Paperless migrants and Norwegian general practitioners

BACKGROUND In Norway, the rights of paperless migrants are restricted. We wished to investigate the extent to which Norwegian general practitioners give treatment to this group and their grounds for doing so, as well as to identify the health problems that were presented.

MATERIAL AND METHOD In 2010, an online questionnaire was distributed to 3 994 general practitioners who were members of the Norwegian Medical Association.

RESULTS Altogether 1 027 GPs responded. Of these, 237 (23 %) reported to have treated paperless migrants. Mental problems, pregnancy-related issues and respiratory ailments were the most frequently reported reasons for contact. Of the 237 GPs who reported to have treated paperless migrants, altogether 166 (70 %) stated that they would continue to receive these patients.

INTERPRETATION The fact that most of the GPs who had treated paperless migrants would continue to receive this patient group and thus provide health services beyond this group's entitlements, we regard as a wish to comply with the Code of Ethics for Norwegian doctors.

Svein Aarseth
svein.aarseth@vikenfiber.no
Department of General Practice
Institute of Health and Society
University of Oslo

Trygve Kongshavn
Fjell Medical Centre
Drammen

Kjell Maartmann-Moe
Department of General Practice
Institute of Health and Society
University of Oslo
and
Norwegian Directorate of Health

Per Hjortdahl
Department of General Practice
Institute of Health and Society
University of Oslo

MAIN MESSAGE

General practitioners all over Norway have contact with paperless migrants

Approximately 70 % of the doctors who accept paperless migrants will continue to do so, irrespective of the reason for the contact

It has been estimated that in 2006 there were 18 000 paperless migrants in Norway (1). Rejected asylum applications or expired tourist visas are common reasons why people remain illegally in Norway. A total of 1.9–3.8 million paperless migrants are assumed to live within the EU (2, 3).

Like everybody else, these people need health services. Some suffer from chronic ailments, others are predisposed to illness because of a stressful life situation. The need for health services among paperless migrants represents a challenge to the health services. In 1972, Norway signed the International Covenant on Economic, Social and Cultural Rights, which was incorporated into Norwegian legislation through the Human Rights Act in 1999. The text of the convention states: «The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health» (4). This implies that health services shall be available, including financially.

Pursuant to the Patient Rights Act and the Regulations on prioritisation of health services, paperless migrants at the time of the survey were entitled to emergency help by the specialist health services, treatment of generally hazardous communicable diseases and serious mental disorders, as well as pregnancy care and health services for children.

Enquiries from paperless migrants may present the doctor with a moral dilemma – between the public instructions to supply restricted services on the one hand, and the requirement for provision of help to those who need it, as set forth by the medical code of ethics, on the other. We have little knowledge on how frequently doctors encounter these issues and how they address them.

We wished to learn more about the extent of contact between GPs and paperless migrants, who these doctors are and where they are located, and whether they provided any treatment beyond what is defined by the prevailing guidelines. We also wished to learn more about the paperless migrants and the reasons why they contacted a doctor.

Material and method

The study was undertaken in June 2010 as an online survey. We used Questback and sent two reminders. Experience from a previous and smaller mapping study (5) provided the basis for the questions, which were mainly in the multiple-choice format. The term «undocumented migrants», which is the most frequently used term internationally, was defined as illegal immigrants and paperless immigrants in the questionnaire (6). «Paperless migrants» is the most frequently used term in Norway and has therefore been used in this article.

The information on the doctor included gender, age, specialist status, size of the municipality, staffing of the medical centre and its affiliation to a health region. The distinction between the Southern Norway and Eastern Norway Health Regions was retained in order to provide a better basis for assessment of the geographical distribution. The doctors were also asked whether there was or had been an asylum reception centre in their municipality.

The doctors who received these patients were asked whether they received only those who were entitled to treatment or whether

they received this patient group irrespective of the reasons for contact.

The doctors were asked to report the gender, age, diagnosis, country of origin and the reason for paperless status, if possible, for the last patient they had treated or the last one they could recall.

The reason for contact was reported as an ICPC-2 diagnosis or in the doctor's own words. The latter were classified in accordance with ICPC-2 by one of the authors (7, 8). Because the material is small and the response rate low, no statistical analyses have been made. No personally identifiable information was collected, nor were any health registries used. We therefore considered an approval from the regional committee on medical and health research ethics to be unnecessary. Use of the Norwegian Medical Association's register was approved by the Norwegian Social Science Data Services (NSD).

