Immigrant Experiences with Healthcare Access in Finland

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Abstract

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Abstract

This thesis explores the experiences of healthcare access among immigrants in Finland, a project intended to inform health policy directions for SDG (Sustainable Development Goals) 3 and 10. The development task was to identify individual and structural factors and evaluate existing policies while accounting for differing ethnic blocs. Grounded in the behavioral theoretical framework of Anderson which understanding that healthcare access encompasses timeliness of care, logistical ease, and cultural beliefs, this qualitative study employs semi-structured interviews (Appendix 2) with immigrants, and those with experience in care attention, using purposive sampling. Ethical considerations were prioritized, with informed consent and data protection measures carefully observed. Findings reveal significant barriers such as language difficulties, systemic inequities, employment status, and discrimination, which disproportionately affect immigrant groups, particularly those from African and Middle Eastern backgrounds. This research contributes to a more inclusive healthcare system, ensuring that universal healthcare truly reaches all residents. The study recommends that healthcare institutions should enhance language services by hiring multilingual staff and providing standardized interpreter training, focusing on the languages of major migrant communities, decentralization of care networks to increase rural service points and a health-first approach regardless of residency status.

Keywords: Immigrant health, health promotion, health literacy, health equity

Contents

1 Introduction

Healthcare access is a concept that involves more than the presence of services. Beyond available remedial services, it involves key factors which include, timeliness of rendering care, financial means to pay, confidence in communicating with healthcare personnel, and trust in the ethical compliance of service providers to render satisfactory care and maintain privacy (Gulliford et al 2002).

Finland prides itself as a strong social welfarist country, a feat made possible by commitment to universal healthcare. However, this remarkable feature in care access is only enjoyed in part by its immigrant community. Recent data from a comparative analysis conducted between 2014 and 2022 revealed that the rate of immigrants' unmet healthcare needs rose by almost 15%, spiking to 33.7% in 2022 from 25% in 2014 (Nykänen et al 2024). Though the level of dissatisfaction among immigrant groups is layered, African and Middle Eastern immigrants report the least satisfaction (Kieseppä et al. 2022).

Immigrants, who now constitute over 8% of Finland's population, face unique challenges integrating into the labor market and navigating a complex healthcare system that may differ significantly from their countries of origin. As the Finnish Institute for Health and Welfare reports, immigrants are underserved by existing provisions, finding them insufficient (Health and Social Services for Immigrants, n.d.).

Far from a statistical abnormality, this is consistent with a general issue of health access among immigrant populations in Europe, who experience lower quality of healthcare access compared to indigenes (Safarov et al. 2024). They experience serious blockades with health examinations, communication with care centers, and even booking medical appointments.

This reality is however not uniform among all immigrants. Employed immigrants – which corresponds to the elite level – are typified by their use of occupational health care, though not more than the average Finnish employee (Finnish Institute for Health and Welfare, n.d.). Low income, often a result of language barriers, discrimination, and limited recognition of foreign qualifications, can harden these challenges affecting the economic integration of migrant workers (Tibajev & Hellgren 2019).

The Finland Health report of 2023 pointed out that income differences were a serious factor in unmet healthcare needs as the highest earners didn't suffer long wait times (Finland Country Health Profile 2023). Also, gainfully employed residents enjoyed greater care coverage, benefiting from free and fast access (Finland Country Health Profile 2023). Issuing from this, it becomes pertinent to probe the subcurrents informing healthcare access. This

would help to ensure that universal health coverage trickles down to all. This study explores immigrants' experiences of healthcare access in Finland, finding supporting and hindering factors, and evaluating the effectiveness of current policies and culturally relevant solutions.

2. Background

Finland's healthcare system, per its constitution, is built on the principle of healthcare access for all. It mandates guaranteed socio-medical services for everyone in both the private and public administration of care services (Healthcare System in Finland 2024). The private arm comprises a fourth of health and social service. In 2023, the Finland Health system underwent a serious shift designed to improve care delivery. Responsibility for health and social services was divided among twenty-two well-being counties. This is done to increase accessibility to primary health care and cut down on geographic and socioeconomic inequalities (Finland Health System 2023).

Finland is a moderate spender on healthcare, ranking below the average spend of the European Union. Though its health spending has been on a steady rise since 2014 by 10% with a year-on-year augmentation except in 2018/19 and 2019/20 cycle, it yet leaves a little to be desired. Going forward, Finland has prioritized lesser wait times and healthcare digitization to bolster its strength. However, out-of-pocket expenditure (spent mostly on drugs and dental care) by its residents rank higher than the average in the European Union. Out-of-pocket spending represents over 16% of aggregate health expenditure (Finland Health System, 2023).

Taken together with the fact that Finland has more people than the European average in reportage of unmet medical needs, these facts indicate a healthcare system that is maintained by individuals and the private sector rather than the government. The outsourcing of care coverage to the private economy has seen service users that are old of age, leading families or of low social standing using municipal health centers, while relatively well-off service user's resident in urban areas use occupational healthcare (Manderbacka 2019; Finland Health System 2023).

Despite the commitment to universality, some inequities make the migrant experience of healthcare difficult. As Kieseppa et al. (2024) find in the survey of over 2700 migrants and more than 6600 natives on the topic of primary care health service satisfaction, nearly all foreign-born groups saw the care received as not beneficial, or, at least, not as beneficial as the quality received by native Finns.

Appointments are deemed less useful and East Asians report violations of privacy in the course of receiving care (Kieseppa et al. 2024). Finland bridges the challenge of language barriers by providing interpreters for non-native speakers but due to the requirement of pre-

ordering, they are limited in supply, and even in the most severe health conditions (Safarov 2024).

A similar available-but-not-accessible issue is also observed in the obtaining of electronic identification (e-ID), a means to digitized health services which simplifies making appointments, service chats, remote consultations and having access to personal health records. Migrants find it difficult to obtain access to this, too (Safarov 2024). Income-influenced health inequities continue to plague the Finnish healthcare access for immigrants. This reflects a broader pattern of economic imbalance illustrated by the Finland's Gini/Inequality coefficient of 72.5% measured in 2020, pointing to 27.5% income inequality ratio (Finland n.d.). Non-native populations earn considerably lesser than indigenes and are generally unemployed compared to Finns (Vaalavuo & Rask 2024). Immigrants earn comparatively less than indigenes due to their low-paid jobs that are non-attributable to their technical skill base i.e. underemployed (Vaalavuo & Rask 2024).

On the gender level, the difference in employment between natives and foreign-born Finn women after half a decade of residence is 40 percentage points (Vaalavuo & Rask 2024). Given these differences in accessing care and the normative status of out-of-pocket health expenditure among Finnish residents, immigrants have it worse in staying healthy and/or overcoming physical and mental infirmity.

Mental health is an important aspect of overall functioning, and equal access to mental health services is important for an inclusive healthcare system. Despite Finland’s universal healthcare model, immigrants often encounter challenges that significantly limit their access to mental health care (Finnish Institute for Health and Welfare 2023). These challenges are multi-tiered systemic barriers, cultural issues, and individual factors that contribute to inequality of access in mental health services.

Recent data from the MoniSuomi 2022 survey conducted by the Finnish Institute for Health and Welfare (THL) indicates that psychological distress is more prevalent among immigrants compared to the general Finnish population. According to the data, precisely 23% of immigrant women and 20% of immigrant men report experiencing psychological distress, compared to 19% and 17% among Finnish women and men, respectively (Finnish Institute for Health and Welfare 2023). Notably, the prevalence of psychological distress among immigrants increased between 2018 and 2022, especially among individuals from Russia, the former Soviet Union, and South Asian countries.

This data deeply underlines the psychological effects of immigration, possibly triggered by experiences of uncertainty, discrimination, and culture shock. The migration process typically involves psychological stressors, including the loss of social support resulting in loneliness,

language barriers, and challenges in adapting to new cultural norms, all of which are mental health triggers (Satinsky et al. 2019).

Nonetheless these higher levels of psychological stress, immigrants in Finland tend to use mental health services less frequently and with lower intensity than native Finns. A nationwide register-based study found that immigrants were more likely to receive low-intensity psychiatric treatment (operationally defined as 1-3 visits) compared to Finnish. This pattern is especially prevalent among immigrants from Eastern Europe, sub-Saharan Africa, the Middle East, and Northern Africa (Markkula et al. 2019).

