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How do people on a low-income interact with oral health clinics: A qualitative study in Norway of perceptions and experiences

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Abstract

Background: Many people today in Norway fall between the cracks of the oral health care system being unable to afford dental treatment. This is the case even with the presence of multiple coverage schemes (subsidies for specific groups) by the government. Those on a low income may particularly face challenges in maintaining their oral health.

Aim: The aim of this study was to uncover how people on low income in Norway interact with the oral health clinics and additional the experience of oral health care system. In particular, the aim was to better understand how being with few financial resources influences their perceptions and use of oral dental health care.

Methods: The gathering of data was done in accordance with a qualitative design. There were 11 participants in the study with varying backgrounds but had in common that they had low income and/or had difficulties accessing oral health clinics. Semi-structured interviews were used, audio recorded and subsequently transcribed verbatim. The questions asked of the participants related to the accessibility, acceptability, quality and affordability of the oral health clinics. Thematic analysis was used to identify themes from the qualitative text with the goal of better understanding the personal perceptions and experiences of the participants of this topic.

Findings: Four themes were generated by the use of thematic analysis. These where: “Wishing for better oral health”, “availability towards the patient needs”, “Wishing for better quality of oral health” and “The good experience”.

Conclusion: The themes indicate that there are multiple barriers of entry when wanting to visit oral health clinics, especially when it comes to bureaucracy inside and outside of oral health clinics. There is also a discrepancy when it comes to knowledge between the participant who had coverage and those who did not, leading to worse outcomes in the oral health among those who did not fall under the coverage plan. Both economic resources and knowledge tended to act as barriers to dental health care and/or bad experiences of treatment.

Implication: The implications of the findings show difficulties in accessing the clinics in affordability, consumer acceptability and information/bureaucracy barriers. For the public health there needs to be more focus on providing information to the person about the structure of the dental health care system and their right to oral health care. Currently most of the focus is upon the dentist or oral health clinics in providing the necessary information for their patients. There needs to be an empowerment of the patient in the form of knowledge or information to allow for better manoeuvring of the oral health sector.

1. Introduction

1.1 Oral Health as an Important public health issue

This thesis focuses on dental public health, which has as its main goal the prevention of oral disease, promoting good oral health, and thereby improving peoples quality of life (Mohamed & Robinson, 2021). These goals are fulfilled through dental programmes, services and policy which vary from country to country (Mohamed & Robinson, 2021). The key issue preventing achieving universal good oral health is dental caries, tooth loss and other oral diseases (Mohamed & Robinson, 2021). Even through in theory they can be prevented there is still the issue of inequality and lack of promotion (Hayashi et al., 2020; Northridge et al., 2020; WHO, 2022). Decayed, missing and filled teeth (dmft a measure of oral health) has also been shown to strongly correspond to social inequality (Carlsen et al., 2022; Hayashi et al., 2020). This means that there is a clear social gradient in oral health, with those from lower social classes more affected than others higher up the social hierarchy (Hayashi et al., 2020), making it necessary to better understand this phenomenon of an unequal pattern. Since oral health is a human right and is the basis of healthy and productive lives towards a society (WHO, 2022). Making this both a public and a human rights issue when there are difficulties in accessing necessary treatment.

Oral health is often viewed as a Cinderella service among the healthcare sciences and professions in most countries where the focus is primarily on curative rather than preventive treatment for both dental and gum diseases (Hayashi et al., 2020). This increases the burden of oral disease on the individual when treating them (Grytten, 2017). This is especially true for those in lower social classes who often have poorer oral health (Knorst et al., 2021). In the long run, dental treatment will be more expensive for these people rather than prevention (Kjøstad, 2018). Furthermore, in many countries people from lower social classes experience difficulty in accessing dental services (Molarius et al., 2014; Nicoll et al., 2016). Because the price of treatment is expensive and increases over time (Peres et al., 2019). This means that it is often not feasible for some people to seek out treatment at some point (With, 2022). However, to date, there has been little research on the challenges of accessing dental services for those who are in difficult economic circumstances, especially in Norway. This is the departure point for the current study, which aims to contribute knowledge on how such individuals experience this phenomenon. Such knowledge could inform policy and strategy in

relation to dental services. Thus, the research question is how people in low income interact with the oral health clinics.

Generally speaking, oral health in Norway is quite good compared to other countries. The number of 18 years olds that have no dental caries is 32.3% as of 2022 (Statistisk Sentralbyrå, 2023c). This has been part of the historical development in Norway as we see that there has been a gradual increase in the number of people who have not experience caries (Statistisk Sentralbyrå, 2023b). To be more exact the increase has been from 65,7% to 77,2% for individuals with dmft under the age group of 18 (Statistisk Sentralbyrå, 2023b). This concerns mostly the age group of 18 years of age and below that. When it comes to adults, we can see that there has been a gradual increase in more adults getting subsidy on their treatment. From 2016 to 2022 we can see a steady increase in 3-5% increase of subsidy usage (Statistisk Sentralbyrå, 2023a). Interestingly enough this increase has been noted to have been seen in lower education groups such as grunnskolen and videregående (Statistisk Sentralbyrå, 2023a). This can be attributed to the improvements of the educations system through reforms (Grytten & Skau, 2020). Meaning that this increase in usage can be attributed that more people in lower social class have better basic education. This positive development does pose the question of how the experience was of dental clinics for the adults. Since the oral health has increased for the younger generation because of the coverage and focus on early prevention (Helsedirektoratet, 2019). When these people enter the adult age group we see worsening in their oral health (Åstrøm et al., 2017). How do these age group experienced the oral health clinics when they stop being qualified for coverage. We see that the rise in the demand for such a treatment is continuing none the less for the adults (Grytten & Skau, 2020). Since if the overall oral health increases or the demand for it, it does not mean that people in lower social class and alike experience the same benefits or experience (Castañeda et al., 2010). We see from the information that there is a clear gap between the young and old age groups when it comes to oral health. How do people who experience worsening in oral health and do not have the same opportunities as the rest of the population. Thus, armed with the knowledge of the current context and the deeper understanding of the thesis issue. We can better understand the data and also improve our literature search for relevant articles.

1.2 Context: dental health services in Norway

It is important to understand the national context of this project. Norway is a social democratic welfare state, and this reflects in its health plan (Regjeringen, 2024), which focuses on providing universal coverage of oral health to achieve overall good oral health in the population (Regjeringen, 2024). This is achieved through routine dental examinations by the dentist where the purpose of the government subsidy is to lessen the economic burden on to specific age groups or those with health conditions (Dudko et al., 2017). Children up to the age of 18 receive free dental treatment (Helsedirektoratet, 2023) Another group is young adults from 18 to 24 years of age, where only 75% of the treatment cost are covered with the person paying the rest (Helsedirektoratet, 2023). Mentally disabled people both at home and in institutions groups of elderly and long-term care patients living in institutions or receiving care at home also get free oral care (Helsedirektoratet, 2023). Outside of this municipalities decide themselves if they want to prioritise any other patient group (Mohamed & Robinson, 2021). It is also the duty of the dentist that the patient gets the coverage that they deserve and it is the dentist who does the paper work for the application (Helsedirektoratet, 2023). As it stands there is almost no adult coverage of oral health treatment aside from very specific cases (Helsedirektoratet, 2023). Such cases are when a person does not have enough money to cover essential oral health treatment and needs to go to Norwegian Labour and Welfare administration (NAV) to get partial coverage (Nicolaysen, 2018). The issue with this coverage is that it is only partial and is deeply rooted in bureaucracy when it comes to who qualifies or not. With variation from one office centre to the next in what the qualifications are to get coverage, but what they have in common is that the patient themselves is responsible to seek out coverage themselves not the dentist (Nicolaysen, 2018). This situation has created the need for private sector oral health businesses in a social democratic welfare country. An important caveat to mention regarding coverage is that it differs from private to public. Where the private sector does not follow the coverage scheme proposed by the government and is based on payment for services (Grytten, 2017). Private clinics have their own prices on treatment while the public sector prices are determined by each municipality in Norway (Helsedirektoratet, 2023). This results in that even though the private and public sector are operated by dentist, dental hygienist, and dental nurses (assistant) they have different goals and treatment plans based on their sector. The private sector operates as a business (Mohamed & Robinson, 2021), with the goal of making profit through providing a set of services mostly to the adult age group (Helsedirektoratet, 2019; Paisi et al., 2020).

Where the appointment of the positions at the clinics is done by the owner of the clinic (NTF, 2023). While in the public sector the municipality specifically appoints the job positions at the oral health clinics (NTF, 2023). Giving the public sector the prerogative to act in the stead of the local government (Helsedirektoratet, 2019). The public sector has the goal of improving dental health in the population through curative treatment and preventive oral health care, with the additional task of increasing knowledge and interest for what can be done to improve the general oral health (Helsedirektoratet, 2019). Usual in the Norwegian context cross sectoral work can be done. Meaning that a dentist at a private clinic can work at a public clinic too (NTF, 2023). When it comes to specialist dentist, they mostly work at the private sector with some deciding to go public sector (Regjeringen, 2024). This shows the intricacies of the dental sector when it comes to private and public clinics. How do these intricacies then show themselves in the experience of accessing the clinics.

1.4 Clarification of key terms

Before proceeding onward there are some terms that need further clarification. The first one being oral health. The term oral health covers the teeth, gums and entire oral-facial system these aspects enables individuals to perform essential functions such as eating, breathing and speaking (WHO, 2024; Willumsen et al., 2019). Where good oral health is not only defined the absents of disease but also that the person has a good experience of life through social interaction and achieving their potential (WHO, 2024). The term Affordability, accessibility, acceptability and quality (AAAQ) framework is a framework for assessment of a health service. Through analysing and assessing barriers that impede access to a service apparent or not. We assess this barriers in four different groups that being affordability, accessibility, acceptability and quality (Unicef, 2019). Self-oral-health-related quality of life (OHRQoL) is a subjective method of evaluation of the individual's oral health, functional wellbeing, emotional wellbeing, expectations and satisfactions (Willumsen et al., 2019). In other words this tool allows for understanding of how the oral health has impacted the individuals life and is often used in many research articles (Willumsen et al., 2019). Dmft is a more detail evaluation of the oral health in a community in comparison to OHRQoL (Castañeda et al., 2010). By looking at the overall number of missing, decaying or missing teeth. Allows for a non-subjective analysis of how the oral health is in a community (Castañeda et al., 2010).

1.5 Structure

The structure of the thesis will be as following. First will be the introduction, which introduces the research issue and relevant background. The following chapter will the literature review. Showing and explaining the state of knowledge on the subject and showing the gap in the research which this study seeks to address. The third chapter will be methodology including reasoning for the choice of methodology, plan for data gathering, pilot study and how the data was gathered. Fourth chapter will be about the findings of the data gathered. The findings chapter will present the code and themes generated from the interviews with the participants and how it relates to AAAQ framework. The last chapter will be discussion about how the findings in this thesis stand up towards the literature found and what the findings mean for future research. This chapter will also conclude in answering what the experience of oral health clinics was.

2. Literature Review

A lot of research regarding oral health and inequality centres around the lack of coverage of affordable treatment. Norway stands in an interesting point where there is a coverage and affordable treatment. But this is not enough. As shown by that the people in low income groups having hardships in accessing the dental services (Carlsen et al., 2022). Rasing the question of why this people have such a hard time accessing the treatment they need. Also making the contextual background quite unique to do research in. What happens after achieving good dental coverage. Does the rising dental budget actually serve as a good response when it comes to covering the low income. Questions that need to be raised when the goal of so many national services is to reach this outcome (Hayashi et al., 2020). To achieve this, we have to go include a literature review chapter in this thesis. The goals of this chapter are to present the state of knowledge on the topic of oral health care services, especially among those on limited income. All of the research presented is drawn from a variety of countries, which makes it possible to see Norway in a global context and find similarities and differences. The review of literature also highlights what is not known on the subject in order to show how the current study aims to make a contribution to the identified gap.

2.1 The literature search

First and foremost, the key words used in the search process were social class, low social class, low income, acceptability, accessibility, affordability, quality? and oral health. These key words were used in different combination to find relevant articles relating to the research question. Another key word used was Norway or Scandinavia, but it was not always used since the international arena affords more research on this topic. The Norwegian articles will be at the forefront because of the focus and context to the thesis. The search engines that were used where pubmed, academic search complete, google scholar and Oria. Both low social class and low incomes were used in order to find articles regarding the group of interest for the thesis, namely, people who may have difficulties with the affordability of dental clinics. The literature that was identified and used via this process was organized into four themes, relating to the AAAQ framework (Unicef, 2019).

2.2 AAAQ framework

The reason for the use of AAAQ was to allow the finding of the literature and for formulation of the questions in the interview. The aspects of AAAQ go into answering how the oral treatment is experience but also other aspects that are important for the patient. These aspects serve directly into answering how the experience of oral health clinic was when questioning the participants. AAAQ also allow for finding literature because there is no clear monitoring framework in place to evaluate the integration of oral health in a population (Jashni et al., 2023). At the same time as AAAQ allowed for the realization of the human right towards good health and good life experience (WHO, 2022). Because the original purpose of AAAQ is to ensure that the rights of water, sanitation, food, housing, health and education are being fulfilled or to find out the reason for why they are not. Additionally, there is the possibility of comparing the findings in this thesis with other literature. Through looking at what was found when analysing one of the aspects of AAAQ and comparing with what was found in this study. This approach is necessary because there was not found any research articles who both used the AAAQ framework and looked at the experience of oral health clinics by low incomes. Thus, AAAQ is justified by the reason that we get a good method of data gathering and evaluation of oral health services towards the low income.

2.3 Affordability of oral health care services

The first theme, affordability, was a focus of many studies, which found that the price of dental treatment had a huge impact on people accessing dental clinics. One qualitative study explored the impact of the introduction of government subsidy unto children and teenagers in Japan (Ono et al., 2023). They found that the base price of dental treatment was very low to begin with. Thus, the introduction of subsidies yielded little results in comparison to the original inspiration of the study (Brook et al., 2006; Ono et al., 2023). In which they had shown positive result among poor adults individual, but the difference was in the pricing (Brook et al., 2006). Meaning that the base price has more of an impact on the usage of dental clinics than subsidies (Ono et al., 2023). This is a common theme throughout the research found where partial cost sharing or full cost resulted in fewer visits to the clinics (Brook et al., 2006). Interesting enough in the inspiration study the poorest and sickest had the better outcomes by the end of the study (Brook et al., 2006). This indicates that for the consumer pricing is an important factor in their decision whether or not to use a dental clinic especially

for low income (Al Mugeiren & Al Sanea, 2018; Brook et al., 2006). This statement is also in line with research from Molarius., et al (2014) where the reform of dental care in Sweden did not yield any favourable result in the low income group when it came to OHRQoL (Molarius et al., 2014). This again was mentioned by the focus group of low income in the study by (Wallace & MacEntee, 2012). These people often found that economic barriers were the hardest to overcome when contemplating visiting the dentist (Wallace & MacEntee, 2012), citing that they had other priorities aside from dental health. An alternative view was put forward by the dentist another focus group participating along with low income that the priorities of such individuals was sometimes misplaced (Wallace & MacEntee, 2012). This shows us that this is a complicated issue because of different perspective and interests of the parties. It is interesting to note that the dentist also cited that government bureaucracy was also at fault (Wallace & MacEntee, 2012). "Dentistry has to run as a business first and healthcare second … it's not a benevolent healthcare service" (Wallace & MacEntee, 2012, p. 35). This study raises not only the question of affordability for people but also how they are treated by practitioners. According to the AAAQ framework, these kinds of issues relate to the concept of acceptability. Otherwise, the context of the other studies that where mentioned can be found in (Appendix D).

