

Undocumented immigrants and the experiences of Norwegian general practitioners with this group of patients

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Preface

During my internship in autumn 2007 at the Norwegian Medical Association I worked in a department of Public Affairs and Health Politics, where I began a work with a 2008 status report. The report was about non-western immigrants and the health services available for this type of patients in Norway. I got a position in a status report working group and got my topic, which later extended into my master thesis. Thus, the present master thesis investigates the problems of undocumented immigrants in getting the access to health care services. It analyzes the experiences of Norwegian GPs in dealing with this particular group of patient. The data used in our analysis was collected and later presented to us by the Oslo Medical Association. I sincerely hope that it will be read, and its implications and conclusions used to improve the access of undocumented migrants to health care services in Norway.

Acknowledgements

I would like to express thanks to the nice people working at the Norwegian Medical Association (Den norske legeforeningen), Department of Public Affairs and Health Politics for their help: Terje Sletnes, Matias Nissen-Meyer and Anjam Latif Shuja. To Svein Aarseth and Trygve Kongshavn (Den norske legeforeningen, OSLO), thank you for the data. To Karin Harsløf Hjelde (researcher in NAKMI, Dr. philos./social anthropology and medical demography NAKMI), for being my second- supervisor and for interesting discussions about undocumented immigrants in Norway. Particular thanks go to my supervisor - Ivar Sønbo Kristiansen (MD PhD MPH The Institute of Health Management and Health Economics, University of Oslo) - for his original and constructive criticism. Finally, I am grateful for great help and support from my friend Mark Rubtsov.

ABBREVIATIONS AND ACRONYMS

CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
CEEC	The European Committee of Construction Economists
ECHR	European Convention of Human Rights
EEC	European Economic Community
EUROSTAT	Statistical Office of the European Communities
EUROPOL	European Law Enforcement Organisation
EU	European Union
GCIM	Global Commission on International Migration
GP	General practitioner
ICERD	International Convention on the Elimination of all forms of Racial Discrimination
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICMW	International Convention on the protection of the rights of all Migrant Workers and members of their families
IOM	International Organization for Migration
MSF	Medecins sans Frontieres (Doctors without borders)
NAV	The Norwegian Labour and Welfare Administration (Ny arbeids- og velferdsforvaltning)
NAKMI	Nasjonalt kompetanse- og forskningsnettverk for minoritetshelse (Norwegian Centre for Minority Health Research)
NGO	Non-governmental organization
NMA	Norwegian Medical Association (Den Norske Legeforening)
OAS	Organization of American States
OECD	Organization for Economic Cooperation and Development
PICUM	Platform for International Cooperation on Undocumented Migrants
SOPEMI	Systeme d'Observation Permanente sur les Migrations (International Migration Outlook)
UN	United Nations
UDHR	Universal Declaration of Human Rights
UDI	Utlendingsdirektoratet (The Norwegian Directorate of Immigration)
WHO	World Health Organization
(Author,year)	Reference
word^a	Footnote

Abstract

Background: One of the consequences of the increased migration activity is the growth in the number of undocumented immigrants. Many of them end up living in difficult life conditions and require health care. Some, such as war refugees, bring psychological and other traumas with them when arriving at their destination country. During the last decade there has been a growing amount of research in the area of migration and health. However, not many results are available for Scandinavian countries, Norway in particular. More specifically, there exist few research results regarding the phenomenon of undocumented immigrants in Norway, and no results at all concerning the experiences of general practitioners in dealing with this group of patients.

Methods: In November 2007, the Norwegian Medical Association, in cooperation with representatives of the municipalities of Oslo, Drammen and Lier, undertook a questionnaire survey of registered and non-registered GPs in the fore mentioned municipalities. The questionnaire was sent for 580 respondents. In total, 215 out of 580 GPs (38%) returned a completed questionnaire. The response rate varied from 34% in Oslo to 56% in Drammen and Lier, and it was 36 % among registered GPs and 47 % among unregistered ones. The data were analyzed by means of frequency tables and contingency tables. Differences between groups were tested by means of Pearson's chi-square test, a G-test or the Fisher's exact test. The analyses of the data were performed in Excel and SPSS (Statistical Package for the Social Sciences).

Results: GPs that saw more "non-western" patients also saw undocumented immigrants more often; somatic sickness, mental illnesses and infections were the most common problems of undocumented immigrants who contacted GPs; non-registered GPs saw more patients with undocumented immigrant status, than registered GPs did; undocumented immigrants chose to come to particular doctors, because those doctors had been recommended to them by others; there was no association between the perceived level of medical competence and the perceived difficulty to refer patients to higher levels of care; the location of the GPs' office did not matter for how many undocumented immigrants sought GP's help; GPs did not receive any payment for their services delivered to undocumented immigrants in one third of the cases, whereas in other cases either the patient himself or the patient's relative/other person paid for the medical services in full, or the check was sent to the NAV.

Interpretation/conclusion: The results of this study indicate that there is a clear need to organize a better access of undocumented immigrants to health care services. That would be in the interest of both the immigrants and society in general.