Also, immigrants with pre-diagnoses of depression or anxiety disorders were less likely to receive high-intensity treatment compared to their Finnish-born counterparts. The differences are most pronounced among immigrants from Eastern Europe, the Middle East, and Africa (Kieseppä et al. 2021). These differences in treatment intensity show that immigrants may not be receiving adequate care for their mental health needs.

The duration of an immigrant's residence in Finland appears to have an influence on their use of mental health services. Longer residence is linked to an increased propensity of receiving higher-intensity treatment. For instance, among immigrants who have lived in Finland for over 15 years, only 46.8% received low-intensity treatment, compared to 51.7% among those who had lived in the country for less than five years (Markkula et al. 2019). This shows that over time, immigrants may become more familiar with the healthcare system and more comfortable seeking mental health services.

Elsewhere, research shows that differences in mental health service utilization are not the same across all immigrant groups. This is instantiated in a study examining mental health service use among immigrants from Russia, Somalia, and Kurdish regions which found that all groups were underrepresented in rehabilitation services. Even when accounting for affective symptoms, these immigrant groups are less likely to use mental health services compared to the general population (Koponen et al. 2020). This shows the need for targeted interventions that are fitted to the needs of different immigrant communities.

Language proficiency also governs effective mental healthcare access. In Finland, immigrants often face significant language barriers, which hinder their ability to communicate symptoms accurately, understand medical advice, and navigate the healthcare system (Khanal 2025). Scarce interpreter services and concerns about the quality of interpretation and confidentiality issues discourage some immigrants from using these services.

Discrimination in healthcare settings is a big barrier to accessing quality care for immigrants. Studies show that immigrants in Finland experience higher levels of discrimination in healthcare compared to the general population. As Klemettilä et al. (2024) finds in their

study, this discrimination is about twice for the foreign-born, even when they have high status in the society. Experiences like these can sabotage trust in the healthcare system and affect care-seeking behaviors, causing delayed treatment, and worsening health conditions. As research by Rask et al. (2018) on Somali, Russian, and Kurdish immigrants reveal, both overt and covert discrimination, though not far apart in occurrence, increase the chances for poor mental health.

As the foreign-born population of Finland grows amidst tighter immigration rules, the freedom to utilize health services is instrumental in informing health policy directions that aim to sustain Finland's welfarist status locally and internationally (as an EU netto payer contributing €800 million in 2023 (Yanatma 2024) and also meet broad-reaching goals of SDG 3 (Good Health and Well-being) and SDG 10 (Reduced Inequalities).

2.1 Access, Socio-Ecological, Health Belief, and Behavioral Models

This theoretical review evaluates four prominent models for analyzing healthcare access disparities among immigrant populations, namely: Andersen's Behavioral Model, Penchansky and Thomas's Access Framework, the Social-Ecological Model (SEM), and the Health Belief Model (HBM).

2.1.1. Penchansky and Thomas's Access Framework

Developed in 1981, the Penchansky and Thomas Framework is a widely respected model that assists in conceptualizing what "access" to healthcare really means by breaking it down into five key dimensions. Instead of seeing access as a simple yes-or-no question translating to whether someone can get care or not, it views access as a measure of how well the healthcare system fits the needs and circumstances of the patient (Anderko et al. 2000). This concept of fit is all-important as the better the alignment between what the healthcare system offers and what the patient requires or can manage, the better the access. The theory is predicated on five dimensions which are:

Availability: This refers to the extent to which the right type and amount of healthcare services exists to meet the needs of the population. Availability extends beyond presence to cover usable presence as low doctor-to-patient ratio is tantamount to poor access even if care is charge-free.

Accessibility: This focuses on the physical location of services compared to average locations of patients. This includes factors like distance, cost of communication with healthcare providers, transportation options, and commute time.

Accommodation: This factor explores how healthcare services are organized to accept patients. Elements of accommodation are appointment systems, office hours, walk-in availability, and how well the system adapts to patients' schedules and needs. Ease and speed of treatment are the two defining elements.

Affordability: This is about the relationship between the cost of services and patients' ability to pay.

Acceptability: This deals with the attitudes and perceptions of both patients and care workers. This includes cultural compatibility, provider characteristics, and patient comfort with the healthcare environment. In the research exploring low healthcare access and health-related quality of life in Swiss patients, access theory is implemented in a slightly modified manner (Wehrli et al. 2024).

2.1.2. Social-Ecological Model (SEM)

The Social-Ecological Model (SEM) is a broad, nested framework used to understand how different levels of society influence individual behaviors, including health and healthcare access (Harper et al. 2018). This theory issues from a sociological conception of influence on individuals' health-seeking behavior. It posits that people's actions are shaped not just by their own choices, but also by social forces from relationships, communities, and the larger society. These forces exert their influence at four concentric levels.

At the individual level, factors like knowledge, attitudes, and skills play a role. For an immigrant, this might mean understanding how to book a doctor's appointment or knowing when to seek help. At the interpersonal (relationship) level, the primary circle of family, friends, and social networks are influential. Admonitions from any of these circle members determine views about the system.

The community level is the domain of cultural norms and the presence or absence of larger support systems more experienced than the primary circle. The community level assists in health-seeking behavior through provision of access. It also informs group attitudes towards particular health problems. The societal level is the legal and policy level and also the domain on deeply entrenched cultural values. Laws make or break individuals in a society and the societal level is the most powerful level because National policies arrived at determine the quality of care received by individuals. This model was applied in a study assessing the effect of interventions on critical health consciousness. It was found that brief interventions had good impact on enlarging responsibility for health from personal to social (Ewald et al. 2023).

2.1.3. Health Belief Model (HBM)

Opposed to the Ecological model that is concerned with influences from the outside, the Health Belief Model (HBM) is a psychological theory that explains why people make certain health choices (Alyafei & Easton-Carr 2024; Rosenstock 1974). It focuses on the individual's perceptions and beliefs about health problems, which in turn influence whether they seek care or take preventive action. This theory, like others above, is also built on some concepts such as:

Perceived Susceptibility: The level of risk an individual holds for an health issue, which prompts a sense of urgency and proactiveness.

Perceived Severity: This is a measure of how serious an individual views an health problem.

Perceived Benefits: Belief in the efficacy of seeing a healthcare provider

Perceived Barriers: Imagined obstacles of cost, discrimination, language or other factors that discourage health-seeking behavior.

Cues to Action: What triggers individuals to act (e.g. health campaign, advice from a friend, or a worsening symptom)

Self-Efficacy: Confidence in leading themselves to take health-positive actions and do all required to restore health. This theory is instantiated in the research of Ghorbani-Dehbalaei et al. (2021) which investigated the role of health belief and literacy in promoting health-positive behavior. As the study found, self-efficacy was the most important factor for over half of preventive behavior.

2.1.4. Andersen's Behavioral Model of Health Services Use

The Andersen Behavioral Model is a classic framework that assists in discerning because people do-or do not-use healthcare services (Radhamony et al. 2024). Rather than blaming individuals or only focusing on system-based loopholes, this model situates an approach between personal and societal factors. It organizes these factors into three main categories: predisposing, enabling, and need.

Predisposing factors are the characteristics people bring with them before they ever need care. These include age, gender, education, cultural beliefs, and attitudes towards health.

Enabling factors are the logistical and resource-based elements that make it possible (or not) for someone to access care. This includes things like income, health insurance, transportation, language skills, and the availability of services.

The need factors are about the person's actual or perceived health status. This includes both how sick someone feels (perceived need) and what a healthcare professional determines (evaluated need).

This theory is the operative framework guiding this research study. Andersen's model outperforms alternatives by integrating macro-level policies into micro-level behaviors. It frames access as the cooperation of personal and external factors, combining the best elements of other theories. The work of Travers et al. (2020) utilizes this behavioral model in the research on long-tern health support of old people.

2.2 Legal, Cultural and Socioeconomic Factors

2.2.1. Legal Entitlements and Policy Frameworks

Finland's healthcare system is highly welcoming and accommodating with costless health services provided to refugee immigrants on the condition of possessing residence permits and living for less than less than three years. This permit entails total health coverage inclusive of dental care, emergency treatment and dental care. This wide health coverage also extends to asylum seekers, including maternity care, though service points for them are specialized reception centers (Health care services for immigrants n.d.).