2.4 Acceptability of dental health care

In terms of research relating to the concept of acceptability, there were two dimensions based on the studies found. One was centred around how the patients are met at the clinics. The other one centred on acceptability by the peers and close ones. The concept of acceptability is a common theme found in many other studies on dental health care both qualitative and quantitative (Ortíz-Barrios et al., 2019). The reason for this is how one is viewed by another has a major impact OHRQoL of a person both inside the clinics and outside (Ortíz-Barrios et al., 2019). Through negative reactions, a person can feel less value in the eyes of his family, peers or other people (Holden et al., 2021). This can result in feelings of shame or humiliation, which can be manifested in the form of smiling less or being very focused on their appearance especially in a social context (Goulart et al., 2018). This shows us that the aesthetical or how one looks is important to people when it comes to oral health in the same way as function or the ability to eat (Klages et al., 2004; Spanemberg et al., 2019). Showing that there are two dimensions of acceptability this being accepting the treatment provided and being accepted in a social context. The second aspect of how people are met is quite intricate. First, is the personal experience of the dental clinics. Studies have shown that the dental

clinics often had a cold hearted attitude towards their patients (Wallace & MacEntee, 2012). This is because they were primarily a business service focusing on profit rather than a social one resulting in a focus on getting as many patients done by the end of the day as possible, rather than take their time with each one (Mohamed & Robinson, 2021). Another issue put forward to explain these experiences was that they were catering towards a specific demographic no matter which sector, this being the middle class (Wallace & MacEntee, 2012). An example of this was given that related to how dental clinics operated with their scheduling of appointments, which. placed more emphasis on a stable and predictable lifestyle that is associated with the middle class and not with low income (Wallace & MacEntee, 2012). This made it hard for individuals from low social class to enter the clinic because they often led an irregular lifestyle that made it difficult to keep appointments (Castañeda et al., 2010; Wallace & MacEntee, 2012). With variation in if they can afford a dentist in a certain period or if they need to prioritise food first leading to different acceptance of oral health (Paisi et al., 2020). The participants often accepted that oral health is important, but changing their outlook if they had different priorities (Castañeda et al., 2010). Inviting the thought of them not being completely honest about their values (Wallace & MacEntee, 2012). First impression for the patient on how the staff looked left an impression that they were well off (Nicoll et al., 2016). Creating a disbalance in trust between the patient and the dentist (Nicoll et al., 2016). This all shows that there are many aspects of how the clinics operates and looks. That impacts the perceived acceptance of the patients (Wallace & MacEntee, 2012). With such perception the patients will not feel accepted and seek further treatment (Wallace & MacEntee, 2012). Another important aspect to keep in mind when collecting the data and further context of the literature shown can be found in (Appendix D).

2.5 Accessibility of oral health services

Another important theme together with economy that came up was accessibility. This is particular important in the Norwegian context where it is mentioned a rise in seeking out more oral health than before (Grytten & Skau, 2020). When somebody mentioned accessibility the first thing that come to mind is geographical access. This is true in some regard as shown by Japanese study (Yamamoto et al., 2023). Where access of dental clinics was hugely impacted by the geographical distance from the persons home (Yamamoto et al., 2023). This is especially true for the elderly that sometimes cannot overexerts themselves when it comes to traveling (Yamamoto et al., 2023). Thus a big priority for them is having the clinic close by when evaluating to go (Yamamoto et al., 2023). Another important factor that

was mentioned was that geographical access was not the only implied factor to accessibility (Yamamoto et al., 2023). The other factor mentioned where willingness and resourcefulness to service the needs of a particular community (Hovden et al., 2020; Yamamoto et al., 2023). This was further elaborated by Wallace & MacEntee (2012) that there is tailoring between service and needs. Together with geographical accessibility there needs to be a good balance between these factor to allow for good access (Nicoll et al., 2016). From the perspective of low income communities this is not always the case (Hovden et al., 2020; Wallace & MacEntee, 2012). Where there is a clear preference towards costumers that can afford treatment to be "automatically paid" (Wallace & MacEntee, 2012, p. 36). This relation can been seen in how some clinics "they want money up front even before they look at you" (Wallace & MacEntee, 2012, p. 36). This shows a connection between accessibility and affordability, but it is not the only one. Geographically can also be attributed to an economical barrier of entry (Neutens, 2015). In the sense that it places a further burden on people who have bad economical citation at home (Neutens, 2015). Making it harder for them to travel to clinics because of cost, long distance and fear of not being accepted (Wallace & MacEntee, 2012; Yamamoto et al., 2023). This further guide us in asking not only how far it is for a person to travel to a clinic. But also, what is waiting for them in the end. Further context of the literature presented can be found in (Appendix D).

2.6 Quality of oral health care services

Quality was also mentioned in relation to the perceived perception of the treatment by the person. A factor than effected this perception was being harmed by treatment or care (Nikoloski & Mossialos, 2013). Leading to worse perception of quality and neglecting accessing the services (Nikoloski & Mossialos, 2013). Thus leading towards to worse oral health outcomes (Spanemberg et al., 2019). A particular interesting mention was the trust between the patient that came from transparency (Nikoloski & Mossialos, 2013). Transparency between the two parties effected the perception of being harmed (Nikoloski & Mossialos, 2013). Mitigating the bad perception and allowing for a better relationship between the parties (Nikoloski & Mossialos, 2013). This can especially true if the patient is afraid for the dentist. Serving as a basis for good interaction and subsequently patient returning for further treatment or check-ups (Willumsen et al., 2019, pp. 38–40). Aside from the perception of the treatment the perception of post treatment was also important (Spanemberg et al., 2019). Aside from personal interpretation QoLROH can also be viewed in a different way. In the lack of pain or issues that prohibit the normal use of the mouth or

teeth (Spanemberg et al., 2019). This interpretation leads to the idea that both quality of treatment and quality of life are interwoven. The reason of mentioning this is to better understand why we should separate these terms. When asking questions such as "how your experience of dental treatment was "we should also ask question about what happened after the treatment, what was the change, how it was returning to the previous dentist. To better understand how the interaction and treatment have impacted the individuals life (Spanemberg et al., 2019). Creating an insight in that we should be asking to separate questions rather than one. Both the statements surrounding the quality and life quality are important to take into account (Nikoloski & Mossialos, 2013). Because the patient must feel that the oral health and other institutions server personal and the interest of the community to allow for treatment of high quality (Northridge et al., 2020). But they represent different aspects of the received treatment (Spanemberg et al., 2019). In the end this gives us valuable guidance on what questions to ask and what to focus on. During the interview with the participants. Further context of the literature presented can be found at (Appendix D).

2.7 Summary of the findings

Throughout all the presented literature we do get a good understand of the topic. Concerning that many other countries experience similar issues in regard to low-income individuals and dental health. In some cases, differing slightly because of the government subsidy, priority of the national dentistry and overall number of dentists. What also comes out from the literature is that concerning the nature of this master thesis. Very few research projects have decided to use the AAAQ framework in their research. The closest article found to the master thesis is by (Wallace & MacEntee, 2012). The main difference between their article and this thesis is the number of participants and fewer personal characteristics. Reason being the limitations of this study. What makes this master thesis differ from the article by (Wallace & MacEntee, 2012), is that we focus more on the Norwegian context. Focusing on the use of subsidy and what the reasons are for not using it. This also fills the knowledge gap presented in the literature. Where there is few Norwegians article that focuses on this groups with the angle of subsidy and access. This insight has provided with valuable justification. Justification in the sense that it serves as a reasoning and groundwork for the formulation of the question used in methodology. What sort of question and the method will be revealed shortly. The most important aspect to keep in mind is that these interpretations can serve as a guideline. In an example concerning acceptability. As mentioned, it is not only how particularly how the

patients experience the treatment procedures but also what happens afterwards (Goulart et al., 2018). Thus, creating necessary outlines for what questions will be asked of the participant.

Another use for some of the literature presented will be a better comparison of the results found in this project with other similar articles. To provide a method of evaluate the process of data collection and the end result. With the end goal of answer the issue of "how do people in low social class interact with dental clinics". It is important to mentioned that all the literature found about AAAQ framework and social class are tools for finding useful literature. Literature than can be used in the discussion to better discuss the result and to show how the result fits with similar designed literature. Reason for mentioning this is that it is important to mentioned how this literature will be used in the thesis. Since the gathering and analysing of data should not be impacted by other theories. Impact meaning in the form of being the sole reason for the thesis. Where the hole focus should be on generating new theories to be used (Tjora, A., 2021). With the clear idea of the present literature found on the topic. The next logical step remains is how do we plan on answering the issue presented for the thesis.

3. The research process

3.1 A qualitative approach

Given the topic of the thesis, a qualitative approach was chosen to better suit the nature of the task at hand. Personal experience – in this case of navigating the Norwegian dental health care services when on a low income – can best come out from individuals own retelling (Tjora, A., 2021, pp. 128–130). Qualitative research at the same time allows for a deeper analysis of the data (Tjora, A., 2021, pp. 36–38). Given the literature found on this topic and presented previously. It stands to reason that the issue at large is quite nuance and deep. Requiring a more qualitative methodology to gather the necessary data to apprehend the experience of oral health clinics. The quantitative research approach does not focus on the individual experience and the deeper meaning behind the answers (Tjora, A., 2021). The goal of this method often revolves around testing an already existing theory rather than explore avenues of generating new theory (Tjora, A., 2021). This further strengthens the choice of qualitative type of study to better answer this question. Further on individual interview was also chosen to gain rich detailed data to answer the research question. that explores what the participant really thinks or feels about a topic (Tjora, A., 2021, pp. 140–143). At the same time oral health as a topic can be a sensitive subject for some people, which may limit their willingness to participate in the study (Holden et al., 2021). This was the basis for why exactly an individual interview was chosen in the end: it meant that it would be more possible to get personal experiences as each person would be more open (Hollander, 2004) to share their experience The aim was to be able to answer the question: How people in low social class experience oral clinics.

An important aspect of a qualitative approach that it is described interpretivist of data. The interpretation of data gathering will be done by one person leaving room for different interpretation by other people (Bryman, A., 2016, pp. 389–390). This is intact with the nature of qualitative study. The goal of qualitative study is to open way to creation of an new theory and allow for further researchers on this theory (Tjora, A., 2021, pp. 26–29). Since the interpretation is done by a person there is a guarantee that personal experience or beliefs will play a part in the interpretation. As Gramsci (2011, p. 131) best put it "The notion of the "intellectuals" as a distinct social category independent of class is a myth. All men are potentially intellectuals in the sense of having an intellect …, but not all are intellectuals by social function". The believe that the intellectuals are not affected by their background and

class is not true. Based solemnly on the fact that quantitative research is always impacted by the world the researcher live in (Bryman, A., 2016, p. 396). As Bryman writes it "… the researcher can act as a mirror on the social world, reflecting its image back to an audience. Instead, the researcher is always engaged in representations or construction of that world" (Bryman, A., 2016, p. 396). Where the researcher are an reflection of their class or origin (Gramsci, 2011). Promoting the ideals or goals of their respective social class (Gramsci, 2011). Since individuals from high class are those more often who go into becoming researchers (Holligan, 2015). Making their relevant problems and world view more prominent in the research sphere (Gramsci, 2011, p. 131). This is in clear connection with the data gathered from the participants in regard to their viewpoints and world view further explained in the discussion chapter.

This is relevant towards the qualitative approach because it is an important aspect to keep in mind when we are gathering data or analysing it. That we are always impacted by what we think or believe (Holligan, 2015). In large part we cannot escape this from effecting our work because of the social aspects involved resulting in subjective interpretation of the results gathered (Bryman, A., 2016). of the At the same time the nature of qualitative research is always based on the idea of creating groundwork for new theories (Tjora, A., 2021, pp. 26–29). The questions of generalisability in the face of recreating the circumstances when creating theory renders impossible to be done (Bryman, A., 2016, p. 388). Because the context of the data gathering will always differ slightly and interpretation will often be different of the findings (Bryman, A., 2016, pp. 389–390). Qualitative study aims rather than focus on generalizability to focus on validity (Bryman, A., 2016, pp. 389–390). In other words, the focus is more strongly how the data is presented. Where the validity comes from internal workings of how the data was gatherer and raises proportionally to the relation between observation and the theoretical ideas (Bryman, A., 2016, p. 390). This places strong emphasis on how the data was collected to begin with. Where longer periods of participation in a person life gives a more stronger connection between concepts and observations (Bryman, A., 2016, p. 390). Because of resource constrains there is a set limit to how deep this project can go into the personal life of a participant. Since there is not much focus on low income individuals in relation to oral health clinics there is a clear gap in this fuelling the goal of breaking ground on a topic (Tjora, A., 2021, pp. 26–29). Allowing for further research done on this topic as mentioned especially in a Norwegian context. Fulfilling the goal of

enlighten a research gap and showing forth the interest and values of an underrepresented group.

3.2 The use of Semi Structured interview

When it comes to questions that were formulated for the interview. They were done in a semi structured interview style. Allowing for some guidance for the discussion but retaining the openness to allow for the participant to discuss openly their experience. Thus, the questions were formulated in open ended design with a focus on the AAAQ framework. Where the participant was allowed to answer the question however they wanted. Creating a discussion rather than a questionnaire with yes or no answers. The questions formulated to best gathered the data from the participants were as follows. We begin the interview by asking background questions (Appendix A). The participants age, education and occupation or previous occupation. This is to gain the contextual information that can describe what kind of participant where in the study. Since education and occupation has shown in the literature to effect accessing the dental clinics (Grytten & Skau, 2020; Jiang et al., 2022). Giving further explanation for why exactly this answer was given by the participant.

The first line of questions where about the dental clinic. More accurately going into the personal experience of dental clinics. How was the dentist and how was the quality of treatment are some examples of the question. Another type of questions was also asked about how important teeth for the participant are. To gain the understanding of what was important for the participant the aesthetics or the functional side. The last questions of this group were if they at any time had no opportunity in accessing the dental clinics. This led naturally into questioning about the economical group. In this group the questions centred around the economical side of oral health. As the literature has shown as that this topic is quite important for people (Wallace & MacEntee, 2012). Requiring a separate section by itself to best manoeuvre the discussion. Some examples of the questioned asked where "have you avoided the dentist because you did not have enough money" or "have you ever gotten full or partial coverage of the treatment (Appendix A). If yes how was the experience". This last question is of a quite the importance for understanding the experience. Since coverage as mentioned for the adults is only done in some cases. Making this an interesting context factor for how the answer will be. Will the lack of coverage lead to worse experience and vice versa. The last group was about knowledge (Appendix A). Asking questions about the participant knowledge of dental health, treatment coverage and if has been any information given on these topics, if

yes how. Reason for why was to uncover the current knowledge level of dental sector. To understand if the participant has the knowledge in who is eligible for dental treatment coverage. Uncovering if this also is a barrier of entry since there is much more emphasis on dental coverage because of high prices (Ono et al., 2023). Those are all the questions that were created to gather the data for the thesis. After the collection of the data the next step of methodology will be analysis of the gathered data.