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1. Introduction

The recent trends in globalization indicate a sharp increase in the number of immigrants in economically developed countries. According to the International Organization of Migration, in 2003 one of every 35 persons in the world was a migrant. In the last decades, Western Europe has been a popular destination of migration flows. Economic wellbeing, in particular in the Nordic countries, has been one of the most important factors attracting foreigners.

One of the consequences of the increased migration activity is the growth in the number of undocumented immigrants. Every year thousands of migrants arrive at the EU countries and decide to stay there without any legal authorization. Many of them end up living in difficult life conditions and require health care assistance. Some, such as war refugees, in addition carry psychological and other traumas with them when arriving at their destination country. At the same time, the legal status of this group of migrants prohibits them from obtaining a regular access to health care facilities. The fact that these people are undocumented makes it impossible to assess their health conditions with any degree of certainty. This constitutes a considerable problem for undocumented immigrants and creates a potential risk for society as a whole.

During the last decade there has been a growing amount of research in the area of migration and health. However, not many results are available for Scandinavian countries, Norway in particular. More specifically, there exist few research results regarding the phenomenon of undocumented immigrants in Norway, and no results at all concerning the experiences of general practitioners in dealing with this group of patients. In my thesis I attempt to shed light on these problems. The thesis will first analyze the causes and the extent of migration, as well as the concept of undocumented immigrants. It will then look into the living conditions of the undocumented immigrants and discuss the legal their rights to health care. Finally,

the thesis will provide an analysis of opinions and experiences among some Norwegian GPs with providing health care to undocumented immigrants.

The plan of the paper is the following. Chapter 2 introduces the reader to the general background for the topic of this research. It provides a brief outlook of the motives and roots of migration both worldwide and in especially Europe. It explains who exactly the undocumented immigrants are, the general reasons for the increase of such immigrants in Norway, as well as their typical living conditions, including their health situation. Chapter 2 concludes with an overview of the international conventions on human rights, as well as the relevant acts of the Norwegian legislation concerning the rights to health. Chapter 3 describes the scope of the research and sets the study objectives. It includes a detailed description of the research hypothesis which are investigated in the later chapters. Chapter 4 presents the statistical data on which the later conclusions are based. It also describes the statistical methodology used to analyze the data. Research results are presented and discussed in Chapter 5. Finally, Chapter 6 concludes the paper.

2. Background

This chapter is a summary from the relevant literature on the subjects of migration and the rights to health.

"In 2000, the global number of international migrants, defined as someone who lives in another country than in which he or she was born, was 175 million, or one out of every 35 persons in the world. This number represented more than a twofold increase from 76 million in 1960. By comparison, the world population only doubled from 3 billion in 1960 to 6 billion in 2000. As a result, international migrants represented 2.5 per cent of the world population in 1960 and 2.9 per cent in 2000" (International organization of migration, 2003).

In Europe, the number of international migrants also increased significantly, particularly in the 1990s. "Between 1970 and 2000, their numbers rose from 19 million to 33 million, and their share of the total population increased from 4.1 per cent to 6.4 per cent. Excluding all former Communist countries from Europe, the migrant stock increased from 10 million in 1970 to 29 million in 2000" (International organization of migration, 2003).

2.1 Why do people migrate?

Any migration process begins from the "decision" of the migrant to leave his or her home country. Whatever the underlying motives of migrants are, organizations that maintain contact with them on a daily basis agree that they indeed have strong reasons to be in Europe. (World Bank, 2006)

The motivations for migration may be described as combinations of social, cultural, economic and political factors. Additionally, these factors can be characterized as "push" and "pull" factors – the negative factors at the migrant's home country that

force him to leave, and the attractive factors at the destination country that compel him to migrate. (Table 2.1.1).

Table 2.1.1 Migration factors

Motives for Migration	Push factors	Pull factors
Economic and demographic	Poverty, unemployment, low wages, high fertility rates, lack of basic health services and education	Prospects of higher wages, potential for improved standard of living, personal or professional development
Political	Conflict, insecurity, violence, poor governance, corruption, human rights abuses	Safety and security, political and religious freedom
Social and cultural	Discrimination based on ethnical, gender, religious or other differences	Family reunification, ethnic homeland (diaspora migration), freedom from discrimination

Source: World Bank

Generally, the decision made by individuals to leave their homelands and migrate abroad, is based on a number of factors rather than one simple reason. In particular, several features of today's globalization increase migration pressures: (1) armed violence; (2) ethnic and racial conflict, (3) globalization of the free market economic model, (4) environmental degradation, (5) development-induced migration, (6) denial of democracy, and (7) large-scale corruption. We study these factors in more detail below. Based on the "Book of Solidarity" (PICUM, 2003)

(1) Armed Conflict; a Pervasive "Culture of Violence"

According to the UN, in 2003 there were about 40 major armed conflicts (defined as those with deaths exceeding 1 000 during the course of the conflict). The number of armed conflicts with death toll below 1 000 is estimated to be somewhere between 75 and 150. Two significant characteristics of wars today are that they are generally waged within countries, and that they cause a big number of civilian deaths.