More than 99 % of all Norwegian GPs are members of the Norwegian Association of General Practitioners (personal communication, Anders Taraldset, Norwegian Medical Association). Members with a registered email address were invited to participate. Those who had not practised medicine during the last six months were excluded after the first question.

There were 4 612 non-retirees with an address in Norway. Of a total of 4 561 members, altogether 4 098 were listed with an email address, but this proved functional only for 3 994. These received the questionnaire. Altogether 1 131 responded, whereof 1 027 of the 3 994 (26 %) had practised medicine over the previous six months. Women accounted for 39 % of the responses and 34 % of the non-responses. According to statistics from the Norwegian Medical Association, those who responded constitute a representative sample of the doctors (9).

Results

A total of 237 doctors (23 %) reported to have had contact with paperless migrants, whereof 153 had been contacted during the previous three months. The patients were in all age groups, although the majority were adults in the age group 19–66 years. The patients hailed from 40 different countries, the majority from countries in Africa or Asia. Men accounted for 59 %, women 41 %. Altogether 34 % of the doctors who had treated paperless migrants lived in municipalities with more than 50 000 inhabitants, compared to 26.1 % of the other doctors.

In each of Norway's health regions, approximately one-fourth of the respondents confirmed that they had been in contact with paperless migrants (range 17–26 %).

Of the 237 doctors who reported to have treated paperless migrants, altogether 166 (70 %) stated that they intended to continue receiving these patients – irrespective of their type of health problem. Of the remaining 71 doctors, 52 had provided emergency help to patients, 17 had treated patients with a suspected generally hazardous communicable disease, and 17 had treated patients with a serious mental disorder. A further 16 had treated/examined pregnant women, and 10 had treated children.

The reason for contact refers to the last contact the doctor had or could recall having had with a paperless migrant and is reported in 160 cases. In 120 of these cases, the doctor had been in such contact during the last three months. Mental disorders accounted for 29 % of the cases, with anxiety, depression and post-traumatic stress disorder as the main diagnoses. Altogether 14 % of the patients suffered from pregnancy-related issues, 11 % had respiratory disorders and 8 % were registered as «general and unspecified» (of which infections constitute a major group). Among those 48 patients for whom the doctor reported that their asylum application had been rejected, 50 % suffered from mental problems.

Discussion

Undertaking research on paperless migrants is a challenging task. They are afraid, live in hiding, do not appear in any statistics and often have poor Norwegian language skills. If we as doctors wish to improve the provision of health services to this marginalised patient group, we need better knowledge about it. Previous studies have largely been based on mapping studies undertaken in non-public health clinics that are frequented by paperless migrants (10–12).

With the aid of the membership register of the Association of General Practitioners we were able to reach virtually all Norwegian GPs to ask them about their experience of paperless migrants. This approach has provided us with new insight into the contact that Norwegian GPs have had with this group, but the method has weaknesses. Although nearly 100 % of all Norwegian GPs are members of the Association of General Practitioners, we had no functioning email address for 10 % of them, and another 20 % were temporarily absent from their practice and could thus not be invited to participate in this study.

Paperless migrants seek health assistance all over Norway. In our study, GPs in all health regions report to have had contact with paperless migrants. This finding contrasts with the findings made by a Dutch study from 1997, which indicated that GPs in poor regions in the major cities are those who primarily have contact with this patient group (13). One practical outcome is that Norwegian GPs all over the country must expect to encounter this patient group, not only those in urban regions. The mapping also encompassed the GPs' use of interpreters. The results from the questions pertaining to the use of interpreters have been published in a previous article (9).

In light of this study, Norwegian GPs seem to encounter the same health problems in paperless migrants as those faced by doctors in other parts of the world (11, 12). These primarily include mental problems, to which a stressful life situation before the arrival in Norway, the stay in a reception centre and life as a paperless migrant may be contributing factors. In our study, the doctors reported that 50 % of those whose asylum application had been rejected contacted them due to mental issues, compared to 29 % for the group as a whole, but these figures are fraught with considerable uncertainty. In a Swedish study, the prevalence of anxiety, depression and suicidal thoughts was ten times higher among paperless migrants than in the Swedish population in general (10). An overview of migration and mental health in Europe indicates that when compared to the general population, there is an elevated prevalence of schizophrenia among migrants and refugees, and among paperless migrants in particular. Anxiety, depression and post-traumatic stress disorder are common diagnoses (11).