3.3 Qualitative thematic analysis

Another aspect concerning analysis is the how we are going about doing it. Since the literature provided us with the understanding that this topic is quite complex. Thus, requiring a method that covers multiple different experiences and themes. Looking at what other similar projects used as their method (Castañeda et al., 2010; Wallace & MacEntee, 2012). We find that what comes up often is thematic analysis. Upon further dive into this method is that it can be quite useful. Since it works well with the theme of this thesis. Because as shown in the pilot study the answer to the question can have numerous variations. Requiring a method that allows for a broader analysis that is able to collect all the information under one umbrella. This is important because having such a wide array of answers will lead to difficulties in deciphering the deeper meaning. Lacking also a view of the big picture across all of the interviews. With these issues it becomes hard to give an organised and good understanding of experiences provided. Thematic analysis fills this gap by allowing good flexibility when it comes analysing the data. This flexibility comes from the theoretical aspect (Braun & Clarke, 2022, pp. 100–104). The generation of theory is based upon the themes generated by the codes found in the interviews (Braun & Clarke, 2022). With this allowing for the use of other theoretical framework to explain the end result (Braun & Clarke, 2022). An example of such a framework would be the AAAQ framework in evaluating a health service (Unicef, 2019). Allowing for a better discussion of the result because of the theoretical prism. Without such a tool it will be hard to explain the data in the wider context of inequality and accessibility. Since this is only one individual experience and thus not go into an upstream approach perspective. Answering the question of why this happened to the particular participant. Thus, completing the goal of this thesis in provided an exploration of personal experience surrounding dental clinics.

As mentioned, a big issue with the use of thematic analysis as with qualitative research is generalisability (Bryman, A., 2016). Because the gathering of data, coding process and

creation of themes is done by one person. This allows personal views and background of the research to effect the end result (Gramsci, 2011). As mentioned above the solution for this issue is validity. How was the data gathered an analyse in the end (Braun & Clarke, 2022). Creation a detailed narrative of how the practical process was done. This being the next chapter of methodology. Where we go into detail what was done to collect the data. Allowing for scrutiny and replication if needed. Before conducting the actual interviews, it is important to test out the design of the interview. This is the reason for conducting a pilot study before collecting data (Tjora, A., 2021). Thus, this is the next chapter of methodology.

3.4 The pilot study

It was important to test out the design of the study based. Thus, a pilot study was conducted to better improve the design and gain experience in conducting interviews. The first draft of the questions was created together with preparing all the equipment, which equipment consisted of dictafon app, nettskjema, an interview guide and an information letter. Seven individuals were recruited to participate in the pilot. They consisted of students at høgskolen innlandet, colleagues from dental clinics and friends. These people were recruited instead of the target demographic was because of difficulties recruiting such participants from the local environment. based on this knowledge, the recruitment area was extended to Lillehammer and Oslo for the main study. All had previous experience with dental clinics. The consent process was rehearsed with all agreeing to participate on the condition that this was a test study, and participants would have full anonymity. The pilot interviews also indicated that participants varied in the extent to which they talked about their experiences, with some having a lot to say while others were more reserved. One interesting not to take is that among the questions one aspect war particularly of importance towards the pilot participant. They talked in length about it and steered most of the interview towards this direction. An important experience to take into the data gathering where it will be important to be able to control the flow of the interview to cover as many aspects of the experience as possible. The pilot study also allowed the researcher to practice interviewing and learn how to generate longer, relevant and detailed responses. This key improvement resulted in much more longer and detailed answers given.

3.5 Practical Description of the process

A purpose sample was recruited to the study, which specifically targeted those who were on a low income. The characteristics required to participate in the study were low income, if the

person had previously had any experience with dental services and if they had any bad or positive experience or wanted to share their opinion of how they were treated. The recruitment of participants was done through voluntary or non-profit groups and institutions such as Havang Brukerstyrt – Senter, Tjenesteområde psykisk helse og rus Lillehammer and Frelserens Armeen (Oslo and Lillehammer). The reasoning for this choice was that these organisations often interact with or are run by people who have experience with low income. The recruitment entailed a visit to the organization and the explanation of the project, what it entailed and what was expected from the participant when participating and what the data would be used for. In almost all organisation there was no cooperation with the workers or voluntaries because they all were too busy to be helping with this project. What they allowed was to performer the scouting and recruitment by me and this was done through initiating discussion with the visitors. The participant was then asked to give their written informed consent on the information provided and would then provide a suggestion for when the interview could take place if not taking place right after agreeing to participate (Appendix C). The participant was informed of their rights when it comes to the ownerships of the data and how to contact the researcher if they had any request or questions (Appendix C). Another question was if the interviewer should be taken in Norwegian, English or Russian as there were many possible recruits who spoke these languages and where more comfortable having the interview in that language.

3.6 Semi-structured interviews

Data gathering consisted of an individual semi-structured interview, over a timeframe of 30 minutes to 1 hour interview with the participants. In the process of data gathering the actual time used on the interweaves was 28 minutes being the shortest and the longest one being 52 minutes. As mentioned, this was an individual interview consisting of the participant and the researcher who met in a private space. The basis for the questions formulation was also informed by the AAAQ framework and the research reviewed earlier. Based on the literature found the question were formulated to target the similar issue presented in some of the articles, which included clinics in the form of availability. access, acceptance, affordability and quality.

3.7 Data processing and analysis

After the gathering of data, the final step remains which is data processing. When it comes to the practical side of data process a couple of tools where used. The first of these tools was

amberscript. This allows for a quick transcription of the interview into plain text files. With the use of machine transcription allowed for an automated process in transcribing. That save a considerable amount of time and effort. To ensure that the transcription was accurate it was personally inspected. By listening to the original recording and checking for any misspellings or inaccuracy. Afterwards F4a program was used to code the interview text files. The result of this will be shown in the results chapter. Afterwards was the start of thematic analysis of the result that were gathered from the data in the form of codes. The goal of both amberscipt and F4a tools was to improve the workload and reduce the time spent in this process. To allocate the time towards the analysis and writing of this master thesis.

3.8 Information about the participants

Table 1

This table shows the information about the participant of the study gathered through background questions.

Participants	Age	Education	Current or previous work experience	Dental Coverage
Wesley	50	Grunnskole	Variation	No Coverage
Allen	60	Cand Mag Chemical Manufactory	No work	Coverage
Franz	28	Baking	Baker	No Coverage
Elena	54	Sports and science bachelor	No work	No Coverage
Carmilla	30	No education	No work	No Coverage
Josh	73	Teacher	Pension	Coverage
Sam	45	Cooking and serving	No work	Coverage
Magnus	50	Cook assistant	No work	No Coverage
Johann	32	No education	No work	Coverage
Luke	30	Industrial food production degree	No work	Coverage
James	52	Carpenter Education	Construction	No Coverage
11 Total	Average 46	4 high education, 4 specializations, 1 school, 2 no education	2 working, 1 pension, 8 no work	Coverage 5, No Coverage 6

Background information about participant variation that comes up is the age of the participants. As mentioned previously that the age varied between 30 to 73. Reasoning for this being that the target group is quite diverse in both age, ethnicity and background. Since there is no specific age group that does seek help from these organizations. One factor that binds them all together is their work occupation. Where most of all participants did not have any stable job position or any work at all. Reasoning for this is numerous varying from health problems, previous substance abuse, poor language capabilities and many more. This was the contributing reason for everyone being at the organisations. To receive advice, help or food to help them in their life situation. The few exceptions were the individuals who had some work

and were qualified for the support. Thus, being there to receive some benefits in the form of free food and social gathering. Example of this being a participant who was a pensioner and was in the centre because of social reason to visit some friends. The third interesting background was the educational one. Surprisingly only one person had no previous education and one who had only the basic school level. The most dominant one was without a doubt specialisation education. Where the education sorted around a specific manual occupation such as baker, carpenter and cook. The second predominant group was those with a bachelor level of education. From fields such a sports sciences, teacher and chemical manufactory. There was nothing higher than bachelor level among the participants.

The last important factor to mentioned was if the participants did get coverage for their dental treatment. Five people did cite to have received at their last visit to the dentist a partial or full coverage of their treatment. Reasoning for getting this coverage varied. From being a pensioner, being registered substance abuser or being hospitalized for over three months. Subsequently this resulted in a very positive outlook for the dental clinics. Where the participant cited to have no big complaints towards their practitioner. Citing because of the positive experience they had at the clinic. While the other group that did not receive coverage had the opposite perspective. Contributed largely by the fact of not being able to afford treatment at their dentist clinic. Where they were stuck in bureaucracy in trying to get the coverage for the treatment or in conflict with the dentist on the appointed treatment. Where the appointed treatment was too expensive to be covered by the participant. An interesting concept that will be further discussed in the next chapter. Otherwise, the background information of the participants show that they were the intended demographic for the study. This can be seen in their current occupation an education level. The average age does also fit with the target group being mostly adults with a possibility of elderly that are not institutionalised. Thus, the demographic goal was achieved when it comes to the participants. The next goal of the study will be the data gathered.

3.3 Ethics

The goal of any research paper is to seek the truth and this is no different to this paper (National Research Ethics Committees, 2022). In the search of truth, it is vital that the gathering of data is done in cohesion with ethical standards. This is part of the validity of the research paper as mentioned before, but also part in factuality, accuracy, transparency and

accountability (National Research Ethics Committees, 2022). To achieve this it is necessary to follow the methodological norms, institutional norms and the truth norm (National Research Ethics Committees, 2022). We have covered before the truth norm with why we are doing this research and methodological norm was fulfilled in the previous chapter. What remains is the institutional norm that need to be covered. This was done in accordance with the guidelines presented by the national research ethics committee in Norway. One of the requirements that need to be fulfilled is to have an ethics based research is approval from an ethics committee (National Research Ethics Committees, 2022). In accordance with these a request was sent to SIKT (Appendix B). A committee that evaluates if research is in accordance with rules for personal data gathering. To get an evaluating if the planned process of data gathering is qualified and does not need additional clearance from REK. Because the participants are not recruited as patients in dental clinics, the only data gathered is personal experience and nothing more and the human dignity and autonomy is preserved (Appendix C). It was decided that it is enough to get clearance from only SIKT as the data gathered does not fall under red data or sensitive data. Going back to the personal dignity and autonomy of the participants. This was upheld by the use of information letter and participants voluntary agreement (Appendix C). Meaning that when a person was recruited an information sheet was presented to them. Going through the reason for the study, what was expected of them and how the data would be used (Appendix C). After reading and agreeing to participate in the study. A signature was signed to confirm the contract between the participant and the student. Where the participant had all the rights to the data and could at any time choose to leave the study. Including the deletion of the data gathered as well as any mention of them (Appendix C). At the same time there was a clear clause in that any information about the participant would be anonymise and they would not be recognised to have participated in this study. By sending this and a project outlining to the SIKT where we able to get their approval (Appendix B). Additionally, before submitting to SIKT approval from the institution INN was also necessary. Including the submission of project outline to get the approval for the project.

By getting the clearance from SIKT and INN the only remaining important factor is responsibility. Responsibility in how the researcher interact with their participants. This does include the upholding of personal human dignity and autonomy. But also showing respect and understanding towards the participants. Where the participant was never force into participating or were enticed by financially or materially. The common motivating factor to participate were personal stories or to talk about the current state of oral health system. The

interviews took place in meetings room of the organizations. That allowed for privacy and neutral environments for the participant. Participants of the study were fully aware of the goal of this study and did give a written agreement. With how the data was gathered and the clearance from SIKT and INN. The study was done in an ethical and respectful manner.

4 Findings

4.1 Thematic Analysis

Table 2

This table shows all the codes generate based upon interview transcriptions and where later used in thematic analysis.

Codes	Sub-codes >					
Patient Responsibility						
Lack of Knowledge						
Accessibility	Time	Long Distance				
Quality	Do be Heard and understood	Trust in the practitioner	Personal Relation	Lack of Trust	Bad Treatment experienc e	Rep utat ion
Immigrant and Limited possibilities						
Fear of Dentist						
Justice						
Beauty						
Function over Beauty						
Bureaucracy	Bureaucracy via Proxy	Bureaucracy within health sector				
How one is accepted	Good communicatio n	Improvement	Education			
Experience of Life	Bad Oral health	Treatment associated with cleanliness				
Different prioritise						
More Coverage	Good result because of coverage					
The government	Being heard on the topic of oral health	Other priorities by the Government	Indifference between health sector	Financin g of oral health		

Economy Centred	To Expensive	Economical Barriers	Travel Abroad			
Economic issues						

From the transcripts of the interviews conducted multiple codes where generated that where then categorised into categories to be use in the thematic analysis. In development of a theme related to an individual's economic situation categories were developed to bring out the specific theme. For example, the analysis was able to grin out dimensions such as it being too expensive to receive treatment locally and possible evaluation of traveling abroad. Another dimension relating to economic barriers was related to them stopping the person from going to the oral health clinics. In this way, through the coding and categorisation process relating to economy the different dimensions of the theme could be brought out and thus present a more nuance analysis. All the codes together form a common thread of for example accessibility that explains the codes and allows for a creation of a common theme. With these themes we get the understand what the experience of oral health is among the participants of this study.

Based upon the codes generate and the thematic analysis what was created as a result where 4 themes the good experience, availability towards patient's needs, outside the clinic barriers of entry, wishing for better quality oral health. These four themes illuminate the overarching research question of how people in low income interact with the oral health clinics and are formed with the help of AAAQ framework. To help understand the creation of themes illustrative quotations from participants where use to understand the context of how the theme was created, which have been anonymised using pseudonyms.

4.2 Theme good Experience

Table 3

This table shows the generations of the theme good experience.