In 2023, Finland expanded the beneficiary net of health coverage to include adults and undocumented minors. Adults in this special category are now able to enjoy non-urgent healthcare (pregnancy, childbirth, vaccinations, medical treatments, chronic illness treatment) within a set cost limit above which would require compensation from the state (Updates, n.d). Much older adults (50 years and above), according to Safarov et al. (2024) report a multiplicity of barriers traceable to the Russian speakers' migratory status which also attracted discrimination.

In the United States, the country with the highest immigrants globally, eligibility for public insurance and healthcare services is tightly tied to legal status. Undocumented migrants are restricted to emergency care only, a fact intensified during the covid 19 (Appendix 5) period when undocumented and temporary visa holders experienced heightened exclusion from testing, treatment, and vaccination services due to fear of deportation and lack of insurance coverage (Hill et al. 2021).

Policy-wise, funding exists to cater for uninsured treatment, but this provision is counteracted by the lack of reimbursement guarantee (Hill et al. 2021). Immigrants are further dissuaded from utilizing healthcare services by a public charge rule that dampens the chances of adjusting immigration status after using health services (Hill et al. 2021).

In a systematic survey of 1559 articles on immigrants and healthcare, researchers found that non-citizens and recent immigrants are significantly less likely to have health insurance, or a regular source of care compared to U.S.-born individuals (Derose et al. 2009). Immigrants also collectively report lower levels of satisfaction and higher rates of discrimination. Although health access costs were cheaper compared to natives, emergency treatments for immigrant children were expensive (Derose et al. 2009).

Disparities such as the highlighted informs avoidance behavior of immigrants who limit access to worst case scenarios, even though they are costlier and less effective for managing chronic conditions. A similar health care situation obtained in Norway as a qualitative study of 19 Polish migrants in Norway reveal. The study, which sought to explore barriers to access and utilization, found that language differences and discriminatory treatment were the major hindrances to proper care (Czapka & Sagbakken 2016)

The Polish immigrants lacked enough know-how of the rather complex and utilitarian philosophy of health care and medication allocation. Many obtained information about Norwegian healthcare system from a potentially misleading broad range of people, which comprised colleagues, family and friends (Czapka & Sagbakken 2016). The Norwegian system, different from the insurance-based care access mechanism of the Poles, was designed to allocate resources to those who needed it urgently.

This meant that immigrants were sometimes a second-order priority. Participants reported partiality in treatment administration, noting Doctors' reluctance to prescribe real examination and treatment or the equivalent of what was prescribed to native Norwegians. Newly arrived immigrants (below 6 months) were granted a temporary personal number which gave them no right to choose a General Practitioner like others (Czapka & Sagbakken, 2016).

In addition, Polish immigrants experienced the unexpected demands of displaying erudition about their health challenges when in dialogue with the attending General Practitioner (Czapka & Sagbakken 2016). As a Pan-European review suggests, these inequities are not local to Nordic areas.

A scoping review of literature from 9 European countries which consisted of Austria, Cyprus, France, Germany, Greece, Italy, Malta, Spain, and Sweden established that, despite best efforts, a stubborn streak of inequality existed in accessing healthcare between migrants and non-migrants in Europe. The review highlighted broad-reaching challenges in proper dental

and mental care, communication barriers and discriminatory practices against immigrants (Lebanon et al. 2020).

2.2.2. Linguistic and Cultural Barriers

Khanal (2025) set out to probe the under-researched realities of Nepali immigrants in dealing with language challenges to access healthcare in Finland. The results showed that Nepali migrants were seriously disadvantaged by how appointment scheduling, comprehension of medical instructions, and communication with providers were hamstrung by limited Finnish fluency. These language discordances place them at the mercy of the translation proficiency of informal networks including employees or co-ethnic communities for obtaining health information (Khanal 2025).

There was a reported stark shortage of interpretation services, and respondents reported feeling exposed at the thought of using community interpreters. Respondents, who belong in a close-knit group despite their status as the third largest newly arriving group, feared that their personal information would be inadvertently leaked to other members of the community (Khanal 2025). Insufficiency of interpreters had serious consequences, including the loss of a child, as one female respondent reported.

2.2.3. Socioeconomic and Geographic Disparities

Financial constraints and regional resource distribution create stark access gaps. The Healthy Finland Survey (2023) notes a 10% rise in healthcare access difficulties nationwide (Khanal, 2025). Russian-speaking migrants over 50 years report that expensive out-of-pocket costs and transportation barriers as primary difficulties (Safarov et al. 2024), with 33% of immigrants reporting insufficient doctor appointments compared to 25% of the total population (El-Showk 2025).

Immigrants of Middle Eastern and North African extraction (43%), as well as those from Russia and the former Soviet (36%) were the most affected by access problems (El-Showk 2025). In the May report, 1 in 3 immigrants' resident in wellbeing services counties (Central Finland, Helsinki, Satakunta, West Uusimaa) frequently reported dissatisfaction with medical services more than the general population (El-Showk, 2025). The report also noted instances of health inequities in accessing social services owing to gender or income (El-Showk 2025).

Similar to the situation in Sweden, another Nordic country, migrants lack awareness of occupational healthcare (OHC) rights, fearing job loss or loss of residency status if they take sick leave. This misinformation is further entrenched by surrounding ethnic enclaves whose limiting information discourages prompt use of healthcare (Khanal 2025).

The beliefs of immigrants in the United States also deter care utilization, but for a different reason. American immigrants simultaneously avoid healthcare because of the intensive, prohibitive costs and severe lack of awareness on the long-term consequences of living with comorbid conditions such as cardiovascular disease, diabetes, obesity etc. (Hall & Cuellar 2016).

2.2.4. Mental Health and Vulnerable Populations

Immigrants report elevated psychological distress, especially Post Traumatic Stress Disorder, occurring for adjustment-related problems (Kieseppa et al. 2021). These immigrants — often makes — received a comparatively low-intensity quality of treatment compared to native-born Finns (Kieseppa et al 2021). Contributing factors include trauma, acculturative stress, and delayed care due to linguistic or bureaucratic barriers. Nepali migrants usually misinterpret long wait times as discrimination, unaware that systemic delays affect all residents (Khanal 2025). Such perceptions, compounded by social isolation, amplify mental health burdens. Cost implications of utilizing healthcare are also a source of distress, especially in undocumented immigrants who can't afford costs incurred above the set threshold.

3. Aims and Objectives:

This research aims to investigate the lived experience of immigrants in Finland as it pertains to healthcare access and utilization. Specifically, this study is intent on identifying the major facilitative and inhibiting factors on the social and individual level and their corresponding impact on healthcare utilization among different immigrant groups. The study also intends to peruse the effectiveness of existing policies and programs aimed at equitable healthcare access and the provision of culturally relevant solutions for different ethnic blocs.

4. Study Methods

4.1 Research approach

This research adopts a qualitative paradigm that is a function of post positivist thought which states that social reality isn't fixed in immutable determinism as obtained in hard sciences. Consequently, this research is based on an inductive approach where theories are built from captured experiences with high fidelity to practical reality (Tenny et al. 2022).

4.2 Research Design

The method of choice for this research study is qualitative research which excels at exploring lived experiences, perceptions, and the meanings that individuals attach to their interactions with systems like healthcare. In the case of immigrants in Finland, access to healthcare is

determined by factors aside from formal policies and service availability such as personal histories, cultural expectations, language proficiency, and encounters with discrimination or support. These are deeply personal and context-dependent issues that cannot be fully understood through quantitative measures alone (Tenny et al. 2022).

Deploying the use of semi-structured interviews (Appendix 2) qualitative approach permits the researcher to create a space where participants feel comfortable sharing their stories in their own words. This approach allows for probing questions and follow-up, which can reveal layers of context and meaning that structured surveys might miss. The broadly labelled responses of quantitative study dissolves in the pro-experiential probe of qualitative research, with granular details that could lead to a re-evaluation of initial assessment (Tenny et al. 2022).

