatisation strategies

In response to experiences of not being taken seriously in healthcare interactions, the Pakistani women appeared to employ compensatory strategies. Some spoke about coping through exaggerating pain to counter the consequences of ethnic boundaries when encountering Norwegian healthcare professionals or GPs. Fatima, an older participant, reported 'having to put pressure on the doctor' and 'to tell more than it actually is'.

Bushra, a caregiver, also reported that her mother adopted pain exaggeration as a strategy to get attention from healthcare professionals:

> She would have pain and discomfort … and here, they often say that you take paracetamol and stay at home for few days, then come back. They wouldn't [help] immediately, I mean. Unless they see something … but it's obvious that it's an internal pain, so the doctor can't see it immediately. Then one has to do it a little … exaggerate. (Bushra, caregiver)

Bushra perceived that exaggerating pain was also necessary in other circumstances, such as when seeking care in emergency centres, and noted, 'She [mother] tells me, if you don't cry in front of them … they are not going to call you inside'. Thus, pain exaggeration was a strategy adopted by some participants, irrespective of their age, to get attention from healthcare professionals.

In contrast, other participants resorted to de-stigmatisation strategies to cope with not being taken seriously by healthcare professionals. Participants constructed 'them' vs. 'us' categories and ascribed hierarchical attributes of more knowledge/capability to Pakistani doctors. Thus, they constructed boundaries through the normative inversion strategy (i.e., reversing the stigma and reinterpreting their own identity positively):

403 Our doctors know, they can just prescribe a medicine, just by hearing about our
404 problem, and [the Norwegians] have to open books and look, then they write the
405 prescription…. [T]hey have to open their book! We've said this many times [to
406 each other]: 'Are they even doctors? Is it a joke that they can't even prescribe
407 medicines by memory?'… [S]o the general conclusion is that our doctors … are
408 more capable … I mean, they have deep knowledge … they have a much better
409 understanding. (Fatima, older participant)

410 In the FGD, a similar narrative emerged, in which one participant noted that 'the medicines in
411 Pakistan … they are not very good. And the medicines from here are good. But the doctors here
412 are useless, and the ones from Pakistan are very good. They take every illness seriously, the
413 Pakistani doctors' (Soha, older participant). Similar perceptions were shared by some
414 caregivers.

415 Some older Pakistani participants, however, were satisfied with their health care, despite poor
416 experiences. They were critical of other Pakistani women's complaints and their behaviour
417 when interacting with doctors. This might be interpreted as a de-stigmatisation strategy. For
418 example, when asked how to improve healthcare services, an older participant, Zubaida,
419 reported that women in their community unnecessarily 'whine' about their poor health and
420 added that the Norwegian government helps them a lot. Another older participant, Zeenat,
421 reported that doctors in Pakistan get annoyed by patients asking them irrelevant questions such
422 as, 'Should I sleep or stay awake after taking the medicine?' She believed many Pakistanis
423 continue to ask doctors irrelevant questions in Norway, perhaps due to a lack of education. She
424 distanced herself from other Pakistanis by emphasising only discussing 'important' matters
425 with her own GP. Thus, some women employed a contingent detachment strategy.

426

427 # Discussion

428 In our study, we explored older Pakistani women's healthcare encounters through the lens of
429 ethnic boundary-making, expanding this theory by including an intersectionality approach. The
430 study shows how micro-interactions in health care are influenced by the broader public
431 discourse about immigrants. Thus, this study demonstrates both the construction of ethnic
432 boundaries in health care as well the spill-over of ethnicised discourse from other contexts into
433 health care, creating or reinforcing barriers to care.

434 This is the first study that expands ethnic boundary-making into the context of health care in
435 Norway. While drawing comparisons between GPs along ethnic lines, the women's accounts
436 highlight the perceived ethnic differences in the ways in which Norwegian and Pakistani GPs
437 approach health care. Through their narratives, participants constructed 'them' vs. 'us'
438 categories, perceiving Pakistani GPs as more caring than Norwegian GPs. They pointed not
439 only to symbolic boundaries but also to social boundaries. The material element of boundaries
440 also emerged, as the participants perceived potential inequalities in accessing health care and
441 pushed back through compensatory and de-stigmatising strategies.