Quotations	Codes	Sub Themes	Themes
"It is possible, because I have not gotten into a discussion with the Norwegian dentist. The Russian one tried to explain everything, show the different options of treatment. Which options are cheaper, which ones are more expensive and which one is the better one. They try to explain this" (Elena)	Trust in the Practitioner	Good experiences	The good experience
"How long is this, half a minute, a second. Ok open and close. Ok it took half an hour. It is too much for a half an hour to take 1000 kr. I understand the rent, electricity but where do these number come from" (James)	Lack of Trust	Good coverage	
"As I understood from my dentist is that I have porous gum and because of this I have a higher risk of caries. This is what I have seen where I develop caries in the same places again and again." (Sam)	Good result because of coverage		
"They even called out for my dentist and asked if she could just come in and say hi. She did come and say hi to me. There were problems about the tooth, and she came back and held my hand, and everything went well" (Sam).	Personal Relation		
"It is difficult to travel abroad to go to a dentist. You have to sleep at a hotel and have the pain in multiple days. Yes, I do not know if it is worth it" (Josh)	Travel Abroad		
"Communicating with patient. You used to just say yes with everything the dentist said, this is not any longer. People have gotten better education and can ask critical questions. Everybody can make mistakes, both doctors and dentist. We are all human after all " (Allen)	To Be heard		
"When I finally came and complained, that the crown was wobbling. The answer was that it is not the crown wobbling, that it is my tooth that is moving below the crown. And that was it. It was the end. I was of course surprised of the quality of work and general work" (Josh)	Quality		
"They had some steep prices there, but they did everything so well. I have never heard of any bad treatment or complains. Because they have good reputation, and everybody recommends them" (Franz)	Reputation		
"I have to do a good job when flossing and toothpicks. So that I reduce the quantity of tooth stone, and the dentist will use less time and equipment on me" (Sam)	Patient Responsibility		
"I think it is because of how they are taught in become humbler. If you're going to be working with people, then you have to be humble. If not, then you should not be working with people. There have been great improvements in this" (Allen)	How one is accepted		

Among the many critique and negative experiences around the oral health clinics and oral health coverage an opposite experience came up. That being of positive nature towards both the dentist, clinics and the coverage that they have received. Granted these participants are part of the group that did get coverage on their treatment influencing their response on this topic. It does provide with a contrast towards the other experiences and show a different side of coverage towards oral health. Thus, the themes that was created in the end was the good experience. This was of course based on the sub themes of the good experience and good coverage. Through looking at the good experience that the participants experience of the clinics we can better understand why this experience was positive and how was it achieved. With the goal of contrasting the negative experience and giving a full picture of their experiences.

A key aspect of providing an acceptable dental health care service for the participants is related to trust between the patient and the dentist. This was perceived as the key to creating a good dental health care experience. This experience happens because the patients gain the trust in that the dentist is on their side. "*I have not gotten into a discussion with the Norwegian dentist. The Russian one tried to explain everything, show the different options of treatment, which options are cheaper, which ones are more expensive and which one is the better one."* (Elena). On the other hand, the reverse was also the case in that a lack of trust resulted in the uneasiness and a suspicion of the dentist because the intentions were unknown, especially when sums of money are involved in an interaction. In the most extreme of cases, a person could refuse to visit the dentist because they do not trust them at all, as one person explained: "*How long is this, half a minute, a second. Ok open and close. Ok it took half an hour…. I understand the rent, electricity but where do these numbers come from*" (James). Having to pay for treatment created a context in which distrust towards one of the parties involved in oral health can emerge. Trust was important in these situations and creates an understanding of the patient's perspective in terms of the need to explain everything and be open towards a discussion with them. The analysis gives further understanding to how trust can be gained and squandered.

An aspect of trust that was important to participants was the existence of a personal relationship between the dentist and the patient. This personal relationship often consisted of feeling they were viewed as a human being by being listened to This was specifically visible when the relationship went beyond the treatment room: "*They even called out for my dentist and asked if she could just come in and say hi. She did come and say hi to me. There were*

problems about the tooth, and she came back and held my hand, and everything went well" (Sam). This illustrates that when the dentist showed empathy towards patients it was noticed and perceived as important. This also creates trust but also serves to reaffirm the personal relationship with the patient. When the dentist did not only say but also showed that they cared, this was part of building such a relationship. Being heard was important in this regard of feeling accepted. The common early experience of dentist by the participants was that of talking to a figure of authority rather than an ordinary person. This authority comes from the position the dentist finds themselves in but also from the manner in which they talked with the patients. One participant observed: "*Communicating with patients. You used to just say yes with everything the dentist said, not any longer. People have gotten better education and can ask critical questions. Everybody can make mistakes; we are all human after all* " (Allen). The dentist was viewed as having a position of authority because of all the knowledge on the subject of oral health. This divide could lead to not listening to what the patient said However, from Sam the presence of being heard leads to a positive outcome in terms of making the dental care service acceptable from the point of view of the patient. These personal experiences illustrate the human dimension of what patients find acceptable to the whole treatment process.

Acceptability is an important dimension of quality, especially as it relates to the individual satisfaction with the performed oral health treatment. In most cases the job done by the dentist was to the satisfaction of the participants with some exceptions. Often this was because the treatment was perceived to have been done in a sloppy or badly planned way. For example: "*When I finally complained that the crown was wobbling. The answer was that it is not the crown wobbling, that it is my tooth that is moving below the crown. I was of course surprised by the quality of work*" (Josh). This was one of such examples given by participants, but in most cases the treatment receive was good. The subjective positive experiences in most cases consisted of the treatment being successful and necessary for the patient. Another important aspect during the treatment is how one is accepted by the staff and the dentist. In this regard the focus was on how the people are met by the clinics. In this regard there was some perception that this had improved in recent years, for example: *"I think it is because of how they are taught in becoming humbler. If you are going to be working with people, then you have to be humble. If not, then you should not be working with people...."* (Allen). Being humble impacts on how one is accepted by the clinics, thus contributing towards the overall description of the theme of good experiences.

Good coverage consists of understanding how the system works for such individuals. The reputation of the clinics or specific dentist was recognised by participants. As far as immigrant were concerned an aspect of this specifically related to language abilities beyond English or Norwegian, which gave an increased wish in visiting them specifically. Word of mouth seemed to influence which clinic the individual wanted to go to Additionally, the prices also influenced choices as participants sought out such information within the oral health clinic but were also interested in the quality of the work and experiences. One commented: "*They had some steep prices there, but they did everything so well. I have never heard of any bad treatment or complains. Because they have good reputation, and everybody recommends them*" (Franz). In some cases, even with the prices the reputation more than makes up for that barrier.

Participants often voiced the perception that they were themselves responsible for their oral health. They partially blamed themselves or their circumstances for their poor oral health rather than the dentist. The dentist in their eyes was the one who could find a way of improving their current problems, but not by solving it completely. For example, "*I have to do a good job when flossing and toothpicks. So that I reduce the quantity of tooth plaque and the dentist will use less time and equipment on me*" (Sam). So, the dentist in this instance acts not as trying to cure something but to help the patient in mastering taking care of their own oral health. This underlines that complete coverage at its core those allow for the easiness of the economic burden on the person. What this illustrates is that dentists can support patients in terms of providing for the opportunity to change habits and approach towards oral health as part of their preventive work.

Good coverage for people on low income is the cornerstone of availability, accessibility and acceptability because the basis for good dental care experiences lies in people not having to think about cost. It was also thanks to the coverage that the treatment was able to go under the participant's budget. "*I do get free treatment, so I just call the dentist if there is pain…It was a very nice coverage. My teeth where very bad and I was saved from paying a couple thousand kroner*" (Allen). This gives us insight into what happens when the system and coverage do work for such individuals. Traveling abroad entails seeking oral health treatment outside of Norway because of its low cost and availability Among the sample, this was shown not to be possible since it was quite difficult to travel to remote destinations for people on a low income. "*It is difficult to travel abroad to go to a dentist. You have to sleep at a hotel and have the pain in multiple days. Yes, I do not know if it is worth it*" (Josh). Coverage for all of

its issues does allow for an easier use of clinics when you have low income. Giving more credence toward the coverage system for allow for easier access of oral health clinics and resulting in positive outcomes for the oral health of the participants.

Together the theme of good experience shows what happens when there is not barrier in place before the participants. The experience is that of an oral health clinic that are available towards the participant and that the treatment offered is of acceptable quality. In regard to the opposite experience the participant is not able to even discuss much about the availability or the quality of an oral health clinic because of the issue of accessibility. What we do see that the aspect of both quality and availability are of acceptable standard when the individual is able to access a clinic. The main issue lies within accessibility that creates inequality within the low-income group. Those participants who do visit clinics more regularly have shown a better understanding of how the coverage works for their case and how oral health clinics are operated. In contrast towards low income who showed less understanding and found it harder to accesses the oral health clinics. The findings show that the issue lies not withing exactly availability or the quality for the participant, but that they are not able to visit the clinics at all. The next theme will highlight in detail why this is the case.

4.3 Theme availability towards the patients' needs.

Table 4

This table shows the generation of the theme availability towards the patients needs

Quotations	Codes	Sub Themes	Themes
"For me it took about three days before I felt it. I had to pay the dentist for it to work. They did not do a good job." (Horus)	Bad Treatment Experience	Physical access	The availability towards the patients' needs
"I cannot confidently say, because my Norwegian is very bad and maybe if I was a Norwegian. Maybe the dentist would have tried to explain to me or offer other variants of treatment. Because of the language barrier this did not happen." (Elena)	Immigrants	Social access	
"When I was in middle school, it was then when she did not ask. She was good it explaining in relation to what she was going to do. She just did not ask if I wanted anaesthesia, so she drilled without it, and it was very painful. The communication was very lacking" (Sam)	To be heard and understood		
"It was for the last time and I'm only paying private clinic because I was in so much pain. I cannot sit here and wait for NAV. Jeg just want to pay and get it done" (Magnus)	Time		
"If I live in this town then it does not matter. Bu when it is 30 min, 1 hour or 20 min it does not play any role. When it is in another town that is too far. Better in my town. Find a dentist there is the best option" (Franz)	Long Distance		
"Yes, they will send you to a communal dentist. You have to go there as you are told, you cannot go to a private clinic, always public." (Carmilla)	Choice		
"The last time I was at the dentist they used a specific wording. We shall not traumatise you. It was not normal before, right? Kids where traumatised and it sits in your body. Then there are few treatments at the	Fear of Dentist		

dentist. Because it still sits there" (Allen)		

There were two dimensions to this theme: physical access and social access based upon the fact that there a multiple definition of accessibility withing AAAQ including these two (Unicef, 2019). The reason for why exactly these two definitions of accessibility was chose where knowledge, bureaucracy and affordability. These are other definition of accessibility, but their origins stem from affordability among other factors and poses more full accessibility focus. This theme presents more of a focus on the availability of oral health services to accommodate the need of physical access and the needs of the patients or the social access. Defining the physical access is the understanding if the participants found physical hurdles such a distance and time when trying to access the oral health clinics. Where the distance played a big role when deciding on which clinic the participant wanted to go to. The closer the clinic was towards the participant home or neighbourhood the more was the feeling of availability if the need arouse for treatment. This geographical dimension of availability was expressed in terms of urban areas being favourably covered "*I took the bus to come here, from where I live the bus does not go after five in the evening. It is hard to get around when you do not have a car*" (Wesley). Rather, there was a strong understanding that they had to travel a long distance to receive the treatment they needed, often because the offer was not available for the person. This was perceived to because there was an unfair distribution of resources when it comes to local towns. Thus, there was a general feeling that this created unfairness when it comes to accessing oral health clinics. This was seen as particularly unfair because some groups were in a far better position to use the clinics because of their resources.

Time was also a factor in the time it took to get the treatment and the time used to travel towards the clinic. The concern was that the time spent could be used on other important task and that the participant had other responsibilities, thus having little time to spare for a visit. Both these factors impacted on the decision of going to a clinic or not. *"It was for the last time and I'm only paying private for a clinic because I was in so much pain. I cannot sit here and wait for NAV. I just want to pay and get it done*" (Magnus). Regarding for the code of distance the participant Franz said "*When it is 30 min, 1 hour or 20 min it does not play any role. When it is in another town that is too far. Better in my town. Find a dentist there is the best option*" (Franz). All of these codes show us that there is a subtheme of physical access,

but the other codes show us also the issue of social access. In the form of social interaction with the dentist. In particular, they often expressed fear towards the dentist *"The last time I was at the dentist they said we shall not traumatise you. It was not normal before, right? Kids where traumatised …Then there are fewer treatments at the dentist. Because it still sits there"* (Allen). This shows that the persistence of fear can influence a person's decision to seek treatment, especially if they have had earlier negative experiences. Creating a certain need for how the treatment must be to better accommodate their needs to be able to overcome this hurdle. Limited knowledge of Norwegian also affected how immigrants were able to interact with dentists so that communicating with the dentist was difficult because the need of being understood was not meet. When the groundwork for good communication was not in place it made it more difficult to receive good treatment. Without this groundwork between the patient and dentist a patient might seek treatment elsewhere, even if that involved some cost to be able to achieve the desired treatment they want. This could lead to traveling abroad in the case of some of the participants, where the person can get a much cheaper treatment as well as receive the treatment in their own language fulfilling their need. This illustrates that the communication barrier can be more important than the financial one, for some: "*…Because my Norwegian is very bad and maybe if I was a Norwegian. Maybe the dentist would have tried to explain to me or offer other variants of treatment. Because of the language barrier this did not happen.*" (Elena). In this case the bad treatment received was perceived as mostly because of the lack of communication concerning the crown and its placement which resulting in the crown being removed because of bad placement. The end result of this experience for the participant was that they no longer wanted to seek treatment at a Norwegian dentist because they cannot fulfil the participants need.

Choice also refers to the lack of choice regarding clinics such that the person felt "forced" to go to a specific clinic because that is where they could get partial coverage by NAV. They wished for a clinic of their choice that they were familiar with and felt comfortable with. It was apparent that the participants wanted a specific clinic instead of what they got, as one participant said: "*Yes, they will send you to a communal dentist. You have to go there as you are told, you cannot go to a private clinic, always public*" (Carmilla). Interestingly enough this was largely because the participants preferred private clinics, reasoning that it was more time flexible allowing the participant to visit at a later time of the day, and that the participant already was familiar with some of the dentists at the clinic. Both factors being a particular need the participant wanted and expected of the clinics that they again felt unfulfilled. The

situation some of the participants find themselves inn forces them to take the partial coverage even if the optimal choice would be private clinics. This has also a strong connection with the code of being heard an understood together with dental fear. "*She was good at explaining in relation to what she was going to do. She just did not ask if I wanted anaesthesia, so she drilled without it, and it was very painfully. The communication was very lacking"* (Sam). Feeling understood or viewed as a person goes a long way to creating good groundwork for dentist patient communications and accepting the treatment. This can also work in the opposite direction of worsening the situation as mentioned.