More in the way of justification, qualitative research is particularly well-suited to exploring the intersectionality of immigrant identities. Immigrants are not a monolithic group; their experiences differ by country of origin, gender, age, length of stay, employment status, and more. Qualitative data collection allows the researcher to note these differences and to identify patterns or themes that might be specific to certain subgroups (Busetto et al. 2020). This is important for informing targeted policy recommendations, as what works for one community may not be effective for another.

The use of purposive sampling (selecting participants based on their relevance to the research questions) in this research ensures that the study includes voices from various backgrounds, including different ethnic blocs, employment statuses, and lengths of residence. This strategic sampling improves the variegation and relevance of the data, making it possible to paint a comprehensive picture of the immigrant healthcare experience.

Another strength of qualitative methodology is its flexibility. As the research progresses, new themes or issues may emerge, allowing the researcher to adapt to interview questions or seek out additional participants to explore these topics further (Tenny et al. 2022). In analyzing the data, qualitative methods such as thematic analysis or grounded theory enable the researcher to identify recurring themes, patterns, and contradictions within and across interviews.

This study was conducted across different locations in Finland. The study adopted a qualitative approach involving a semi-structured interview (Appendix 2). In this study, participants were gathered through purposive sampling, a calculated and deliberate cherry-picking of participants well-fitted to a study's concerns (Nyimbili & Nyimbili 2024). The survey involved immigrants of different genders and cultural extractions.

4.3 Participant Recruitment

Immigrants were recruited randomly to obtain a good spread of cultural groups and nationalities. This was done using a purposive sampling technique supported by convenience and snowball techniques as the research later demanded. The researcher's close relationship with immigrants facilitated the identification of research participants, which involved two referrals from interviewees. More than 20 potential interviewees were approached, but only 5 had time and patience to spare for the research study. Inclusion criteria for the study included the following:

- Respondents must be over 18 years old
- Respondents are immigrants
- Respondents have used healthcare services at a point in their migrant history
- Respondents are in full knowledge of the research study and voluntarily participating

4.4 Data Collection

The data, total 52.16 Mb of data, (Appendix 4) equaling 15 pages of transcripted text, were collected in five face-to-face interviews. Prior to the interview, respondents' informed consent was obtained and the research topic explained. A complete education on interviewee research rights followed and verbal consent was obtained to audio-record. Interviews were conducted by the research author, who is also an immigrant.

Interviews were also conducted in English throughout, and answers were allowed to veer off as elicited by follow-up questions. Respondents from different backgrounds and with varying length of stay in Finland were involved for balance. Participants were immigrants. The interviews lasted for an average of ten minutes.

The research was conducted, prioritizing the convenience of respondents. Data gleaned from the participants was secured in a password-protected environment using an encrypted file. Access was limited to the researcher alone, who also singularly used the data. The raw data was retained for the duration of the research study, and following the completion of the study was permanently deleted.

4.5. Ethical Consideration

The research study was carried out with a thorough understanding of the TENK ethical guidelines for research integrity and also the Laurea University of Applied Sciences'

guidelines. Participants were provided with clear information about the study's objectives, methodologies, and potential impacts, ensuring their voluntary involvement.

Informed consent, documented through written forms and electronic agreements explicitly stated their right to withdraw at any time without negative consequences, and with assurances that any data collected prior to withdrawal will be omitted. The study avoided interventions compromising physical integrity and focus on qualitative interviews about health service use experiences, minimizing psychological harm.

Data collection was limited to essential demographic and health-related information, with names excluded and placeholder names assigned. Participants were briefed on the research's importance and their role in positive change. Data protection complied with regulations, employing encryption to secure collected data.

4.6. Data Analysis

Data from the interviews was transcribed verbatim. Proceeding with Braun and Clarke's (2006) six-step process, a theory-free inductive process was applied to cohere information into a representative understanding. Analysis began with a deep engagement of the data done through multiple readings. This allowed for patterns to be spotted and first impressions to be coded. Codes were later coalesced into related themes and sub-themes, which in turn, were eventually resolved into general descriptions. In the course of analysis, insider status was acknowledged to take stock of biases. The analysis proceeded with grouping similar questions in a category and sorting the responses to those isotopic questions into themes. Across the questions and responses, four major themes were harvested from the five interviews comprising 5 immigrants living in Finland. Respondents reported a near-perfect outcome in accessing healthcare, even as the process was pocked with nagging difficulties.

4.6.1 Braun and Clarke Thematic Analysis

Thematic analysis is a widely used qualitative analytic method for identifying patterns or themes within data. Clarke and Braun's approach, published in 2006 and refined over subsequent years is a go-to sense making tool in social science research.

Braun and Clarke's approach to qualitative analysis is notable for qualities of flexibility, theoretical openness, intellectual honesty and methodological soundness. It requires that researchers are open about personal assumptions that may interfere with objective interpretation, state their procedures clearly and admit that the themes identified exist as a result of the researcher's choice (Braun & Clarke 2006). A proper thematic analysis is thorough in data included, analytic, convincing, well-organized, and is a good fit between researcher claims and what the data shows (Braun and Clarke 2006)

Types of Thematic Analysis

Approaches in the Braun and Clarke (2006) model are split between three dichotomies of: inductive/deductive, semantic/latent, essentialist/constructionist

Inductive Approach

Inductive thematic analysis begins with the data rather than with chosen theories or categories. Researchers immerse themselves in the dataset, allowing patterns, themes, and categories to emerge organically from participants' accounts. This bottom-up approach prioritizes participants' narratives and experiences over theoretical frameworks. The researcher moves from specific observations toward broader generalizations and theoretical understanding (Terry et al. 2017).

In practice, researchers code data without trying to fit it into pre-existing coding frames or any guiding ideas. This approach is particularly valuable for exploring understudied phenomena or when seeking to understand experiences from participants' perspectives. It strives to stay close to the data, allowing unexpected insights to emerge (Terry et al. 2017).

Deductive Approach

In contrast, deductive thematic analysis applies pre-existing theoretical frameworks or concepts to the data. This top-down approach begins with theories, hypotheses, or specific research questions that guide the coding process. The researcher actively looks for patterns that align with or contradict established theoretical constructs (Terry et al. 2017). Data are approached with specific questions or coding frameworks in mind. The focus is analytical attention on aspects of the data relevant to these marked interests. The approach trades the open exploratory nature of inductive analysis for theoretical precision and targeted investigation. Researchers often move between data and theory iteratively, refining theoretical understandings through engagement with the data.

Semantic Approach

Semantic thematic analysis focuses on the explicit content of what participants say—the surface meanings accessible in the data. Researchers identify patterns within the explicit or surface meanings without looking beyond what has been said or written. The analytical process moves from description, where data are organized and summarized to show patterns, toward interpretation, where there is an attempt to theorize the significance of patterns and their broader meanings.

This approach sticks to participants expressed meanings and obvious content, though it still involves interpretative work beyond simple description. Semantic analysis is particularly useful when investigating explicit beliefs, experiences, or representations (Terry et al. 2017).

Latent Approach

Latent thematic analysis is more subjective in interpretation. It goes beneath the surface content to examine underlying ideas or assumptions that shape or inform the semantic content (Terry et al. 2017). Rather than just describing patterns, latent analysis identifies features that give particular form and meaning to experiences or events. This approach demands serious and extensive interpretative work to identify hidden meanings, social constructions, and implicit assumptions within participants' accounts.

Latent analysis often draws on constructionist paradigms, examining how events, realities, meanings, and experiences reflect various discourses operating within society. Researchers look beyond what participants explicitly say to analyze how language constructs particular versions of reality. This approach requires careful attention to linguistic features, metaphors, and narratives that reveal the recesses of thought.

The development of themes involves interpretative work, and themes themselves are already theorized. Latent analysis is uniquely useful for examining how social and cultural contexts shape individual experiences and perspectives. This makes it well-suited to critical approaches that interrogate taken-for-granted assumptions or examine power relations.

Essentialist/Realist Approach

The essentialist or realist approach to thematic analysis assumes a relatively straightforward relationship between language and meaning. Researchers adopting this position treat people's talk as a transparent window into their experiences, if language reflects and enables articulation of meanings and experiences (Terry et al. 2017). This approach theorizes motivations, experiences, and meanings in a direct way, treating what participants say as an accurate reflection of their psychological and social reality.