442 First, at the macro level, ethnic boundaries were rendered visible through an ethnicised
443 discourse. In a study on labour markets, Siebers (2009) argued that immigrant employees may
444 start feeling insecure, with the risk of being identified by their ethnic markers, such as language,
445 clothing, specific food or religious rituals. Siebers (2017) further argued that there is an
446 interplay between precarity (i.e., insecurity in the context of the labour market) and ethnic
447 boundary construction, in which both fuel each other and the macro-context imposes itself on
448 micro-interactions in the workplace. We found a similar interplay between the macro-context
449 (i.e., the public discourse on Pakistani immigrants in Norway) and the micro-context (i.e., their
450 healthcare encounters). The social and material elements of ethnic boundaries emerged through
451 participants' perceived ethnicised insecurity, resulting from an ongoing negative discourse in

the public sphere. Participants were aware of ethnic boundaries in their healthcare encounters, not only with Norwegian but also with Pakistani GPs. A study on South Asian immigrant women's encounters with healthcare services in Canada also found that othering practices were conducted by South Asian practitioners through essentialising, culturalist and racializing explanations (Johnson et al., 2004).

Second, at the micro level, the combination of language barriers and being an immigrant made ethnic boundaries visible. Language barriers may turn a patient into an immigrant, thus creating a perception of receiving poorer care than other patients. Habib (2008) pointed out that a lack of ability to speak a country's official language, subsumed under the discussion of culture, tends to be viewed as a cultural factor rather than an institutional or structural one. Thus, this view often does not take into account the lack of opportunities to learn the language, for older immigrant women in particular.

Indeed, when the majority of our participants arrived in Norway, there were no formalised classes available (as there are today). Objective differences, such as language barriers, may be emphasised by the majority and made organisationally relevant to make boundaries credible (Barth, 1969). While language barriers and the status of being an immigrant do not necessarily turn participants into an ethnic minority, the resulting feelings of not belonging and of discrimination in health care may induce ethnic boundary work. The fact that such feelings were not stated by the older participants themselves but by their caregivers also highlights the general reluctance of older participants to assert healthcare rights, i.e. showing an intersection of age and ethnicity.

Moreover, this raises the question of whether ethnic boundaries lead to the construction of different cultural or ethnic citizenships in health care (i.e., categorising people into deserving and un-deserving groups on the basis of pre-disposed traits). For example, a study on Mexican and Cuban immigrants in relation to health care showed how different groups of immigrants

477 have different cultural citizenships in health care, based on the larger state-level discourse in
478 the United States (US) (Horton, 2004).

479 Our study explored the various ways in which participants responded to ethnic boundaries, such
480 as boundary-modifying strategies, adaptations to ethnic boundaries and de-stigmatisation
481 strategies. Some caregivers of older Pakistani women, who emphasised their 'cultural
482 distinctiveness', nevertheless cited fluctuating preferences for Norwegian and Pakistani GPs.
483 Midtbøen (2018) writes that this approach (blurred boundaries) is typical for descendants of
484 immigrants who usually are citizens of their parents' destination country, speak the majority
485 language fluently and have often acquired the dominant cultural codes through education and
486 general socialisation. Thus, they are part of the majority community in a way their parents often
487 do not achieve. While they often maintain ties to their ethnic group, they may also face
488 exclusion from the majority on the basis of their ethnic background, thus maintaining ethnic
489 boundaries. Some older participants also attempted to modify ethnic boundaries through
490 individual boundary-crossing, exemplified by their preference for a Norwegian male GP when
491 faced with gendered health matters.

492 We also found that older Pakistani women, as well as caregivers, attempted to adapt to ethnic
493 boundaries without challenging them by exaggerating their pain. This appeared to be a strategy
494 for redressing the power imbalance in consultations when the women felt their complaints were
495 not taken seriously. Studies report that women, in general, often experience their concerns being
496 dismissed in health care (Werner and Malterud 2003; Werner, Isaksen and Malterud 2004,
497 Roberston, 2015). For example, a study in the US found that all women interviewed, regardless
498 of their 'race', recalled doctors who ignored their pain, and that the doctors also ignored the
499 structural challenges in black patients' lives (Pryma, 2017). The author argued that gender, race
500 and class boundaries of citizenship shape who is seen as having a right to pain relief.