4.4 Theme outside the oral health clinics barriers of entry

Table 5

This table show the generation of the theme outside the oral health clinics barriers of entry

Quotations	Codes	Sub Themes	Themes
"They did do additional treatment. I did pay them and everything. But they wanted to do even more. But these were huge sums of money. I did not do it because it was a lot of money to spend on a dentist" (Franz)	To Expensive	Financial Struggle	Outside the oral health clinics barriers of entry
"I have no issues with my teeth, I think. But if I did experience any pain, I would brush my teeth more often. I would also use a dental floss, to clean the teeth completely" (Franz)	Economical Barriers	Structural Bureaucracy Barriers	
"If I continue to work with tooth pain. Absolutely, you have to have pain. When you think about it is alright. It does hurt of course, but you have to do what you have to do to live" (Allen)	Experience of Life	Individual Priorities	
"I have periodontitis. In Russia I would on average 5 or 6 years do a patchwork operation. It is quite deep cleaning of the teeth. Down to the roots of the teeth. In Norway they do not this operation at all." (Elena)	More Coverage		
"I have seen many immigrants from different countries come to Norway. They receive very good treatment. I have nothing against that, I think that is good. But we must not forget our own. Sadly, it is less empathy I think." (Wesley)	Other Priorities by the Government		
"Poor people you have first taken a look and think about it. How to buy food, how to pay for a home and then if there is anything left. Then you can use the money on the dentist" (Franz)	Different Priorities		
"I have applied multiple time to get it covered, but I have been rejected. I have also issued and complain but have again been rejected. At that point I just can't get myself to do this anymore." (Wesley)	Bureaucracy		

"It is fascism. When you come into Nav and have to fill out the same form 3 times. Do they take me for an idiot. Every day the same paper you have to fill out. Because they have nothing to do. That is why" (James)	Bureaucracy via Proxy	
"Every day or every week one must think. How do you survive the next week or the next month. I always look into the future. Where I will be and how much money I have, what are my options, what about my money and how do continue to live." (Elena)	Economic Issues	
"Yes, I'm tired of it, but it should not go over normal people. I think specifically economy because the state and government use a lot of money on art, repairs like the king palace. This in the end effects normal man or woman in the streets" (Wesley)	Financing of health	
"I have studied politics. So, I know my rights. So, I'm disability benefits and I have gotten my rights fulfilled. Without this knowledge I would not have been able to do so" (Allen)	Lack of Knowledge	

AAAQ has the definition that affordability is part of accessibility together with knowledge and bureaucracy. Interestingly enough affordability was the primarily issue or concern among the participant relating to oral health treatment. It was mentioned that many of the issue with bureaucracy or knowledge stem from the fact of economical issues. The primarily issue being the bureaucracy that is another form of barrier relating to accessibility. It does not mean that the issue lies within the structure of the clinics but more so when the participants have to contact proxy institution or services to get coverage for the treatment such as NAV. This aspect often came up in the interviews with the participants and mostly in a negative light Specifically, they referred to the failure of the state, and in particular the rules and practices implemented by NAV, to provide the individual with the necessary funds to afford treatment, given their circumstances of living on a low income. This results in the dependency on this proxy to get coverage because there are no other means of getting necessary funds or complete coverage as an adult. This was an experienced of frustration and unnecessary bureaucracy. As one participant said:*"…When you come into Nav and have to fill out the same form 3 times. Do they take me for an idiot. Every day the same paper you have to fill out. Because they have nothing to do…."* (James). A consequence of such an experience was that people could not proceed until the bureaucratic process was complete.

An important difference to mentioned was between similar experience of bureaucracy and bureaucracy through proxy. Most of the discussion surrounding bureaucracy was in the context of NAV or other institutions or proxy services before getting the treatment. Among some of the discussion was bureaucracy within the oral health clinics in a much lesser amount then NAV. *"I have applied multiple time to get it covered, but I have been rejected. I*

have also issued a complaint but have again been rejected. At that point I just can't get myself to do this anymore" (Wesley). These two dimensions of bureaucracy show that there are multiple instances of bureaucracy in both the clinics and in the proxy services. These two layers of bureaucracy mean that even if the first barrier of bureaucracy is overcome it does not mean that the second one will be. This could mean that a person on a low income could encounter roadblock after roadblock in the form of bureaucracy and price. This resulted in tedious experiences and headaches for the people trying to access dental clinics to obtain treatment.

Participants talked about what a person could afford when it comes to oral health and how this influenced their use of dental health care. Two aspects of the cost of dental health care when living on a low income were identified. One issue related to how use of the dentist could lead to needing further treatment, so that a course of treatment became prolonged and thus more expensive for the individual, which they could not afford. One participant expressed it thus: "*I did pay them and everything. But they wanted to do even more. But these were huge sums of money. I did not do it because it was a lot of money to spend on a dentist*" (Franz). The second way in which living on a low income shaped their access to dental health care was in terms of prevention in that individuals did not have the economy to afford a simple check-up. One participant described it in terms of affecting all their decisions: "*Every day or every week one must think. How do you survive the next week or the next month. Where I will be and how much money do I have, what are my options and how do I continue to live."* (Elena). Living on a low income did not allow for decisions of any kind that would result is becoming homeless or not eating. In these circumstances people become reliant on other services, such as NAV for coverage if they are to be able to afford oral health care and treatment. For participants, those living on a low income should be able to access free dental health care: "*Yes, all people should like me who has poor economy, should get a free dentist. The system in place right now is unjust. I'm just among those lucky to have gotten free dental care because I'm in drug service user* (Allen). They were aware that many other people they knew or talked to did not have such luck themselves. That there is a greater need for extension of the coverage to allow for more fair and better access to clinics.

While living on low income directly affected the participants use of oral health services. In the form of fear of needing oral health treatment that they could not afford meant that participants wanted to avoid visiting the clinic. One participant explained this in the following way *"I have no issues with my teeth, I think. But if I did experience any pain, I*

would brush my teeth more often. I would also use a dental floss, to clean the teeth completely" (Franz). The idea was that pain and tooth decay could be avoided or would pass over with these kinds of actions. The hope was that the person did not want to find themselves in a situation where they have to decide between food and shelter or oral health.

The other common topic that came up in the interview when NAV was mentioned was the lack of knowledge they had about its inner workings. It was mentioned by many participants that they had no idea how the NAV service is operated and how to navigate their way through it. The information and knowledge of this was not common among participants and there was not clear way on how to get the information or knowledge. What they do know is the coverage of acute dental pain offered by NAV "*They cover the whole treatment from 1000 to 2000 kr. It does no cost so much to remove a tooth, but it cost a lot of anaesthesia right? When they inject into you it cost so much*" (Carmilla). There was, however, a lack of knowledge surrounding oral health clinics too. An example of this was when Elena talked about that they did not know they had an option for a translator when attending a private oral health clinic. "*I thought it was only for the doctors or hospital and not the dentist*" (Elena). Without a translator there was a greater chance of having a bad experience of the treatment received in the clinic because the patient could not make themselves understood or understand what the dentist was saying. The reason for such an experience was the lack of awareness of the options available for people about translator. Another issue with the lack of knowledge was that the lack of ability to plan for oral health expenses. In this situation, the participants in particular did not know the costs of treatment and could worry that costs would be excessive, for example, one participant said: "*People I know have told me that if you need anything fixed it will be 10 or 15 thousand if something serious or 5000 kr if something small*" (Franz). Leading to naturally a barrier of access towards seeking oral health when you are unable to plan for it.

People on low income are often viewed as having different priorities about their oral health. However, the findings illustrate how being on a low or unstable income means that they have to calculate possible expenditures beforehand. This means that they have to cut or deprioritize some important expenditures if they are to make ends meet in terms of the essentials. One participant put it like this: "*Poor people you have first to take a look and think about it. How to buy food, how to pay for a home and then if there is anything left. Then you can use the money on the dentist*" (Franz). This indicates that individuals themselves weigh things up regularly and make their 'choices' in circumstances where their options are limited because

they cannot ignore their economical situation. "*I would not prioritise going to the dentist, if I had not gotten an inflammation*" (Allen). Getting a deeper perspective shows how when you are on a low or unstable income your choices are limited and many things have to be taken into account if you are to survive, and that taking into account oral health is particularly hard in the current circumstances.

There was also a particular experience mentioned by some of the participants in that they felt overlooked or not priorities as a group when seeking coverage for treatment. As one participant best put it "*I have seen many immigrants from different countries come to Norway. They receive very good treatment. I have nothing against that, I think that is good. But we must not forget our own. Sadly, it is less empathy I think."* (Wesley). The context for this experience often revolved around seeing other groups of people get easy access to oral health treatment while some of the participant had the opposite experience. Most of the participants blame the government or politics rather than the clinics for why this is the case. When going into detail on exactly why the participant though that the government was at found the most cited reason being how or what the government choses to prioritised or finance. This was mentioned particular well by the same participant "…*It should not go over normal people. I think specifically economy because the state and government use a lot of money on art, repairs like the king's palace. This in the end effects normal man or woman in the streets*" (Wesley). Such viewpoints or experience are not the only one and hint at large that the participants felt left out both in that they are not prioritised or the services they use are not financed enough.

The interesting experience to mentioned in the end was about life experience or how the person experiences there day to day life in relation to their oral health. What the participant had experience was the acceptance that teeth pain was part of their everyday life. An example of this acceptance was put forward by one participant "*If I continue to work with tooth pain. Absolutely, you have to have pain. When you think about it is alright. It does hurt of course, but you have to do what you have to do to live"* (Allen). The participant does understand that pain is a negative aspect of life, but there is little in the way they can do to remove it. Especially true when their economic situation does not allow for much deviation in their expenditures. Even if their experience of life is mostly suffering in different forms, they still keep moving forward.

This theme of outside the oral health barrier shows that all of it aspect has their roots in the fact that the oral health is not affordable for the participants. Because of affordability the participants do not visit the clinics, they do not receive the same access to oral health knowledge or literacy in contrast with those who have coverage since they had the opportunity of guidance by the dentist. The situation for the participant does look and feel dire because in the end there is little in what they can do to change the situation.

4.5 Wishing for better quality oral health

Table 6

Table show the generation of the theme wishing for better quality of oral health.

Quotations	Codes	Sub Themes	Themes
"I have been in Oslo, and I have seen people who use a lot of drugs and they do not smile because they have some of their teeth. I have noticed that the looks have a lot of influence" (Johann)	Beauty	Health Disparities	Wishing for better quality of oral health
"When people are poor or middle class. Then it is not the most important that the teeth look good. The most important is that there is no pain. If there will be any problems, then yes of course you need a dentist. To go to him and get your teeth fixed" (Franz)	Function over beauty	The importance of oral health	
"When I look into the mirror then I see what is important. It is important to get the back teeth, but they are so very far aways and hard to get too with a normal toothbrush. It is very important to get too" (Sam)	Treatment associated with cleanliness		
"They do listen, but nothing ever happens. I could have just stood by the wall and talked. Nothing happens" (Wesley)	Being Heard on the topic of Oral Health		
"The biggest profit lies in the rich people, because the poor do not want to treat their teeth. If there is any pain than they will not go to the dentist. Better to take the pain." (Franz)	Justice		
"Yes, it means that the oral health to most people in urban areas. It is not prioritised, and it is everywhere here" (Wesley)	Indifference between health sector		

The fourth theme generated was wishing for better quality of oral health, which consisted of two sub-themes. The first of these concerned the importance of oral health for participants. While there was some variation in what mattered to them in terms of their oral health, there were two aspects that commonly discussed. The first of these was that their teeth should be esthetical pleasing or look good to them. This could include multiple factors but all together what was important was the ability to smile and have confidence in so doing. One person put it like this: "*I have been in Oslo, and I have seen people who use a lot of drugs and they do not smile because they only have some of their teeth. I have noticed that the looks have a lot of influence*" (Johann). Having the confidence to smile was the corner stone for why oral health was important for some participants in the study. The second aspect of wanting better oral health related to function being more important to how good their teeth looked. This related to the use of teeth for eating and lack of pain. "*When people are poor or middle class then it is not the most important that the teeth look good. The most important is that there is no pain."* (Franz). These two dimensions tended to be seen together although they tended to give slightly more priority to one side that being function. Both were seen, however, as relating to their wellbeing. This shows that there is difference in what the consumer finds as quality treatment and sometimes this does not align with what is possible to achieve with low income. Reflecting in why the dominating opinion was that function was more important than looks because that what was feasible to achieve for the participants.

A third dimension of oral health and treatment was associated with cleanliness. Participants perceived that after receiving treatment or going into a regular check they had a feeling of cleanliness. This was also seen as the dentist doing a good job when it comes to cleaning their teeth. For example, one participant said: "*When I look into the mirror then I see what is important. It is important to get the back teeth, but they are so very far aways and hard to get too with a normal toothbrush.*" (Sam). This reveals that participants value dental care. This was an important part of individual experience and gives insight and understanding of what drives people on low income to try to protect their oral health and show what they expect of the treatment.

The second sub-theme generated related to health inequalities when it comes to oral health and low-income individuals. To be more precise, the individuals in the sample who were living on a low income wanted their voices to be heard. In particular, their goal was to improve their current situation and achieve better health and oral health. In practise, people wanted things to change: "*They do listen, but nothing ever happens. I could have just stood*

by the wall and talked. Nothing happens" (Wesley). This issue was perceived as a matter of "social justice" in oral health. This does not only involve the justice of better access to oral health clinics but also their affordability for everyone, including those on low income. One participant put it this way: "*The biggest profit lies in the rich people, because the poor do not want to treat their teeth. If there is any pain than they will not go to the dentist. Better to take the pain*." (Franz). Social justice is about fairness for all no matter what our social position. In dental health care some people have more opportunity to visit the clinics, which adapt by catering specifically for them. In this context, participants perceived that they were less of a priority and could not receive the quality care they needed.

These two-sub theme form the theme of wishing for better quality oral health where the individual clearly has the desire for better oral health. The circumstances surrounding fulfilling this desire are not allowing them to do so. There was a clear desire among participants for better oral health but there was no possibility in fulfilling these desires: "*You can pay yourself for the dentist, ok, you take the receipt and then they do not want to pay. I cannot say they do not do their job. But sometimes we need help, and we do not get it*" (Carmilla). This reflects in that the participant feel that they themselves are not able to improve their oral health and require the help of clinics or dentists. Since they feel that the quality of the clinics will allow them to achieve good oral health. There is also the clash between what the participant wants and what they can get from the oral health clinics. The inability to access oral health clinics compound this notion of skewed expectation of quality.

4.6 Overall finding

In terms of understanding how people on a low income navigate the system of dental health care in Norway the overall findings show that there are multiple complicated factors in place when it comes to accessing the oral health clinics. The economical barrier is at the forefront of most of the issue on why the participants cannot access the oral health clinics. This is a major hindrance in what is a good quality treatment that allows for the improvement of the current health status. Coverage is what is the defining difference between the different experiences by allowing for the lessoning of economical burden the other issues tend to follow suit. Other factor that was of major importance was the availability of service to be close by to save time and distance for the participant. Otherwise, the need to be heard and understood was also a desirable aspect to have when visiting the dentist and feeling accepted. The last important factor was the lack of knowledge or information surrounding oral health and coverage that had negative ramifications on the experience of oral health clinics. Overall,

even if the participant has coverage or not there is a clear desire among everybody in having a good and healthy set of teeth. The issue of coverage is the main issue in why this desire has been left unfulfilled and the question arise what can be done to improve this experience of oral health clinics.