In 2007, Doctors of the World (Médecins du Monde) conducted a mapping study in which 835 doctors from nine European countries participated (12). Digestive disorders, «general and unspecified» and musculoskeletal afflictions were the problems with which paperless migrants were diagnosed. This indicates that this group suffers from many of the same health disorders as the general population (14).

Regulations adopted in 2012 stipulated the rights of paperless migrants to health assistance (15). These were later replaced by the *Regulations on the right to health and care services for persons not permanently resident in the realm*, which grants the right to emergency care and necessary health care that cannot be delayed, as well as health assistance for pregnant women, children and people with serious mental disorders. The patients must pay for these health services themselves.

As we see it, there is no political will today to grant this group of people regular access to health services. There are national and local guidelines for handling of asylum seekers, refugees and those who have been granted family reunification, but none for how paperless migrants should be addressed. As a member of the Schengen Agree-

ment, Norway's commitments with regard to asylum seekers remain unchanged, meaning that the results of this mapping study are still relevant. At the time of mapping, our neighbouring countries maintained similar restrictions, whereas other countries, including Spain and Italy, granted more rights to documented migrants (2).

The response rate in this study was low, at 28 %, but approximately as expected for an electronic survey (16, 17). Altogether 23 % of the respondents reported to have treated patients who were illegally resident in Norway. In our study in 2007 (5), the response rate was 37 %. The higher response rate on that occasion may have come as the result of a shorter questionnaire. Then, 43 % reported to have treated patients who were not legally resident.

We may reasonably assume that GPs who have a positive attitude to treating paperless migrants have been more inclined to respond to the survey than doctors who do not share this positive view. The study is retrospective, and thus involves a possibility of recall bias. These factors and the relatively low response rate indicate caution in drawing any general conclusions from our findings. We nevertheless believe that they provide useful information about this patient group.

The paperless migrants' right to health services is also a political topic. Many politicians find it unacceptable that this group is denied health services on an equal footing with Norwegian residents (18). The political parties, including the government coalition parties, do not share this view and use limited health rights as an instrument in immigration policy (19–21).

Norwegian doctors are bound by their medical oath and the Codes of Ethics of the Norwegian Medical Association and the World Medical Association (22). The rules affirm that doctors shall provide health services according to need, irrespective of the patient's civil or political status. In our study, altogether 70 % of the doctors who had treated paperless migrants indicated that they would continue to receive this patient group, irrespective of the health problems they present with. The remaining 30 % would only treat this group in accordance with the prevailing guidelines. We did not pose this question to those who had not treated any paperless migrants, so we have no knowledge of their attitudes in this respect.

At the time of the mapping, the legislation and regulations were open to interpretation. Whether or not paperless migrants will receive general medical help will often depend on the attitudes of each individual doctor with regard to Norwegian immigration policy and his or her assessment of medical ethics – a situation that frequently presents the doctor with a moral dilemma (23). A qualitative study conducted in Norway corroborates this view (24). The way in which the doctor-patient relationship is handled depends on the doctor's ethical considerations, set alongside the commitments laid down in international conventions.

The fact that health services for paperless migrants have been established by non-governmental organisations must also be regarded as indicating that this group's need for health services is not being met by the public providers. When this study was conducted, a low-threshold clinic had opened in Oslo under the auspices of the Church City Mission and the Red Cross. In Bergen, a clinic opened in 2014. In other regions of the country, however, this group remains reliant on contacting GPs or emergency rooms to access normal health services.

Conclusion

Paperless migrants constitute a small, marginalised patient group found in all of the country's regions. Altogether 23 % of the GPs who responded to our survey had received and treated this group, and 70 % of these intended to continue to receive these patients irrespective of their health needs. In other words, they would provide health services in excess of the entitlements granted to this group by legislation and regulations. The remaining 30 % would only provide treatment in accordance with the prevailing guidelines.

Health services to paperless migrants give rise to crucial questions of a medical, ethical and political nature that require better insight and more research, professional and political discussion, and humanitarian action.

We wish to thank the Norwegian Medical Association and the Association of General Practitioners for their forthcoming attitude, as well as Lisbeth Kongsvik for her important assistance with the Questback survey. This work was supported by a scholarship from The Norwegian Research Fund for General Practice.

Svein Aarseth (born 1950)
specialist in occupational medicine and general practice and GP.
The author has completed the ICMJE form and declares no conflicts of interest.

Trygve Kongshavn (born 1953)
specialist in general practice and GP.
The author has completed the ICMJE form and declares no conflicts of interest.

Kjell Maartmann-Moe (born 1951)
specialist in general practice and senior adviser.
The author has completed the ICMJE form and declares no conflicts of interest.