501 Because language was a barrier for many of our older participants, they had limited ways of
502 expressing their pain and symptoms and relied on their caregivers to convey their health
503 problems. While women, in general, face the risk of their health problems being ignored in
504 healthcare encounters, older Pakistani women may face an imbalance of power in health care
505 at the intersection of gender, ethnicity, age and language barriers. Such imbalances could
506 reinforce a stereotypical ethnicised discourse about immigrants as those who exaggerate pain,
507 concealing actual barriers in their access to health care. A Danish study found that immigrant
508 patients often worry about not being taken seriously by doctors, resulting in a tendency to
509 exaggerate their conditions. Amongst Danish doctors, this is colloquially known as 'ethnic
510 pain' (Chahal and Poulsen, 2008). In Norway, a study found that 'GPs believed that people
511 from different cultural backgrounds have different thresholds for, and experiences of, pain'
512 (Goth, 2012). This can lead to a shift in focus from the patients' symptoms to the patients
513 themselves as the problem (Sandvik and Hunskår, 2010). Several participants adopted the
514 practice of exaggerating pain to compensate for existing boundaries in health care and adapt to
515 existing ethnic boundaries. Paradoxically, this might also fuel the macro-discourse about
516 immigrants being 'exaggerators'. The ethnic boundary-making approach highlights this
517 interplay between macro-discourse and healthcare interactions.

518 As a response to stigmatisation, the de-stigmatisation strategies adopted by the participants
519 represent acts of boundary-making by the participants themselves and the agency they exhibit
520 in attempting to rectify the imbalance of power in inter-ethnic encounters. While some women
521 adopted normative inversion strategies, others adopted contingent detachment. Furthermore,
522 the ways in which immigrants develop self-worth and forge de-stigmatisation strategies are
523 possibly the outcomes of their past experiences and personal resources (Celik, 2017). Celik
524 found that immigrants who were less exposed to ethnic boundaries in the form of
525 socioeconomic and residential segregation resorted to the contingent detachment strategy, as

526 compared to others who adopted normative inversion (Celik, 2017). Our study corroborates this
527 finding for older participants (i.e., when ethnicity and gender intersected with older age). For
528 example, two of our older participants, Adina and Nadia, who used contingent detachment
529 strategies, indicated that they were of higher socioeconomic status than many 'other' Pakistanis.
530 They both resided in non-ethnic neighbourhoods and spoke about having Norwegian
531 acquaintances. In contrast, Fatima and Noor lived in ethnic neighbourhoods and appeared to
532 have a lower or moderate socioeconomic status. They coped through normative inversion. This
533 shows that the choice of de-stigmatisation strategies was influenced by the intersection of
534 ethnicity and class.

535 Our study also explored how ethnic boundaries intersect with gender boundaries. Participants
536 constructed two different types of gender relations among Norwegians and Pakistanis, despite
537 the fact that this reified gender relations among Pakistanis as less open and more unequal than
538 among Norwegians. Ethnicised perceptions of less open gender relations were strategically
539 maneuvered by the women by choosing between male Norwegian GPs and male Pakistani GPs.
540 The strategies used either reinforced boundary-making, i.e. when they choose to visit male
541 Pakistani GP, or led to boundary-crossing, when they would rather go to a male Norwegian GP.
542 Boundary-making was exemplified by the participant who dismissed her concerns of her
543 Pakistani GP being male after finding out he was much younger than she was. Thus, the
544 intersection of ethnicity with gender and age influenced ethnic boundary work A convergence
545 of intersectionality and ethnic boundary-making thus highlights the dynamic nature of ethnic
546 boundaries. The intersectionality of gender, ethnicity and age also makes it possible for women
547 to exhibit agency in healthcare interactions, by choosing between male Pakistani and male
548 Norwegian GP, and thus creating a new group identity of being Pakistani 'women' or 'older
549 Pakistani women'. By taking intersectional processes in analyzing boundary formations, we see

that actors strategically draw on multiple markers of difference to produce "groupness" and engage in an intersectional process of identity formation (Sang., 2016).

While our study contributes to an understanding of ethnic boundary-making in health care in Norway, some considerations need to be borne in mind. Because our findings are based only on older Pakistani women's experiences, at varying intersections of age, education, social and economic circumstances, we cannot conclude that they are transferable to other immigrant groups. However, this study illustrates ethnic boundary-making in healthcare interactions. By subsuming barriers to health care under 'cultural differences', we are masking the power of a stereotypical public discourse, language barriers and the ways in which being an immigrant turns older immigrant women into an ethnic other in the Norwegian healthcare system.

Conclusion

Our study has shown how ethnic boundaries are constructed in healthcare interactions and fuelled by the macro-discourse in the public sphere. Our findings contribute to the ethnic boundary-making approach by showing how it is influenced by the participants' social positions of gender, age and class.

Furthermore, we have shown some of the ways in which the delivery of healthcare services, despite being largely state-funded, contributes to fundamental social inequities in older Pakistani women's access to and utilisation of healthcare services in Norway. The study has also provided knowledge about the role of health care in maintaining ethnic boundaries, undermining the professional ethos of healthcare practitioners and Norwegian healthcare services' commitment towards equity.

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