Under this framework, researchers can theorize about participants' experiences through their accounts while acknowledging the social context that influences those accounts. The analysis focuses on individual psychology, reporting experiences as lived by participants rather than examining how these experiences are constructed through language. This approach is particularly valuable for research focused on understanding participants' experiences of specific phenomena, such as illness experiences or significant life transitions.

Constructionist Approach

Constructionist thematic analysis is predicated on the idea that meanings are subjectively produced through self-select diction. It examines how meanings, experiences, and realities are actively constructed through language and social interaction. Rather than viewing language as simply reflecting reality, this approach understands discourse as constitutive—creating particular versions of reality while making other versions less visible. Constructionist analysis explores how events, realities, meanings, and experiences reflect various discourses operating within society and examines the effects these discourses have on social practices (Terry et al. 2017).

This approach situates individual experiences within broader sociocultural contexts, examining how available discourses enable and constrain particular ways of understanding phenomena. Researchers focus on how language constructs phenomena rather than simply how it reflects experiences. Constructionist analysis examines sociocultural contexts and structural conditions enabling individual accounts, revealing how dominant discourses shape what can be said and how it can be said. This perspective is valuable for research inquiries that investigate how power relations operate through language, how social problems are constructed, or how identities are negotiated through discourse.

This research implemented a critical realist stance, which paid attention to the material reality of healthcare barriers while examining how social constructions influence these experiences. Interview questions maintained strong fidelity to the intersectional reality of the respondents, giving gravity to the choice of words used for holistic interpretation of experiences.

As I reviewed the participants' narratives, I became increasingly aware that their experiences within the Finnish healthcare system were not just isolated complaints or compliments but pointers to deeper structural patterns. Many respondents described moments of kindness, efficiency, and inclusiveness, which were often fragmented and contingent. It became clear that what one person received as compassionate care, another experienced as alienation, delay, or even discrimination. This inconsistency led me to look beyond the surface of what was said, toward what those statements implied.

One example of this was when someone mentioned the shift from walk-in visits to digital bookings as a barrier. The research author didn’t just read that as inconvenience but understood it as a sign of a system increasingly structured around digital literacy and bureaucratic rationality, often at the expense of accessibility for migrants. Similarly, repeated mentions of language barriers weren’t just about miscommunication, but about power—who gets to speak, be understood, and ultimately, be cared for.

Through a critical realist lens, began to theorize that these issues weren’t just personal or logistical, but rooted in broader systemic mechanisms. Access is mediated by geography,

employment status, and cultural familiarity with the system. The frequent reliance on translation—often insufficient or unsatisfactory —reveals a deeper institutional assumption of linguistic homogeneity. Rights awareness, when present, emerged from individual clinician efforts rather than from systemic structures, exposing another gap.

These insights pointed the research author toward the latent theme of healthcare as a stratified experience, where formal equality coexists with informal exclusion. What appears universal on paper often feels conditional in practice, especially for those outside the mainstream. This approach helped the research author see that to truly understand healthcare inequities, began to engage with both what participants said and the invisible systems shaping those statements.

4.6.2. The Six-Phase Process

Braun and Clarke (2006) outline a systematic yet flexible six-phase process:

Phase 1: Familiarization with the Data

This involves:

- Immersion of the researcher in the data through repeated reading
- Noting preliminary thoughts on potential patterns and meanings
- Transcription of verbal data if necessary
- Recognizing inchoate aspects of interest in the data (Braun & Clarke 2006)

Phase 2: Generating Initial Codes

This involves:

- Systematic identification of interesting features across the entire dataset
- Organization of data into meaningful groups
- Coding for as many potential themes/patterns as possible
- Coding extracts inclusively (including surrounding context)
- Coding individual extracts into as many different themes as relevant
- Tracking contradictions and inconsistencies (Braun & Clarke 2006)

Phase 3: Searching for Themes

This involves:

- Sorting codes into potential themes
- Considering relationships between codes, themes, and different levels of themes

- Initial visualization of themes
- Development of candidate themes and sub-themes
- Collection of all relevant coded data extracts within identified themes
- Evaluation of theme interrelationships (Braun & Clarke 2006)

Phase 4: Reviewing Themes

This involves:

- Refinement of candidate themes through two levels of review (coherence and relevance to dataset)
- Re-reading the entire dataset to ensure themes capture its meaning
- Recoding additional data if necessary
- Development of a thematic map showing relationships between themes (Braun & Clarke 2006)

Phase 5: Defining and Naming Themes

This includes:

- Refining the specifics of each theme
- Generating clear definitions and names for themes
- Identifying the "essence" of each theme
- Determining what aspect of the data each theme captures
- Ensuring that themes are not too general or overlap excessively
- Analyzing data within themes to identify subthemes if necessary
- Considering how each theme fits into the broader overall narrative (Braun & Clarke 2006)

Phase 6: Producing the Report

This involves:

- Final analysis and write-up of findings
- Selection of vivid, compelling extract examples
- Relating analysis back to research question and literature
- Provision of an analytic narrative that goes beyond description
- Making an argument for findings in relation to research question (Braun & Cllarke 2006)

The Braun and Clarke method differs from other qualitative analytic methods in that:

Unlike grounded theory, it doesn't aim to develop theory grounded in data

- Unlike discourse analysis, it doesn't focus on language use as constitutive of meaning
- Unlike content analysis, it's not primarily concerned with quantifiable aspects of data
- Unlike Interpretative Phenomenological Analysis (IPA), it's not tied to a specific theoretical framework
- Unlike thematic decomposition analysis, it doesn't focus exclusively on latent themes

Braun and Clarke (2006) emphasize the importance of reflexivity in the research process.

Reflexivity is the process of critical self-reflection where researchers continuously examine how their position, assumptions, beliefs, and personal experiences might influence their research. It admits that researchers are not neutral observers but active participants in knowledge construction (Finlay 2002).

In Braun and Clarke's reflexive thematic system, reflexivity involves acknowledging the researcher's active role in identifying patterns, selecting themes, and constructing meaning from data. In the stead of viewing researcher influence as bias or contamination to be eliminated, reflexivity treats it as a useful resource when critically perused and lucidly documented.

Practically, reflexivity translates to admitting agency in interpreting data, noting how researcher’s position (social status, power position, gender) influences analysis and transparency about entrenched epistemological assumptions (Finlay 2002).

Braun and Clarke recommend reports include:

- Clear framing of theoretical framework and assumptions
- Adequate justification for its choice
- Description of the form of thematic analysis used
- Detailed account of the analytic process
- Demonstration of both depth and breadth of analysis
- Examples that illustrate themes without being redundant

Applying thematic analysis to this research began with clarification of my epistemological leaning, which shaped the entire analytical approach. Researcher reflexivity was observed during the research. The author of the research examined how their position as an insider/outsider to immigrant communities, their professional background in healthcare and their own cultural background influenced data collection and interpretation.

The author specifically took into consideration how to hold Western medical system to a very high standard as compensation for the poor version experienced in their home country,

imposed on expectations of healthcare delivery in locals. The research author also recognized the potential sensitivity to microaggressions, differential treatment, or exclusionary practices that stem from their status as an immigrant.

The research author understood how they risk over-identifying with certain narratives of discrimination, potentially interpreting ambiguous situations through a discriminatory lens when participants themselves might attribute experiences to other factors. Their personal experiences with discrimination could create emotional resonance with similar accounts, potentially privileging these narratives in the analysis or seeking confirmation of expected patterns.

Additionally, the research author acknowledged that there are forms of discrimination that exist at the intersectional level and differ from their personal experience, which predisposes them to an analytical blind spot that misses how discrimination intersects with factors like gender, disability, religion, or socioeconomic status in ways they haven't personally encountered.

The research author combined all these blind spots while simultaneously engaging the respondents with a majorly critical realist position that also integrated elements of the latent approach. This was done because the respondents were predominantly immigrants from racialized regions, and their views may be biased by discrimination. As a result, respondent accounts were counterbalanced by personal interpretations and somewhat corrective analysis that balances opinions.