Per Hjortdahl (born 1946)
specialist in community medicine and professor of general practice.
The author has completed the ICMJE form and declares no conflicts of interest.

References

1. Zang L-C. Developing methods for determining the number of unauthorized foreigners in Norway. Rapport nr. 11/2008/. Oslo: Statistisk sentralbyrå, 2008. www.ssb.no/a/english/publikasjoner/pdf/doc_200811_en/doc_200811_en.pdf (22.4.2016).
2. Access to health care for undocumented migrants and asylum seekers in 10 EU countries. Rapport. Paris: Huma network, 2009. www.epim.info/wp-content/uploads/2011/02/Legislative-Rapport-HUMA-Network.pdf (22.4.2016).
3. Carrera S, Merlino M. Undocumented immigrants and rights in the EU. Rapport. Brussel: CEPS (Centre for European Policy Studies), 2009. https://core.ac.uk/download/files/213/5087071.pdf (22.4.2016)
4. International covenant on economic, social and cultural rights. Genève: FN, 1966. www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx (22.4.2016).
5. Aarseth S, Kongshavn T, Kristiansen O. Går papirløse innvandrere til allmennlege? Utposten 2009: nr. 4: 7–11.
6. Biffl G. Definitions and methods of estimation of undocumented migrants. I: Biffl G, Altenburg F, red. Migration and health in nowhereland. Bad Vöslau: Omnium, 2012.
7. Okkes I, Jamoulle M, Lamberts H et al. ICPC-2-E: the electronic version of ICPC-2. Differences from the printed version and the consequences. Fam Pract 2000; 17: 101–7.
8. ICPC-2. International Classification of Primary care. Oxford: Oxford University Press, 1998.
9. Legestatistikk. http://legeforeningen.no/Emner/Andre-emner/Legestatistikk/ (22.4.2016)
10. Gömda i Sverige. Utestängda från hälso- och sjukvård. Stockholm: Läkare Utan Gränser, 2006. www.temaasyl.se/Documents/Organisationer/MSF/StudieGomdaSverige.pdf (22.4.2016).
11. Eick F. Årsrapport 2015 – om det skjulte helsebehovet. Oslo: Kirkens bymisjon, 2015.
12. Chauvin P, Parizot I, Drouot N et al. European survey on undocumented migrants' access to healthcare. Paris: Médecins du Monde, European Observatory on Acces to Health Care, 2007.
13. Reijneveld S, Verheij R, van Herten L et al. Contacts of general practitioners with illegal immigrants. Scand J Public Health 2001; 29: 308–13.
14. Woodward A, Howard N, Wolffers I. Health and access to care for undocumented migrants living in the European Union: a scoping review. Health Policy Plan 2014; 29: 818–30.
15. Forskrift om rett til helse- og omsorgstjenester til personer uten fast opphold i riket. https://lovdata.no/dokument/SF/forskrift/2011-12-16-1255 (22.4.2016).
16. Eysenbach G. Improving the quality of Web surveys: the Checklist for Reporting Results of Internet E-Surveys (CHERRIES). J Med Internet Res 2004; 6: e34.
17. Sheehan KM. E-mail survey response rates: a review. J Comput Mediat Commun 2001; 6: 2.
18. Skille ØB. – Politiet må ta dem. www.nrk.no/norge/--politiet-ma-ta-dem-1.6454439 (22.4.2016).
19. Cuadra CB. Right of access to health care for undocumented migrants in EU: a comparative study of national policies. Eur J Public Health 2012; 22: 267–71.

>>>

20. Vernon G. Denunciation: a new threat to access to health care for undocumented migrants. Br J Gen Pract 2012; 62: 98–9.
21. de Zulueta P. Asylum seekers and undocumented migrants must retain access to primary care. BMJ 2011; 343: d6637.
22. Statement on medical care for refugees, including asylum seekers, refused asylum seekers and undocumented migrants,and internally displaced persons. New York, NY: World Medical Association, 2010.
23. Dauvrin M, Lorant V, Sandhu S et al. Health care for irregular migrants: pragmatism across Europe: a qualitative study. BMC Res Notes 2012; 5: 99.
24. Hjelde KH. «Jeg er alltid bekymret». Rapport nr. 1/2010. Oslo: Nakmi (Nasjonal kompetansenhet for minoritetshelse), 2010.

Received 17 October 2014, first revision submitted 30 May 2015, accepted 22 April 2016. Editor: Lars Frich.