5 Discussion

5.1 Discussion of the findings

The aim of the study was to uncover the perceptions and experiences of the dental health system and oral clinics among people on a low income. The aim was fulfilled in that light has been shone on the social reality of such people trying to interact with a bureaucratic system. We see this clearly in the findings chapter that illustrates how perceptions and experiences are based upon if the individual has coverage or not. One of the often-mentioned aspects of oral health clinics was the fact of affordability. We also see in the literature presented that the factor of economics plays a huge role in a person's use of oral health clinics and does result in better oral health among the poor (Brook et al., 2006; Ono et al., 2023). We see this play out in practice in the Norwegian context too where the current situation for the participants is created through high prices for curative dental treatment such as fillings (Kjøstad, 2018; Moezzi & Hofmann, 2023). This creates a large focus on treatment coverage in order to be able to afford necessary treatment for their oral health because there are no other alternatives especially when you are low income. This can lead to seeking out other avenues that do not involve the oral health coverage system and that being the unemployment coverage in NAV. Although this system does not work or does not do enough according to the perceptions of the participants, nonetheless it does serve a good purpose. When the system of coverage works it provides a great relief both economical and in accessing the clinics as we saw in the theme of good experience making it easier for the person to get access to the clinic and not worry about the expenses leading to a better outlook for their oral health (Carlsen et al., 2022). The theme of outside the clinic's barriers of entry that the factor of affordability has a role in accessibility and the experience of the treatment. However, when the system does not work people on low income must rely on their own resources to address their oral health needs. This means that it is hard and expensive to overcome the entry barriers to the clinics. This is consistent with the findings of other studies on this subject, but there is difference in how the experience was if "Dentistry has to run as a business first and healthcare second" (Wallace & MacEntee, 2012, p. 35). Although this study was done in Canada it does apply towards the Norwegian contest especially the private sector. The private sector does operate as a business as mentioned in the context and is the sector the participants without coverage go to get treatment (Helsedirektoratet, 2019; Mohamed & Robinson, 2021). The profit motive does effect the patient when the goal of treatment becomes financial gain putting extra

economical pressure on the patient (Grytten et al., 2023; Mohamed & Robinson, 2021). The findings from this study show that the participants actually do feel taken care of in most – but not all – circumstances. The circumstances where they are not are because they cannot access the clinics since they do not have coverage. Showing that the coverage is a huge factor together with affordability when it come accessing the oral health clinics in Norway.

The study's findings in relation to quality and acceptability where consistent with the literature found on these topics. Most of the participants did agree that the treatment that they did receive was of good quality and that they trusted their dentist except for some cases. The correlation between affordability and good view of oral clinics was shown in the article by Nikoloski and Mossialos (2013) where rich households had more positive outlook on health quality because they had the resources to cover such expenses. This is similar to the participants who did get coverage because they could use the money, they saved on other expenses a strong contrast to those who did not have this opportunity. Acceptability of oral health care was both in an esthetical and functional manner for both the participants in the current study and other studies. The aspect of physical importance of oral health was the more dominant one within the participants response given where the focus was mostly on the ability to chew. The fact of esthetical aspects of having a good smile were also important for the participants and both these findings are consistent with the literature. Both of these aspects relating to oral health were important towards the OHRQoL of a given person and that they had a good experience of life (Nicoll et al., 2016; Spanemberg et al., 2019). This shows that this is similar to the Norwegian context too when it comes to how oral health is viewed by the citizens.

It is a human right to have both the availability, accessibility, acceptability and quality in their health sector (WHO, 2024). This is necessary to allow for the fulfilment of the goal of reducing the risk and instances of oral health diseases such as caries (Hayashi et al., 2020; WHO, 2024). These diseases have their origin in both biological and social factors (WHO, 2022). What we see together in the findings and the literature that the persistence of oral health disease among low income is largely due to social factors (Castañeda et al., 2010; WHO, 2022). There is a real need for development of intervention or programs that allow for the prevention of oral disease especially at the low-income group. The issue is in the factor that most of oral health care is not well funded or integrated towards the general health care in other countries (WHO, 2022). Funding of oral health in Norway is done quite good in contrast to other countries and is organised to focus on specific patient groups

(Helsedirektoratet, 2019). What we see is that even if these aspects of oral healthcare are quite well manage it still leaves parts of the local population behind and raises the question of if the goal of eradicating oral health disease is a realistic notion at all. Proposing the increasing of coverage is a lofty notion and there should probably be considering other options that involve preventive strategies. With the goal of preventing the oral health and achieving good oral health in a given population as part of the WHO action plan (WHO, 2022). This recommendation will be discussed later on and why there should be focus on preventive rather than coverage. There are other important aspects to cover when discussing the findings of this thesis.

At the same time the aspect of personal relation has also shown to play a vital role in the patient and dentist relation as shown by both literature and participant experiences where the personal relation motivated the patient into coming back to the clinic for further check-up (Hovden et al., 2020; Wallace & MacEntee, 2012). Allowing for the creation of personal relation and further motivation for the patient to visit the clinics with the end result being improved oral health (Hovden et al., 2020). What we find in the end result being that the experience of clinics is lacking by those who cannot afford it. Leading to a more negative experience and association with oral health clinics because they cannot access them, thus further negatively impacting their personal experience of oral health (Wallace & MacEntee, 2012). This experience demotivates the person and will result in worsening of oral health and making it hard for the person to trust other dentist in the future (Wallace & MacEntee, 2012). Making it necessary that the experience of personal relationships is a positive one for the betterment of the patient’s oral health. The issue also lies in that barriers of entry makes it hard to enter the clinics and create opportunity for creation of trust (Nicoll et al., 2016). Emphasizing that the barriers of entry towards the oral health clinics can be more of a detriment for the persons oral health if they are not in place. Thus, the barriers entry to the clinics must be delt to allow for a betterment of oral health.

Interesting aspect that came up from the finding of the study was the factor of immigrants. The fact that some groups of immigrants were overlooked by the oral health system in their need for translator. The findings point at the fact that the participant did not know such an offer was available towards them or that they were not provided with the option. This goes also along the experience of other native participant the feeling that some groups and immigrants are priorities before them. Showing that the oral health has become politicised in allowing for particular groups to be priorities to align with political agenda. Like it was

shown by Casteñeda., et al (2010) that the oral health literacy and understanding of oral health by immigrants and non-immigrants is quite high (Castañeda et al., 2010). The issue lied in social economic factors that prohibit the access of oral health clinics together with uneven coverage system by Medicare (Castañeda et al., 2010). The same situation can be said here in Norway where the inequality stems primarily from the uneven coverage system and bureaucracy. Further oral health literacy on oral health would have a positive effect, but would not be able to allow for better accessibility of the clinics (Castañeda et al., 2010; Ortíz-Barrios et al., 2019). Any further plans of oral health literacy improvement among the low income should involve the education of how the bureaucratic system works in oral health sector. Allowing for the understanding of the patient rights and how to uphold them when the patient does not fall under the priorities of politics or coverage schemes.

Another interesting aspect within the theme of outside of the clinics barriers of entry was the factor of people's knowledge. Previous research has found that there was little discussion about the knowledge aspects when it comes to interacting with the oral health clinics. What was discussed sometimes was oral health literacy in relation to how important oral health was for people (Nicoll et al., 2016). Multiple accounts from the interviews showed that a large factor was if the participant had coverage and their oral health literacy. Those who had difficulties in accessing clinics because of coverage tended to be less informed about clinics or oral health. One of the previous studies found that the perceived importance of oral health stems from knowledge around oral health literacy that impacts the oral health in the form of not prioritising oral health hygiene or visiting the dentist (Arora et al., 2021; Nicoll et al., 2016). In contrast, the current study found that all were aware of how important oral health was towards their general health. The theme of wishing for better quality oral health illustrates how participants really do want to improve their oral health. However, factors such as economy and knowledge prevent them from accessing the oral health clinics. These barriers that prevent the entry to the clinic have to be delt with to allow for a betterment of oral health in the low-income group.

Informing the person on their rights to oral health care and what is available treatment is invaluable when it comes to empowering the patient to take control over their oral health (Willumsen et al., 2019, pp. 73–79). The findings from the current study suggests that a person in most cases is left alone in finding out how they should navigate the oral health sector. There is a chance that they do receive outside help on figuring out how to do this both the bureaucracy of Nav and oral health care clinics. This does happen when it involves a

serious health condition or history of drug use both of which can negatively impact their general health (Hovden et al., 2020) .Outside these cases people tend to not receive the care and assistance they need because the structure of the coverage does not include these people (Helsedirektoratet, 2023). Thus, the individual is left with information that is obscure and hard to understand for those who do not have any knowledge of oral health or how coverage system works. There are no tools or structure in place that allows for independent control over oral health because it is the job of the dentist to inform their patients (Galaasen, 2024; Helsedirektoratet, 2023). What this creates is a dependency on if the person has a team around them or that the dentist does take the time to inform the patient. There needs to be a change in how the information is available and formulates for the individuals, especially in cases where Norwegian is not the first language. If oral public health is to improve, especially social inequalities in oral health need to be dealt with to achieve this goal.

5.2 Implications for the public health

The implication of the findings shows that there is a need for increased empowerment in relation to knowledge about oral health and the oral health care system, including oral health care clinics especially for those on low income. To even out the differences between those who do experience affordability barriers and those who do not. Increasing the knowledge around oral health does not only stimulate empowerment of the patient but also further motivates them towards the betterment of oral health as shown by (Arora et al., 2021; Nicoll et al., 2016). The Norwegian context shows us that there is only the need for empowerment because of the good oral health literacy and that there is a strong incentive among low income to want to improve. Since the improvement of health literacy happens in the clinics by the dentist what we should do would be to move that aspect outside the clinics. In the form of providing information and supportive advice that are outside the oral health clinics especially towards people that find it difficult accessing clinics. This can help improve and even out the knowledge gap between those on coverage and those who are not. Resulting in a better understand of patient rights, difference between private and public sector and highlighting how they can improve their oral hygiene at home. The achievement of such implementations would allow possibly for better prevention of oral health disease and improvement in oral health. This implementation would allow for evening out difference, but regarding the barrier of affordability, it becomes difficult to answer.

Economy is by far the most vital point in accessing oral health clinics shown both by literature and the findings (Castañeda et al., 2010; Hovden et al., 2020; Nicoll et al., 2016; Wallace & MacEntee, 2012). The issue starts when trying to find out how to alleviate this struggle of accessibility. The priority of the of Norwegian government is mostly on the elderly or special needs group and incentivising further research on the topic of oral health (Dahm., K et al., 2020). It is not in the interest of the public health department to focus on low-income group and at the same time this is quite an ethical issue. Increasing the coverage will mean deciding who will get the coverage and who will not, knowing full well that this is for some their only alternative (Castañeda et al., 2010; Nicoll et al., 2016). Budget wise it is also the question of if this is at all feasible endeavour to undertake and if it is worth undertaking from a political standpoint (Hayashi et al., 2020). Thus, it would be best to focus strategies around preventing oral health diseases from manifesting to begin with among low-income population. Through preventive means as mentioned with increasing oral health literacy and clearer transparency on what the patient can demand from their treatment. To ensure that the patient receives quality treatment in accordance to their affordability.

5.3 The limitations of the study

There are some limitations in this study. Time constrains and access to resources meant that there was a set deadline for the submission of the thesis. This sets a specific limit on how long the collection of data could be. A part of this limitation was the collection of the participant towards this study. As the findings point out half of the participant had coverage on their oral health treatment impacting the findings. It would reason that if the hole list of participants would not have coverage the finding would be differ and give more data on this topic. This would be a recommendation on further research done on this topic that the recruitment criteria would be that the participant had no coverage. It would also be advisable that this project was done by a novice and most likely does not cover or do the topic complete justice. This is a very nuance and difficult topic to analyse and study inn dept since there is a difference in experience between the participant and the researcher. This goes into another limitation that being personal experience of the researcher could have impacted the interpretation of the data. If the research had another background or shared similar experience with the participant, the finding and final result could have looked differently. Another limitation is that because of the qualitative design of the study the findings are not quite generalisable towards the general population. This was not the goal of the study because the goal was to develop theory and insight into how the experience was for low income to visit

oral health clinics. If the goal of the study was generalisability that would entail quantitative research methodology on this topic. That is further recommendation on future study to get a complete understand of low-income interaction of oral health clinics.

5.4 Conclusion

Although Norway is a strong social democratic welfare state with a commitment to equality, the findings from this study suggests that people on a low income are not always empowered to access oral health care from which they can benefit greatly. Unless changes to how coverage is operated, including in relation to how accessible knowledge on the dental health care system is, there is little hope for improving access to oral health care by those living on a low income in Norway. People in these circumstances desire to have good oral health but cannot achieve it. It is in their rights as human beings towards a good oral health that is accessible, available, acceptable and qualitive (WHO, 2022, 2024). If the health sector does not fulfil all of the criteria for good oral health proposed by WHO, they are depriving part of the population from their rights and experiencing life without pain. What is most important and desirable for both the participant and low-income people is empathy for their situation and that is the minimum we can do for them.

6. References

Al Mugeiren, O. M., & Al Sanea, J. A. (2018). Dental Service Marketing. *Journal of International Oral Health*, *10*(5), 216. https://doi.org/10.4103/jioh.jioh_194_18

Arora, A., Lucas, D., To, M., Chimoriya, R., Bhole, S., Tadakamadla, S. K., & Crall, J. J. (2021). How Do Mothers Living in Socially Deprived Communities Perceive Oral Health of Young Children? A Qualitative Study. *International Journal of Environmental Research and Public Health*, *18*(7), Article 7. https://doi.org/10.3390/ijerph18073521

Åstrøm, A., Gulcan, F., & Mustafa, M. (2017). *Oral helserelatert livskvalitet blant unge voksne i Norge—En representativ befolkningsundersøkelse | Den norske tannlegeforenings Tidende*. *10*. https://doi.org/10.56373/2017-10-3

Braun, V., & Clarke, V. (2022). *Thematic Analysis a Practical Guide*. SAGE Publications.

Brook, R., Keeler, E., & Lohr, K. (2006). The Health Insurance Experiment. *The RAND Corporation*. https://www.rand.org/content/dam/rand/pubs/research_briefs/2006/RAND_RB9174.pdf

Bryman, A. (2016). *Social research Methods* (5th ed.). Oxford University Press.

Carlsen, S.-E. L., Isaksen, K., Åstrøm, A. N., & Fadnes, L. T. (2022). Facilitators for use of oral healthcare services among people with substance use disorders: A qualitative study in Norway. *Acta Odontologica Scandinavica*, *80*(7), 513–521. https://doi.org/10.1080/00016357.2022.2041719

Castañeda, H., Carrion, I. V., Kline, N., & Tyson, D. M. (2010). False hope: Effects of social class and health policy on oral health inequalities for migrant farmworker families. *Social Science & Medicine*, *71*(11), 2028–2037. https://doi.org/10.1016/j.socscimed.2010.09.024

Dahm, K., Denison, E., & Hafstad, E. (2020). *Tannpleietiltak for å bedre oral helse hos personer som mottar kommunale helse- og omsorgstjenester og andre prioriterte grupper*. Folkehelseinstituttet.

Dudko, Y., Kruger, E., & Tennant, M. (2017). A national analysis of dental waiting lists and point-in- time geographic access to subsidised dental care: Can geographic access be improved by offering public dental care through private dental clinics? *Rural and Remote Health*, *17*(1), 1–10. https://doi.org/10.3316/informit.151467441984360

Galaasen, T. (2024). Kan tannleger droppe Helfo-systemet? *Tannlege Tidende*, *3*, 134.

Goulart, M. de A., Condessa, M., Hilgert, B., Hugo, N., & Celeste, K. (2018). Concerns about dental aesthetics are associated with oral health related quality of life in Southern Brazilian adults. *Ciência & Saúde Coletiva*, *23*, 3957–3964. https://doi.org/10.1590/1413-812320182311.24172016

Gramsci, A. (2011). *Prison Notebooks*. Columbia University Press.