5. Results

This research aims to spotlight the lived experiences of diverse immigrant groups with healthcare access and utilization in Finland. The research results reveal a snapshot of the outcomes of among immigrants, bringing to light lesser-known factors that ease access as well as pinpoint barrier areas. This analysis reveals how structural and personal factors shape healthcare utilization patterns and offers solutions relevant to all ethnic blocs in the interest of equitable healthcare access. The results consist of four themes.

Theme 1 Structural and Systemic Challenges

Theme 2 Pervasive Language and Communication Challenges

Theme 3 Employment and Healthcare Access

Theme 4 Healthcare Rights and Clinicians Conduct

5.1 Structural and Systemic Challenges

Broadly viewed, the Finnish healthcare system has a number of positives balanced out almost completely by challenging factors. On the same health privileges, such as right awareness and ambulatory services, some respondents had good things to report, while some didn't. One experience common to all respondents however was the long wait times and low language support. Considered as a whole, Finland's healthcare system, as gathered from the respondents, has a satisfactory equipment infrastructure, but needs an upgrade on the access and personnel delivering the services.

5.1.1 Positive Experiences

In describing their first experience with the Finnish healthcare system, Respondent 2 noted their first encounter as:

> very easy and helpful and the whole session was interactive (R2).

This spotlit the interactive nature of consultations. Similarly, Respondent 4 reported a seamless emergency response for their injured child, noting ambulance services and hospital care were

> perfect despite non-life-threatening injuries (R4).

5.1.2 Challenges

The transition from walk-in services to digital appointment booking created friction. Respondent 5 lamented a nationwide strain on primary care capacity with the words:

> You must make an appointment now... sometimes you stay on waiting lists for months (R5).

Also, migrants living outside the metropolitan areas received slow health support as they encountered longer delays. As reported by the respondents, swift healthcare access is hamstrung by issues related to geographic mobility and bureaucratic complexity, as well as other structural disturbances. Respondent 5 experienced deteriorating access after relocating from Helsinki to Vantaa.

> There was a little bit of problem assessing healthcare, and now it's getting even worse. Sometimes you could just go to the hospital and pick a crew number, but now it's not possible anymore, especially in Vantaa, where I live. You must make an appointment (R5).

They shared a similar situation to his friend's experience:

> I have a friend out of Vantaa. They are out of the metropolitan area. She told me that sometimes they stay on the waiting list for months. Even after booking an appointment, they stay waiting for months, so in that case it's a little bit more challenging (R5).

They also experienced staff hostility and stricter appointment systems in addition to the stock challenges of immigrants, which included language barriers and a deficit of cultural competence.

Secondly, respondents reported cost challenges for non-urgent care, especially in dental care which €40 was described as prohibitive. As respondent 1 remarked,

> I'd rather have it free (R1).

Such out-of-pocket expense strained respondents who were mostly low-income earners.

A different type of neglect was experienced by kids of the undocumented population who as Respondent 5 advocated,

> shouldn't die because parents lack paper (R5).

5.2 Language and Communication as Pervasive Challenges

Respondents experiences were mixed as half reported unhindered communication access attributed to the presence of translators and the relatively rare occasions of a bilingual Doctor or nurse. Others bemoaned a disturbing experience communication-wise. They were at the mercy of a translator who misinterpreted their words and healthcare providers who were mostly unable to communicate with multicultural client lists.

5.2.1 Positive Experiences

Participant responses noted occasional examples of good language access. The positive experiences of smooth communication reported by respondents stemmed from available translation services or bilingual healthcare providers who could also speak English.

As respondent 1 happily reported,

> It's been great honestly; I think I've never had a negative experience with a healthcare professional in Finland. (R1)

Other accounts of smooth communication were depicted as thus:

> Well, I would say there was no challenge simply because the doctor understood both English and Finnish Language, so it was good. (R2)

> …the nurse assigned to me understood English. (R3).

> His school arranged a meeting with a translator. A Persian interpreter. (R4).

5.2.2 Challenges

Respondents expressed a majoritarian dissatisfaction with the quality of communication. Respondent 3 reported a general lack of facility with English among healthcare providers:

> A lot of them don't know how to express themselves in English. It's a bit challenging. Even if they do, it's not so much. A lot of times, they have to use translators. A lot of times they give you something to read. So, it's different from someone having to talk to you and explaining well. That way you guys can interact. Communication barrier here is a bit challenging. (R3)

In dealing with this barrier, he mentioned the reliance on written instructions, noting,

> A lot of times you want to ask them questions, but you can't do that, because of the language barrier. When they give you a paper, you just have to go with that. (R3)

> They often required the middleman services of a translator who was sometimes averagely versed in correctly translating health information.

Respondent 5 (R5) lamented that

> interpreters don’t translate what I’m saying... leading to wrong prescriptions (R5).

This presents a serious concern as inaccuracies in relaying health information could result in aggravated health conditions. On the service user side, limited Finnish/English proficiency slowed the navigation of booking systems and understanding health entitlements.

5.3 Employment and Healthcare Access

Employment status was found to be correlated with speed and quality of health service, but employees outside the public service such as corporations, or students reported a relatively superior service. They, however, complained of high service charges and inconsiderate leadership which limited access.

5.3.1 Positive Experiences

One respondent described the healthcare system as egalitarian and wellness-first, with service care non-contingent on the employment status of service users. As they described:

> Again, I just said that the healthcare in Finland is highly accessible to everybody. You are not expected to be rich to access their healthcare. Everyone is attended to equally. Maybe later there can now be bills sent to your house, but you would get what you want. You will be well-treated and well attended to. So, whether employed or unemployed, firstly, what matters to them is attending to you. That's what they do here. In fact, all the time I was attended to I was unemployed. I was greatly attended

> to. There was no discrimination as to whether I have a job. Again, that's commendable. (R3).

Another respondent (a student) also had positive reviews, echoing the same sentiment:

> Presently, I'm a student studying Finnish and so I can't say I'm employed or unemployed. Like I said, I don't have any restrictions. I have full access to all health care service provided here in Finland starting from treatment booking, appointment for certain tests. It's been quite easy. I have access to all the services I need presently, so it's been good. (R2).

5.3.2 Challenges

Employment status mediated care quality through occupational healthcare privileges. Employed participants like Respondent 5 accessed superior private services (e.g., Mehiläinen), describing them as

> better but expensive (R5)

Other respondents may not have described their experience with private healthcare in like terms, but their diction also hinted of extra costs. In some cases, immigrant workers' recovery is hijacked by bully bosses who mandate working while sick as the report of Respondent 5 suggests. Participants consistently rated private services higher for speed and personalization. Respondent 1 contrasted private clinics' immediacy with public sector delays for non-urgent care. Cost limited private access, creating inequities between employed/unemployed migrants.

5.4 Healthcare Rights and Clinicians Conduct

Respondents in this study were split between awareness and non-awareness of healthcare rights. Knowledge gaps persisted despite Finland's patient education frameworks.

5.4.1 Positive Experiences

Respondent 5 admitted that they were privy to their rights and the doctors ensured that in addition to learning their rights, they protected them against people who strove to deny them. As he narrated,

> When I moved here, I was not aware of my rights, but now I'm aware because the Doctors most especially also try to educate the customers on their rights especially the immigrants. They tell you what is your right. Because sometimes you work with companies and when you are sick, the bosses tend to bully you as an immigrant. They even call you in the hospital. They want you to come and do their job. They don't care about your health status. In that case of being a victim, a doctor actually from Finland had to answer and pickup one call from my boss and then later on, he had to send a revocation that workers are not supposed to. (R4).

Respondent 3 also spoke highly of clinician conduct. Their report goes this:

> I would say “very good or excellent” because the nurse that was assigned to me was wonderful. I think the first day I went was my birthday. The first thing they said to me was “happy birthday”. My nurse was a very kind person. She was very good with me. (R3).

Respondent 2 described her present pregnancy progress and the helpful role the nurses have played. As she mentioned:

> They've been attending to me, checking up on me, you know, with different appointments, different tests, to make sure I and the unborn child are good. (R2).

5.4.2. Challenges

One account of microaggression was reported. Respondent 5 perceived racial bias when Vantaa nurses were

> rude to triumph (R4)

illustrating how implicit biases may compound structural barriers. This contrasts sharply with Respondent 2's account of culturally competent maternity care accommodating even their dietary/religious needs.

