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 professionals.
- Ethnic boundary-making is dynamic and contingent on the intersection of social positions.
- Ethnic boundaries from public discourse spill over into health care and create barriers to care.
- Ethnic boundary-making may undermine the ambitions of egalitarian and equitable health care in Norway.

Keywords

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

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 (Anonymous, 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

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

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

Pakistani immigrants in Norway and their utilisation of healthcare services

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

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

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

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

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

The ethnic boundary-making approach

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

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

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

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

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

Ethnic boundary-making and Intersectionality

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

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

Methods

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

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

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

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

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

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

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

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

Findings

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

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

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

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

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

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

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

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

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

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

However, Asia later spoke about her own experience with the Norwegian GP, whom she felt would 'put off the matter' and not take her seriously, due to her being 'young'. She attributed 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

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

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

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

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

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

Language and being an immigrant as a barrier to health care

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

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

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

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

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

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

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

Insecurity in accessing health care due to ethnicised discourse

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

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

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

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

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

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

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

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

Discussion

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

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

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

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

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

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

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

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

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

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