Grytten, J. (2017). Payment systems and incentives in dentistry. *Community Dentistry and Oral Epidemiology*, *45*(1), 1–11. https://doi.org/10.1111/cdoe.12267

Grytten, J., Listl, S., & Skau, I. (2023). Do Norwegian private dental practitioners with too few patients compensate for their loss of income by providing more services or by raising their fees? *Community Dentistry and Oral Epidemiology*, *51*(5), 778–785. https://doi.org/10.1111/cdoe.12750

Grytten, J., & Skau, I. (2020). Educational inequalities in access to fixed prosthodontic treatment in Norway. Causal effects using the introduction of a school reform as an instrumental variable. *Social Science & Medicine*, *260*, 113105. https://doi.org/10.1016/j.socscimed.2020.113105

Hayashi, M., Haapasalo, M., Imazato, S., Lee, J. I., Momoi, Y., Murakami, S., Whelton, H., & Wilson, N. (2020). Dentistry in the 21st century: Challenges of a globalising world. *International Dental Journal*, *64*(6), 333–342. https://doi.org/10.1111/idj.12132

Helsedirektoratet. (2019). *Nordic Quality indicators in oral health*. Helsedirektoratet. https://www.helsedirektoratet.no/rapporter/quality-indicators-in-oral-health-care-a-nordic-project-proceedings-in-2012-2018/2019%20Nordic%20quality%20indicators%20oral%20health.pdf/_/attachment/inline/c901a3c8-259b-4484-96d5-34bdf5d85b33:3c3f67502008c978f39e5c739b4157d0b98dd25f/2019%20Nordic%20quality%20indicators%20oral%20health.pdf

Helsedirektoratet. (2023, July 7). *Takster for tannbehandling*. Helsedirektoratet. https://www.helsedirektoratet.no/rundskriv/kapittel-5-stonad-ved-helsetjenester/takster-for-tannbehandling-

Holden, A. C., Neville, P., Gibson, B., & Spallek, H. (2021). Taking responsibility for the tooth: A semiotic and thematic analysis of oral health and disease in the TV show 'Embarrassing Bodies'. *Health*, *25*(6), 739–756. https://doi.org/10.1177/1363459320904419

Hollander, J. A. (2004). The Social Contexts of Focus Groups. *Journal of Contemporary Ethnography*, *33*(5), 602–637. https://doi.org/10.1177/0891241604266988

Holligan, C. (2015). Becoming a researcher: Forms of capital associated with "research capacity" trajectories of young British social anthropologists. *International Journal of Qualitative Studies in Education*, *28*(10), 1249–1270. https://doi.org/10.1080/09518398.2014.974716

Hovden, E. S., Ansteinsson, V. E., Klepaker, I. V., Widström, E., & Skudutyte-Rysstad, R. (2020). Dental care for drug users in Norway: Dental professionals' attitudes to treatment and experiences with interprofessional collaboration. *BMC Oral Health*, *20*(1), 299. https://doi.org/10.1186/s12903-020-01240-1

Jashni, Y. K., Emari, F., Morris, M., & Allison, P. (2023). Indicators of integrating oral health care within universal health coverage and general health care in low-, middle-, and high-income countries: A scoping review. *BMC Oral Health*, *23*(1), 251. https://doi.org/10.1186/s12903-023-02906-2

Jiang, N., Grytten, J., & Kinge, J. M. (2022). Inequality in access to dental services in a market-based dental care system: A population study from Norway 1975–2018. *Community Dentistry and Oral Epidemiology*, *50*(6), 548–558. https://doi.org/10.1111/cdoe.12709

Kjøstad, O. (2018, May 9). *Dyrere tannlegepasienter*. ssb.no. https://www.ssb.no/helse/artikler-og-publikasjoner/dyrere-tannlegepasienter

Klages, U., Bruckner, A., & Zentner, A. (2004). Dental aesthetics, self-awareness, and oral health-related quality of life in young adults. *The European Journal of Orthodontics*, *26*(5), 507–514. https://doi.org/10.1093/ejo/26.5.507

Knorst, J. K., Sfreddo, C. S., de F. Meira, G., Zanatta, F. B., Vettore, M. V., & Ardenghi, T. M. (2021). Socioeconomic status and oral health-related quality of life: A systematic review and meta-analysis. *Community Dentistry and Oral Epidemiology*, *49*(2), 95–102. https://doi.org/10.1111/cdoe.12616

Moezzi, M., & Hofmann, B. (2023). Helsepersonell eller selger? *Tannlege Tidende*, *3*, 192–200. https://doi.org/10.56373/2023-3-3

Mohamed, A., & Robinson, P. (2021). Dental public health. In R. Detels, A. Karim, F. Baum, L. Li, A. Leyland, R. Detels, Q. Abdool Karim, F. Baum, L. Li, & A. Leyland (Eds.), *Oxford Textbook of Global Public Health* (p. 0). Oxford University Press. https://doi.org/10.1093/med/9780198816805.003.0066

Molarius, A., Engström, S., Flink, H., Simonsson, B., & Tegelberg, Å. (2014). Socioeconomic differences in self-rated oral health and dental care utilisation after the dental care reform in 2008 in Sweden. *BMC Oral Health*, *14*(1), 134. https://doi.org/10.1186/1472-6831-14-134

National Research Ethics Committees. (2022, May 26). *Guidelines for Research Ethics in the Social Sciences and the Humanities*. Forskningsetikk. https://www.forskningsetikk.no/en/guidelines/social-sciences-and-humanities/guidelines-for-research-ethics-in-the-social-sciences-and-the-humanities/

Neutens, T. (2015). Accessibility, equity and health care: Review and research directions for transport geographers. *Journal of Transport Geography*, *43*, 14–27. https://doi.org/10.1016/j.jtrangeo.2014.12.006

Nicolaysen, S. (2018). Økonomisk stønad fra NAV til tannbehandling. *Tannlege Tidende*, *2*. https://www.tannlegetidende.no/journal/2018/2/d2e2036/Økonomisk_stønad_fra_NAV_til_tannbehandling

Nicoll, L., Phillips, E., Shaefer, L., & Simoncic, T. (2016). Low-Income Parents' Perceptions of Oral Health and Acceptance of Mid-level Dental Providers. *Journal of Dental Hygiene*, *90*(2), 100–110.

Nikoloski, Z., & Mossialos, E. (2013). Corruption, inequality and population perception of healthcare quality in Europe. *BMC Health Services Research*, *13*(1), 472. https://doi.org/10.1186/1472-6963-13-472

Northridge, M. E., Kumar, A., & Kaur, R. (2020). Disparities in Access to Oral Health Care. *Annual Review of Public Health*, *41*(1), 513–535. https://doi.org/10.1146/annurev-publhealth-040119-094318

NTF. (2023). *Fakta om tannhelsetjenesten*. https://www.tannlegeforeningen.no/fag-og-politikk/pasientinformasjon/fakta-om-tannhelsetjenesten.html

Ono, S., Sasabuchi, Y., Ishimaru, M., Ono, Y., Matsui, H., & Yasunaga, H. (2023). Short-term effects of reduced cost sharing on childhood dental care utilization and dental caries prevention in Japan. *Community Dentistry and Oral Epidemiology*, *51*(2), 228–235. https://doi.org/10.1111/cdoe.12730

Ortíz-Barrios, L., Granados-García, V., Cruz-Hervert, P., Moreno-Tamayo, K., Heredia-Ponce, E., & Sánchez-García, S. (2019). The impact of poor oral health on the oral health-related quality of life (OHRQoL) in older adults: The oral health status through a latent class analysis. *BMC Oral Health*, *19*(1), 141. https://doi.org/10.1186/s12903-019-0840-3

Paisi, M., Baines, R., Worle, C., Withers, L., & Witton, R. (2020). Evaluation of a community dental clinic providing care to people experiencing homelessness: A mixed methods approach. *Health Expectations*, *23*(5), 1289–1299. https://doi.org/10.1111/hex.13111

Peres, M., Macpherson, L., Weyant, R. J., Daly, B., Venturelli, R., Mathur, M., Listl, S., Celeste, R. K., Guarnizo-Herreño, C., Kearns, C., Benzian, H., Allison, P., & Watt, R. (2019). Oral diseases: A global public health challenge. *The Lancet*, *394*(10194), 249–260. https://doi.org/10.1016/S0140-6736(19)31146-8

Regjeringen. (2024). *Meld. St. 9 (2023–2024)*. regjeringen.no. https://www.regjeringen.no/no/dokumenter/meld.-st.-9-20232024/id3027594/

Spanemberg, C., Cardoso, A., Slob, B., & López-López, J. (2019). Quality of life related to oral health and its impact in adults. *Journal of Stomatology, Oral and Maxillofacial Surgery*, *120*(3), 234–239. https://doi.org/10.1016/j.jormas.2019.02.004

Statistisk Sentralbyrå. (2023a, June 15). *12900: Mottak av tannhelserefusjon gjennom folketrygden , etter statistikkvariabel, region og år. Statistikkbanken*. SSB. https://www.ssb.no/system/

Statistisk Sentralbyrå. (2023b, June 29). *11985: Utvalgte nøkkeltall for tannhelsetjenesten, etter statistikkvariabel, region og år. Statistikkbanken*. SSB. https://www.ssb.no/system/

Statistisk Sentralbyrå. (2023c, June 29). *Tannhelsetenesta*. SSB. https://www.ssb.no/helse/helsetjenester/statistikk/tannhelsetenesta

Tjora, A. (2021). *Kvalitative Forskningsmetoder i Praksis* (4th ed.). Gyldendal.

Unicef. (2019). *Availability, Accessibility, Acceptability and Quality framework:* Unicef. https://gbvguidelines.org/wp/wp-content/uploads/2019/11/AAAQ-framework-Nov-2019-WEB.pdf

Wallace, B., & MacEntee, M. (2012). Access to Dental care for Low-Income Adults: Perceptions of Affordability, Availability and Acceptability. *Journal of Community Health*, *37*(1), 32–39. https://doi.org/10.1007/s10900-011-9412-4

WHO. (2022). *Draft global oral ehalth action plan (2023-2030)*. WHO.

WHO. (2024). *Oral health*. https://www.who.int/health-topics/oral-health

Willumsen, T., Myran, L., & Jostein, L. (2019). *Odontologisk Psykologi* (1st ed.). Gyldendal.

With, M. (2022, August 16). *900 000 nordmenn vil ikke klare en stor uforutsett utgift*. SSB. https://www.ssb.no/sosiale-forhold-og-kriminalitet/levekar/statistikk/fattigdomsproblemer-levekarsundersokelsen/artikler/900-000-nordmenn-vil-ikke-klare-en-stor-uforutsett-utgift

Yamamoto, T., Hanazato, M., Hikichi, H., Kondo, K., Osaka, K., Kawachi, I., & Aida, J. (2023). Change in Geographic Accessibility to Dental Clinics Affects Access to Care. *Journal of Dental Research*, *102*(7), 719–726. https://doi.org/10.1177/00220345231167771

Åstrøm, A., Gulcan, F., & Mustafa, M. (2017). *Oral helserelatert livskvalitet blant unge voksne i Norge—En representativ befolkningsundersøkelse | Den norske tannlegeforenings Tidende*. *10*. https://doi.org/10.56373/2017-10-3

Appendix A

Interview guide

This appendix consists of the interview guide used in the semi structured interview. The questions consisted of 5 groups of questions: that being the before interview questions, background questions, questions about oral health clinics, questions about economy and questions about knowledge surrounding oral health. The questions were written in Norwegian because most of the interviews were done in this language making it easier to use the guide when conducting the interviews.

Interview guide in Norwegian:

Før Intervju

- Tusen takk for at du deltar
- Gå gjennom informering skjema og minne på hva forventes og at deltakeren kan trekke seg når somhelst.
- Signere samtykke skjema

Bakgrunnsinformasjon

- Utdannings nivå
- Alder
- Jobstilling

Spørsmål

Tannklinikk

1. Kan du fortelle meg om din personlig erfaring med å bruke tannklinikker
2. Hvor lenge sist har du besøkt enn tannlege (Hvorfor, osv)
3. Hvordan var din opplevelse av kvaliteten til behandling
4. Hva synes du om kvaliteten på behandlingen du har mottatt
5. Synes du at dine tenner spiller en stor rolle i din utseende. (Første Inntrykk, opplevelse)
6. Har du eller har hatt erfaring av dårlig tilgang til tannklinikk (økonomisk eller geografisk). Om ja, hvordan opplevde du denne situasjonen

Økonomi

1. Vil du si at du har råd til å dekke for tannlege hvis det blir noen behandling utover en vanlig kontroll time.

2. Har det vært noen periode hvor du har hatt bedre råd enn andre når det gjelder å gå til tannlege.
3. Har du noen gang unngått tannlegen på grunn av dårlig råd.
4. Har du fått noen gang fått full eller delvis dekning av behandling. Hvis ja, hva har din erfaring vært med det

Kunnskap

1. Hvordan ville du si din kunnskap rundt oral helsen er?
2. Synes du at du har en god kontroll over hvilke rettigheter eller tilbudt du kan få fra tannlegen.
3. Kjenner du til hvordan oral helse sektor opererer i forhold hvordan de behandler sine pasienter.
4. Synes du at det har blitt tildelt noen informasjon om viktigheten av oral helse eller hvordan en person opprettholder god oral helse.

Er det noen viktig innenfor dette tema som har ikke blitt tatt opp i samtalen som du vil nevne.

Appendix B

Sikt Application Letter

The following appendix B is of the application letter to sikt. With the goal of getting clearance on this research projects in relation to the ethical guidelines. This was the letter submitted to sikt and that was cleared to perform this study in relation to ethical standpoint.

Meldeskjema

Referansenummer

707685

Hvilke personopplysninger skal du behandle?

- Fødselsdato
- Stemme på lydopptak

Prosjektinformasjon

Tittel

Understanding how economically vulnerable people interact with dental health services: A qualitative study in Norway

Sammendrag

Oral hselse er en viktig del av personens oral helse og good livs opplevelse. Livs opplevelse som kommer fra mangel av smerte eller hvordan en blir sett på av andre personer. Noen ganger for å oppnå god oral helse så trenger man hjelp fra tannlegen. Spørsmålet som kommer opp hvilken opplevelse personen vil ha når de har ikke råd til tannlege besøk eller videre behandling. Dette prosjektet vil finne ut mer om disse erfaringer for å ha en bedre forståelse om hvordan de har taklet et slik situasjon og hva deres meninger er om denne hendelsen.

Hva er formålet med behandlingen av personopplysninger?

Opplysninger som vil bli arkivert er lydopptak of stemme til deltakeren. Grunnen til dette er å kunne transkribere opptaket på en annen tidspunkt. For å deretter å gjøre data mulig til koding og tematisk analyse.

Dersom personopplysningene skal behandles til flere formål, beskriv hvilke

Til nå har jeg ikke noen ønske eller nødvendighet til å bruke personopplysningene til noe annet en prosjektet. Opplysninger vil bli arkivert i 6 måneder som en del av krav av høgskolen innlandet for å bevise at prosjektet har blitt gjennomført.