5.5. Summary

The experiences of immigrants navigating Finland’s healthcare system reveal a pattern of both promise and persistent challenges. Many respondents described the system as equitable and well-equipped, highlighting positive encounters with kind, attentive professionals and emergency services that functioned efficiently. Some shared how healthcare workers offered medical support and also empowered them by educating them on their rights—especially in instances where employers tried to pressure them during periods of illness. However, systemic issues were consistently reported. A major point of friction was the shift from walk-in services to digital appointment systems, which disproportionately affected those unfamiliar with the language or without digital fluency. Respondents outside metropolitan areas noted long wait times, with some waiting months even after securing appointments. Communication barriers emerged as a pervasive challenge.

While a few experienced seamless communication thanks to English-speaking providers or translators, many faced misinterpretation, and a sense of disconnection from their care. In some cases, healthcare workers relied heavily on written instructions, making it difficult for patients to ask clarifying questions. Employment status influences healthcare access significantly. Those with access to private occupational health services described faster and more personalized care but were burdened by high costs. Conversely, unemployed or undocumented respondents struggled with delays, out-of-pocket expenses, and exclusion

from certain services—particularly in dental care. Some even reported that their children were denied access due to their parents' undocumented status.

Although the healthcare system was largely seen as non-discriminatory in theory, some respondents recounted experiences of rudeness or microaggressions, especially in less culturally competent settings. Despite these hurdles, many still viewed Finnish healthcare as deeply committed to patient well-being, with standout moments of compassion and professionalism. Yet, for meaningful equity to be achieved, the system must improve its communication infrastructure, reduce regional disparities, and expand cultural competence across all levels of care.

6. **Discussion**

Finland's tax-funded healthcare model, applauded for its emergency care efficiency and patient-centered ethos impressed participants, mirroring the country's top rankings in healthcare satisfaction (Nurmeksela et al. 2023), but also left a little to be desired in terms of non-urgent care accessibility for immigrants. Long waiting times for chronic conditions, such as Respondent 1's shoulder injury, are indicative of a systemic strain on healthcare. These delays contradict the OECD's emphasis on timely care as a determinant of health equity ("Health literacy for people-centered care" 2018). Localized service delivery translated to spatial inequities when immigrants had to move within the country to access healthcare. This experience exemplifies a postcode lottery effect where healthcare coverage is geographically determined and un-linked to a patient's health need (Graley et al. 2011).

Communication challenges were visibly present in care attendance. Though Finland mandates interpreter services, overreliance on written instructions (Respondent 3) and interpreter inaccuracies (Respondent 5) risked diagnostic errors, echoing the qualitative research findings of Pandey et al (2015) who find that language barriers led to suboptimal therapeutic relationship, poor disease management, and poor health outcomes. Respondents without a good command of Finnish struggled to utilize digital booking system despite the multilingual feature of the portal. Notably, higher education buffered some participants; Respondent 5's biochemistry background enabled proactive care navigation. This differential access advantage explained how specialized education was a social determinant of health, though equity concerns are raised for less-educated migrants, who may lack the agency to challenge misinterpretations or advocate for appropriate care.

The divide between public and private healthcare access revealed stark employment-based inequities. Employed migrants leveraged occupational private insurance (e.g., Mehiläinen) for faster, personalized care — a privilege unavailable to unemployed peers dependent on overburdened public clinics. Taken together with the fact of long wait times for lower-level quality of care experienced by other respondents, this two-tier approach defeats the

universalist ideals espoused by Finland. As THL's research finds, it would be if great benefit for the broad-reaching extra-legal occupational healthcare to be available for use by also the public (Yle News 2023). A similar disparity was observed in the advocacy for childcare In children from the undocumented population. This complaint is in opposition to the European Child Guarantee which mandates free child health services (Eurochild-Finland's Biennial report 2024). Culture-wise, the Finnish healthcare system is somewhat a mixed bag. Differing reports by the respondents on a migrant-friendly treatment in one hospital and an unprofessional treatment laden with implicit bias suggests the possibility of bias in an otherwise egalitarian health system.

7. Trustworthiness and Evaluation

The trustworthiness and evaluation of this research is framed using Lincoln and Guba's approach (Enworo 2023), which emphasizes four key criteria: credibility, transferability, dependability, and confirmability.

Towards achieving credibility, this study employed purposive sampling to select participants with varied backgrounds, thus capturing diverse perspectives relevant to healthcare access challenges. The insider bias of the research author was acknowledged during the interviews and care was observed to avoid probing with leading questions that serve a forced agenda. Semi-structured interviews (Appendix 2) allowed for in-depth exploration of participants lived experiences, enhancing the authenticity of the data collected. Ethical considerations such as informed consent and data protection were rigorously observed. Additionally, the concordance of findings with existing literature on immigrant healthcare challenges in Finland further strengthen credibility.

This research study provides a moderately representative depiction of immigrant healthcare experience in Finland. The study's involvement of Africans and Asians who provided personal accounts of healthcare use consistent with foregoing literature shows that the results can be generalized to analogous communities with fair amounts of confidence.

The study's methodological rigor is evident in its clear articulation of research philosophy, participant recruitment, data collection, and analysis processes. The transparent documentation of procedures by allows for replication or audit by other scholars. The use of semi-structured interviews (Appendix 2) and thematic analysis provides a systematic approach to data handling, ensuring consistency and reliability over time.

The researcher author-maintained reflexivity throughout the study, no potential biases and ensured that interpretations were grounded in participants' narratives rather than preconceived notions. Data was collected and analyzed according to a defined guiding framework. Findings and extrapolations were built on direct quotes and cross-referenced with

existing studies on immigrant health disparities in Finland. Ethical guards and data protection measures were also observed.

Conclusion

This research reveals Finland's healthcare system succeeds in providing universal emergency care but struggles with equitable access for immigrants in non-acute contexts. Structural barriers (appointment systems, costs) intersect with sociocultural factors (language, discrimination) to create compounded disadvantages. On the macro plane, health reforms have been targeted at tackling undocumented migrants' rights, but a bulk of work remains to be done in cultural and linguistic competence and regional resource distribution, which require urgent policy attention. As migration rate continues to increase in Finland, it is imperative to integrate migrant realities into health policy design for sustainable systems that satisfy the requirements of universal healthcare coverage.

Recommendations

1. Healthcare institutions should provide expanded language services by hiring multilingual staff and standardized interpreter training. Special emphasis should be placed on the languages of large migrant communities.

2. Care networks should be decentralized to increase rural service points and mitigate travel stress. Mobile clinics can be implemented for transient populations. Also, waitlist should be centralized across regions to prioritize high-need cases.

3. There should be a health-first approach to care regardless of residency status. Finland can take a cue from Germany's clearing centers which provide care for the uninsured (Lang et al. 2024).

4. Employers should include health rights education in employee orientation.

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Appendices

Appendix 1


INVITATION TO PARTICIPATE IN RESEARCH ON IMMIGRANT HEALTH ACCESS EXPERIENCES
Are you an
IMMIGRANT
Residing in Finland?
HAVE YOU FACED CHALLENGES ACCESSING HEALTHCARE SERVICES?
PARTICIPATE IN RESEARCH HEALTH ACCESS EXPERIENCES
This research aims to explore the experiences of immigrants in accessing healthcare services in Finland, identifying barriers and facilitators to inform policy improvements.
INTERESTED? PLEASE SEND A MAIL TO
Alelanmolemutiu@gmail.com
for the interview link
Thank you for your participation and contribution to ensuring healthcare access for all
3 GOOD HEALTH AND WELL-BEING
10 REDUCED INEQUALITIES

Appendix 2

Semi Structure Interview Questions Guide

1. Before arriving in Finland, did you have any expectations or assumptions about the healthcare system?

2. What was your first impression of the healthcare system when you arrived?

3. Can you describe your first experience accessing healthcare in Finland?

4. What challenges, if any, did you face in accessing healthcare? (Examples: language barriers, cost, booking appointments, documentation issues.)

5. Were you aware of your rights or entitlements to healthcare services as an immigrant?

6. Have you used public healthcare, private healthcare, or both? How would you compare these experiences?

7. How has communication with healthcare professionals been for you?

8. Have you faced any challenges with language or interpretation services?

9. In what ways has your educational background influenced your understanding of health and healthcare in Finland? Please share any specific experiences or insights.