Ekstern finansiering

Ikke utfyllt

Type prosjekt

Master

Kontaktinformasjon, student

Alexandr Karlsen , alexand.karlsen@gmail.com, tlf: 4797938505

Behandlingsansvar

Behandlingsansvarlig institusjon

Høgskolen i Innlandet / Fakultet for helse- og sosialvitenskap / Institutt for folkehelse og idrettsvitenskap

Prosjektansvarlig

Miranda Thurston, miranda.thurston@inn.no, tlf: +4762430276

Er behandlingsansvaret delt med flere institusjoner?

Nei

Utvalg 1

Beskriv utvalget

Fellestrekk mellom individer er at de har hatt vansker med å betale uforutsigbar kostnad innenfor oral helse, men mottar ikke støtte fra NAV. Hvor fokuset er på personlig erfaring.

Beskriv hvordan du finner frem til eller kontakter utvalget

Jeg finner fram til slike personer via informanter fra frivilige organisasjoner som Frelsesarmeen, Velferdsallisansen, Internasjonal helse og sosialgruppe og selvhjelpens hus. Disse informanter er i kontakt med relevante personer og kan bidra med informering om prosjektet og eventuelt rekruttering. Samt viktige trekk som blir sett etter av informatene er at mulige deltakere er ikke aktive rus bruker, psykisk friskt og er ikke hjemløse.

Aldersgruppe

25 - 70

Hvilke personopplysninger vil bli behandlet om utvalg {{i}}? 1

- Stemme på lydopptak

Hvordan innhentes opplysningene om utvalg 1?

Personlig intervju

Vedlegg

Lovlig grunnlag for å behandle alminnelige personopplysninger

Samtykke (Personvernforordningen art. 6 nr. 1 bokstav a)

Informasjon til utvalg 1

Mottar utvalget informasjon om behandlingen av personopplysningene?

Ja

Hvordan mottar utvalget informasjon om behandlingen?

Skriftlig (papir eller elektronisk)

Informasjonsskriv

Tredjepersoner

Innhenter prosjektet informasjon om tredjepersoner?

Nei

Dokumentasjon

Hvordan dokumenteres samtykkene?

- Manuelt (papir)

Hvordan kan samtykket trekkes tilbake?

Samtykket kan bli trekket tilbake ved å informere informanten eller meg direkte om ønsket å trekke seg fra prosjektet. Ved mottakelse av denne ønsket vil alt data rundt deltakeren slettes.

Hvordan kan de registrerte få innsyn, rettet eller slettet personopplysninger om seg selv?

Ifølge samtykke skjema så kan deltakeren kontakte meg for å få deres data slettet eller forandret på. Ellers så blir det avtalt med delakerne om de har lyst å få tilsendt anonymisert data til dem for vurdering.

Totalt antall registrerte i prosjektet

1-99

Tillatelser

Vil noen av de følgende godkjenninger eller tillatelser innhentes?

Ikke utfyllt

Sikkerhetstiltak

Vil personopplysningene lagres atskilt fra øvrige data?

Ja

Hvilke tekniske og fysiske tiltak sikrer personopplysningene?

- Kryptert lagring
- Kryptert overføring
- Fortløpende anonymisering
- Adgangsbegrensning
- Flerfaktorautentisering
- Adgangslogg
- Endringslogg

Hvor blir personopplysningene behandlet?

- Maskinvare

Hvem har tilgang til personopplysningene?

- Prosjektansvarlig
- Student (studentprosjekt)

Overføres personopplysninger til et tredjeland?

Nei

Avslutning

Prosjektperiode

10.01.2024 - 10.06.2024

Hva skjer med dataene ved prosjektslutt?

Data anonymiseres (sletter/omskriver personopplysningene)

Hvilke anonymiseringstiltak vil bli foretatt?

- Koblingsnøkkelen slettes
- Personidentifiserbare opplysninger fjernes, omskrives eller grovkategoriseres

Vil enkeltpersoner kunne gjenkjennes i publikasjon?

Nei

Tilleggsopplysninger

Selv om dette prosjektet går innom oral helse hoved fokuset er på innsamling av erfaring rundt tannhelsetjenester. Fokuset er på erfaring av behandlingen og ikke selve oral helsen. Det har også vært en diskusjon med prosjekt leder om at denne gruppen er i grå zone når det gjelder sensititv grupper. Siden det er snak om personer som har erfart et slik sitation, men nødvendigvis betyr ikke at de fortsatt i den. Tiltakene om anonymitet og data sikkerhet som er tilsteden har blitt vurdert to nok til å kunne gjennomføre denne prosjektet i en etisk forsvarlig måte. Samt etiske retningslinjer som respekt, rettferdighet, anonymitet oppretholdes så det har blit vurdert å være nok.

Appendix C

Information Letter

This appendix contains the information letter towards the possible participants of this study. This information letter contained relevant information about the study in relation to how the data would be used, stored and further publication if decided upon. Other information included was what was expected of the participants and what their rights were towards the data gathered. When it comes to participation nothing more than agreeing to be recorded, signing the consent sheet and participating in the interview was needed. On the other hand, when it comes to the right of data the participant has complete right towards their data. This includes granting access to data when requested, deleting the data and removing the participant from the study if they voice such a concern.

Vil du delta i forskningsprosjektet

" Understanding how economically vulnerable people interact with dental health services: A qualitative study in Norway"?

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å få et bedre innblikk i hvordan folk som har opplevde økonomiske eller sosiale utfordringer har manøvrerer rundt oral helse sektor. I dette skrivet gir vi deg informasjon om målene for prosjektet og hva deltakelse vil innebære for deg.

Formål

Formål med denne forskningsprosjektet er å skrive en master oppgave innenfor folkehelse. Hvor omfanget av selve prosjektet vil være personer som har hatt vansker med å manøvrere oral helse sektor.

Problemstillinger for prosjektet er "Understanding how economically vulnerable people interact with dental health services: A qualitative study in Norway" eller "Et innblikk i hvordan personer med litte økonomi samhandler med oral helse tjeneste: En kvalitativ studie i Norge". Ellers så er det muligheter at denne prosjektet kan bli publisert i forskningsartikkel i tilfelle der master oppgave får høyt nok karakter.

Hvem er ansvarlig for forskningsprosjektet?

Høgskole Innlandet er ansvarlig for prosjektet. Annen samarbeid er bare med organisasjoner i form av deltakere rekrutering.

Hvorfor får du spørsmål om å delta?

Utvalget av deltakere skjedde via eksterne informanter som rekrutterte deltakere via at de fulførte kriteria av å ha vanskeligheter med å få dekt tannklinikk besøk eller videre behandling hos tannklinikken. Totale antall personer som vil få være med på prosjektet er på ca 10 personer.

Hva innebærer det for deg å delta?

Dersom du velger å delta i studiet så innebærer det et intervju på 30-60 min. Selve intervju vil være semi-strukturert og selve spørsmålene dreier seg om din egen opplevelse av din oral helse og tannlege tjeneste i form av tilgjengelighet økonomisk, geografisk og om hvordan du har eller ikke har klart å manøvrere utfordringer om du har opplevde noen. Andre informasjon som kommer til å bli samlet er din bakgrunnsinformasjon som kjønn, alder, arbeidsstilling og utdannings nivå. Intervjuet vil blitt tatt opp med lydopptaker på forskerens mobiltelefon, og opptakene sendes direkte til skylagring som er sikret for andre vedkommende bortsett fra kun forsker. Opptakene lagres ikke på mobiltelefonen. Det vil også bli tatt notater underveis i intervjuet.

Det er frivillig å delta

Det er frivillig å delta i prosjektet. Hvis du velger å delta, kan du når som helst trekke samtykket tilbake uten å oppgi noen grunn. Alle dine personopplysninger vil da bli slettet. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg. Dette vill ikke påvirker ditt personlig liv fordi alt av personlig informasjon vil bli anonymisert. Forskning gjennomføres ikke i forbindelse med din nåværende behandling ved tannklinikken.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger

Vi vil bare bruke opplysningene om deg til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelverket.

- Opplysninger som blir gitt i intervjuet vil kun være tilgjengelig for meg (studenten) og min veileder Miranda Thurston etter at opplysninger har blitt anonymisert.
- Navn, kontaktopplysninger og eventuelt annet som kan identifisere deg vil bli lagret elektronisk i «nettskjema» som er et dataoppbevaringsverktøy anerkjent av høgskole innlandet.

I den ferdige resultat vil det ikke være mulig å gjenkjenne deltakere ut ifra opplysningen som blir gitt i intervjuet. Andre opplysninger som blir nevnt er hvor utvalget er fra kommune/bydel, kjønn, utdannings nivå og hvordan eller via hjem du har blitt funnet av.

Hva skjer med personopplysningene dine når forskningsprosjektet avsluttes?

Prosjektet skal avsluttes ved innlevingen av masteroppgaven i mai 2024. Intervjuopptakene og personopplysninger vi bli slettet ved prosjektslutt. Personidentifiserbare opplysninger fjernes slik at anonymisert data vil bli oppbevart seks måneder etter prosjektslutt. Dette fordi det kan forekomme at Høgskolen krever bevis på at forskningen har foregått

Hva gir oss rett til å behandle personopplysninger om deg?

Vi behandler opplysninger om deg basert på ditt samtykke. På oppdrag fra Høgskole Innlandet har Nsd/Sikt – Kunnskapssektorens tjenesteleverandør vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Dine rettigheter

Så lenge du kan identifiseres i datamaterialet, har du rett til:

- innsyn i hvilke opplysninger vi behandler om deg, og å få utlevert en kopi av opplysningene
- å få rettet opplysninger om deg som er feil eller misvisende
- å få slettet personopplysninger om deg
- å sende klage til Datatilsynet om behandlingen av dine personopplysninger

Hvis du har spørsmål til studien, eller ønsker å vite mer om eller benytte deg av dine rettigheter, ta kontakt med:

- *Høgskolen i Innlandet* ved student Alexandr Karlsen, epost alexand.karlsen@gmail.com. Eller veileder Miranda Thurston, epost miranda.thurston@inn.no
- Vårt personvernombud: Usman Asghar Høgskolen Innlandet, usman.asghar@inn.no eller personvernombud@inn.no, 47 612 87 483
- Hvis du har spørsmål knyttet til vurderingen som er gjort av personverntjenestene fra Sikt, kan du ta kontakt via:
- Epost: personverntjenester@sikt.no eller telefon: 73 98 40 40.

Med vennlig hilsen Alexandr Karlsen

Prosjektansvarlig: Miranda Thurston Student: Alexandr Karlsen

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Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet *Understanding how economically vulnerable people interact with dental health services: A qualitative study in Norway*, og har fått anledning til å stille spørsmål. Jeg samtykker til:

- ☐ å delta frivillig i et semi strukturert intervju
- ☐ at intervjuet vil bli tatt opp av diktafon app
- ☐ at opplysninger om meg kan brukes i publisering (anonymisert)
- ☐ at mine personopplysninger lagres etter prosjektslutt, til å bevise at prosjektet har tatt sted og vil bli slettet etter 6 måneder januar 2025

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet

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(Signert av prosjektdeltaker, dato

Appendix D

Overview over the literature used in literature review chapter

Table D1

This table includes all the literature found and used under the affordability of oral health care services chapter.

Country	Author	Design	Participants	Result
USA	Brook., et al	Quantitively	Families up to age 61	The sickest and poorest 6% of sample had better outcomes under the free plan
Japan	Ono., et al	Quantitively	1108 Children under the age 10	There was no significant increase in the usage of clinics after introducing the subsidy
	Al Mugeiren	Literature Review	1663 studies	Marketing of oral health services is an important part in being a successful oral practitioner. Especially in the realm of price
Canada	Wallace & Mac	Qualitative	60 participants with low income (60), dentist (6) and social service providers (13)	The biggest barriers towards clinics were financial demands of dentistry and the cultural conflicts
Sweden	Molarius., et al	Quantitively	12235 people between the age of 16-84 were sent questionnaire where 5999 responded	A communality was found between participant that where unemployed, not born in Sweden and had disability reported a worse self-rated oral health.

Table D2

This table shows all the literature found and used under acceptability of oral health care chapter.

Country	Author	Design	Participants	Result
Mexico	Ortiz Barrios	Quantitively	234 older adults participated	Poor oral health is associated with bad OHRQoL in adults
	Spannenberg	Literature Reviews	5030 papers	The OHRQoL is a good tool in assessing a diagnosis, treatment plan and prognosis. It also speaks for the professional-patient relationship.
Brazil	Goulart	Quantitively	1943 persons	Clear relation between OHRQoL with the placements of teeth and their colouring
Canada	Wallace & Mac	Quantitively	60 participants with low income (60), dentist (6) and social service providers (13)	The biggest barriers towards clinics were financial demands of dentistry and the cultural conflicts
Unko	Mohamed & Robinson	Book	Na	Showing in detail why oral health is a public health issue.
USA	Nicoll	Qualitative	75 Parents above 18 years Michigan	Oral health was vital important for the participants, but the access to care was very bad only 8 had visited dentist in the last year, especially for the adults
USA	Castaneda., et al	Qualitative	19 Health Providers and 48 Migrant farmworkers in Florida	Great issue in patient literacy, prioritising the oral health to their children rather than themselves. Also citing to travel to

				Mexico to get cheaper treatment, with the greatest barrier being cost

Table D3

This table shows all the literature found and used under chapter Accessibility of oral health services.

Country	Author	Design	Participants	Result
Japan	Yamamoto., et al	Quantitively	5058 Participants	Proves that the distances is associated with visiting the dentist. Initiation of denture use because of the diet and change in accessibility
USA	Nicoll	Qualitative	75 Parents above 18 years Michigan	Oral health was vital important for the participants, but the access to care was very bad only 8 had visited dentist in the last year, especially for the adults
Canada	Wallace & Mac	Qualitative	60 participants with low income (60), dentist (6) and social service providers (13)	The biggest barriers towards clinics were financial demands of dentistry and the cultural conflicts
	Neutes	Literature Review	15 articles	In the present literature there are a lot of shortcomings when it comes to geographical access when it comes to oral health.
Norway	Grytten & Skau	Qualitative	Supplementary data from the education directorate and health directorate	It has shown that the individuals from lower social class have sought out higher education than before. This has led to further increase in oral health desire for the group.
Norway	Hovde., et al	Qualitative	141 participants both dentist and dental hygienist.	Treating a drug user patient is quite demanding because of fear, poor compliance and disagreements between what is necessary treatment and drugs user's expectations.

Table D4

This table shows all the literature found and used under the chapter quality of oral health care services.

Country	Author	Design	Participants	Result
EU (multiple Countries)	Nikoloski & Mossialos	Quantitively	26000 Participants	The richest households tend to have better perception of health care quality. Corruption tends to also impact the perception of quality on how transparent the country is.
	Spannenberg	Literature Reviews	5030 papers	The OHRQoL is a good tool in assessing a diagnosis, treatment plan and prognosis. It also speaks for the professional-patient relationship.
Norway	Grytten., et al	Quantitively	1237 Participants of dental practitioners	Practitioners in Norway do have few patients in private clinics. They do tend to recall more patient to their clinics up to 7 months on recall to have enough visits. Dentist who are not satisfied with number of patient charge 10 euros more for treatment.
USA	Northridge et al	Literature Review	Not Provided	To lower the gap between income group it was found there is a need for development of integrative technology and health care models that are design to serve people, families or communities of low income.