10. How does your employment status (employed or unemployed) impact your health and access to healthcare services? Please share any relevant experiences.

11. What would you like to see improved in the healthcare system for immigrants in Finland

12. Would you like to share any additional experiences, thoughts, or advice that might help us better understand your journey?

Appendix 3

PARTICIPANTS INFORMATION SHEET

Invitation to participate

Thank you for agreeing to take part in this interview. My name is Alelanmole Mutiu Abiodun. I'm currently a master's student conducting research for my thesis titled, "Immigrant Experiences with healthcare access in Finland." This is a semi-structured interview, meaning that I have a prepared set of open-ended questions, but you are free to elaborate or share any related experience you feel are important. Before you decide whether to participate, I will kindly read the following information carefully, if anything is unclear or you would like more details, feel free to ask me for elaboration.

Voluntary Participation

Participation in this study is entirely voluntary. You have the right to withdraw at any time, skip any question, or stop the interview without giving reason, any data collected up to that point will be deleted immediately.

Purpose of the study

The aim of this research is to explore how immigrants experience, navigate and perceive the healthcare system here in Finland. The findings will contribute to discussions on improving healthcare equity and inclusion.

Who is conducting the study?

This research is conducted by only me and my name is Mutiu Abiodun Alelanmole, as part of a master's thesis at Laurea University of Applied Sciences. There is no external funding or organizational involvement.

What will participation involve?

Participation involves a one-on-one interview lasting approximately 10-20 minutes depending on the conversation. The interview will be audio recorded with your consent and will focus on

your experiences with healthcare access in Finland. All responses will be anonymized, and no identifying information will be included in the final report.

Benefit of Participation

While there is no direct benefit to you, your input will help highlight important issues affecting immigrant communities and may inform future improvement in healthcare services.

Risk and Disadvantages

There are no known risks associated with participating in this study. Your identity will remain confidential and no personal information will be shared or published.

Financial Information

There is no cost to participate, and no payment will be provided.

Sharing of Results

The final thesis will be submitted to Laurea University of Applied Sciences, no personal data will be included in any publication or presentation

Are you comfortable proceeding?

Further Information

If you have any questions or would like more information, please contact:

Researcher:

Mutiu Abiodun Alelanmole

Master's Student, Global Health and Crisis Management

Laurea University of Applied Sciences

Mutiu.Alelanmole@student.laurea.fi

alelanmolemutiu@gmail.com

Appendix 4

DATA MANAGEMENT PLAN

Planner(s):	Mutiu Abiodun Alelanmole
Thesis title:	Immigrant Experiences with Healthcare Access in Finland
Thesis commissioner: (organisation/project/person, if any)	None, the thesis is conducted independently as part of the Master's Degree Program at Laurea University of Applied Sciences
Plan preparation date:	May 14 2025

1.1. Description of the data: Data and materials to be collected or that already exist and their properties

Data	Size	Format
Interview 1 Audio	6.99MB	m4a
Interview 2 Audio	9.71MB	m4a
Interview 3 Audio	9.05MB	m4a
Interview 4 Audio	10.51MB	m4a
Interview 5 Audio	15.90MB	m4a
Interview 1 Transcript	9.5kb	docx
Interview 2 Transcript	9.9kb	docx
Interview 3 Transcript	9.9kb	docx
Interview 4 Transcript	8.4kb	docx
Interview 5 Transcript	11kb	docx

1.2 Ensuring the quality of the data

The informants received a general description of the study beforehand, the interview was done physically, and the researcher read out the consent to all participant and only proceed with the

interview when a verbal acceptance was said. all the interviews were transcribed by me (The researcher) for proper analyzing and for the purpose of the research

2.1. Personal data and data protection considerations

This study collected an indirect personal data through semi structured interviews with immigrants in Finland, including background and healthcare experiences. All data were anonymized using unique code, and no identifying information was included in the final analysis.

Audio recording and transcripts were stored securely on the researcher password-protected computer and cloud base. Only the researcher has access to the data, which was used solely for academic purposes. 24 months after the thesis is completed, all personal data will be permanently deleted using secure methods. Participant were aware informed of these measures during the consent process.

2.2. Main responsibility for the processing of personal data, i.e. controllership

This research was independently conducted by Mutiu Abiodun Alelanmole, a Master student in Global Health and Crisis Management program at Laurea University of Applied Sciences. As the sole researcher, hold full responsibility for the collection, handling and protection of all data involved in the study

2.3 Notifications required for data privacy

Security and privacy of the data were ensured via usage of cloud services with two-step authentication. This kept the data in a controlled environment and prevented unauthorized access. The researcher uploaded all documents to a cloud storage and zipped them with a code only known to the researcher

2.4 Research settings requiring ethical review in master's thesis

This study did not require a formal ethical review, as it involved no physical intervention, vulnerable populations, strong stimuli, or foreseeable psychological or safety risks. All participants were adults who provided informed consent before the interview was conducted. Participation was entirely voluntary, and the research was conducted in accordance with the ethical guidelines of TENK.

2.5 How will you manage the rights to the data and materials you use, produce and share?

This thesis was conducted independently by the researcher without external commission. All materials, including interview data and analysis were produced solely for academic purposes. The researcher retains full ownership and control over the data, which will not be shared with third parties. Access to the original data is restricted to the researcher, and no personal or raw data will be transferred or published. The findings are presented in anonymized form to protect participant confidentiality.

2.6 Informing participants, consent to participate and further use of the data

Rights to the data gathered were agreed upon during the interview. Participants were anonymized, were notified of the transience of the data provided, and its future deletion following research use. Respondents were informed of their ability to discontinue participation in the interview and use of their data, showing that they owned the primary rights to the data.

2.7 Research permit

This study did not require a formal research permit, as it was conducted independently and did not involve the use of organizational data, internal records, or research on specific institutions or their members. The interviews were carried out with individual participants who voluntarily consented to share their personal experiences, No data was collected from or about Laurea University of Applied Sciences, its staff or students. Therefore, a research permit from Laurea or any external organization was not applicable in this research.

3.1. Documentation of the data during the thesis process

Throughout the research process, a separate document was maintained to track key details related to data collection and analysis. This included records of interviews, the dates, participant codes, transcription progress and any modification made during the thematic analysis. Each stage was documented to ensure transparency, consistency and traceability in line with qualitative research best practice

3.2. Data order and integrity

All research data were organized using unique participant codes and stored securely, the data handling process followed a clear sequence to ensure accuracy, prevent loss, and maintain integrity throughout the thesis

4.1. Recording and information security during the thesis process

All interview materials were stored on the researcher's personal computer, secured with a user ID and strong password. The final thesis will be shared securely with Laurea, if any part of the study is published, it will be done with mutual agreement

4.2. Data protection

All data were anonymized, securely stored, and accessed only by the researcher. The study followed GDPR guidelines, and all data will be permanently deleted after the thesis is completed.

5.1 After the completion of thesis: destroying, preserving, or finding further use for and opening data

After the thesis is completed, all personal data will be securely deleted using data overwriting methods, any handwritten notes will be shredded. The data will not be reused for future research. The final thesis will be submitted to Laurea University of Applied Sciences, and no part of the data will be shared externally or published without appropriate academic approval.

6.1 Tasks and responsibilities

The researcher (Mutiu Abiodun Alelanmole) is solely responsible for the collection, storage, and protection of all research data. All data were handled in accordance with Laurea University of Applied Sciences ethical and data protection guidelines. The thesis writing lasted over six months, and the completed thesis is submitted to Laurea as final report. No external review or publication approval is required.

Appendix 5

Abbreviation

SDG	Sustainable Development Goals
SEM	Social Ecological Model
HBM	Health Belief Model
THL	Finnish institute for Health and Welfare
OHC	Occupation Health Care
EU	European Union
IPA	Interpretative Phenomenological Analysis
Kela	The Social Insurance Institution of Finland
OECD	Organization for Economic Co-operation
NHS	National Health Service
USA	United State of America
COVID-19	Coronavirus Disease 2019

Some acronyms like (R1), (R2), (R3) (R4), (R5), refer to respondent identifiers in the interviews