(2) Ethnic and Racial Conflict

Most existing states are inhabited by people of various nationalities, having different ethnic, linguistic, cultural and religious traditions. Some 40% of the world's countries have five or more different ethnic groups. This may be attributed to some extent to past migrations and sometimes to the consequences of the colonial rule. Recently there has been an increase in the number of armed conflicts in which the insurgents attempt to re-divide territories and create new states based on single-ethnic identities. The resultant "ethnic cleansing" and the expulsion of people of other ethnic origins have become major causes of forced human displacement today. One should notice however, that behind ethnic or national identity struggles are usually basic economic and social disparities that need to be resolved.

(3) Globalization of the Free Market Economic Model

"Globalization" has become a common term in describing the trends and initiatives restructuring national and international economic life. These initiatives focus on global integration of economic activity, including production, services, marketing and consumption of goods. A major component of globalization is the elimination of restrictions on the free movement of capital, goods, resources, technology, and services, but not of labor. It is asserted that globalization will improve economic growth and living standards in both developed and developing countries.

(4) Environmental Degradation and Disasters

Migratory consequences of the destruction of the environment are beginning to become evident. Every year around eight million acres of forest disappear. It is estimated that at least 25 million people (i.e., 1 in 225 individuals worldwide) could now be considered environmental migrants. They generally migrate within their own countries in search of a new place of settlement that has better environmental conditions. Environmental migrants can be divided into three broad categories: those temporarily displaced because of local disruptions or natural disasters, such as volcanic eruptions and earthquakes; those who migrate because environmental degradation poses considerable risks to health; and those who resettle because of

permanent changes of their habitat. The latter are the fastest growing population of the displaced people. Environmental factors for migration fall into four categories: land-use abuse, global warming, militarization and armed conflicts (manufacturing, testing and the use of weaponry in “peacetime” military exercises and during war have serious effects on the environment), and disasters.

(5) Development-Induced Displacement

It is now acknowledged that migration can be a direct result of misdirected economic development. While the consequences of the latter may not be immediately life-threatening, they may still constitute a very strong reason for migration. The interrelationship between the effects of industrial development on the environment and the displacement of people from their homelands is becoming of increasing concern. Many environmental and development factors need to be taken into account when considering industrial development projects. Among the important factors are the socio-economic effects of forced displacement, flooding of large land areas by dams, and projects involving the development of the areas considered “unpopulated” - usually forest or savannah lands inhabited by indigenous people who then are displaced.

(6) Denial of Democracy

Oppression, tyranny and violations of human rights remain a global problem. The 1996 annual Amnesty International report identifies two global trends that undermine efforts to establish government accountability to comply with international human rights standards. The first is the proliferation of human rights abuses associated with armed conflicts. Torture and arbitrary killings often becomes tools that are used to gain political advantage. The second is the rapid technological development of new security equipment, which spreads quickly around the world.

(7) Abuse of Power/Corruption

Part of the answer to understanding the conditions that have caused millions of people to migrate is recognizing the connection between the appropriation of public resources for private profit and the loss of those resources to meet the basic development needs of the public (PICUM, 2003).

2.2 Routes of migration

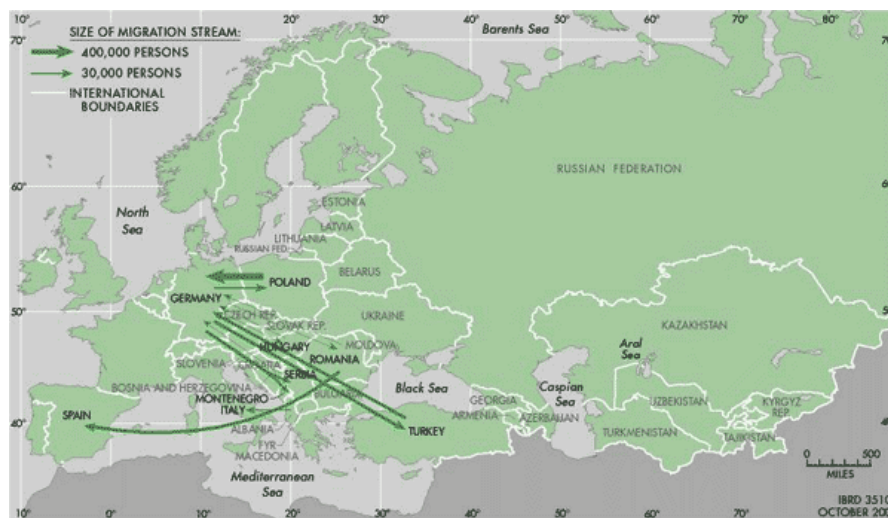
The most common directions for migration are north and west; from poorer, less-developed countries to the more economically and politically stable countries in the West. These account for all of the major migration movements of the last few years, including from the Former Yugoslavia, Afghanistan, Iraq and China.

According to The World Bank group report “Overview of Migration Trends in Europe and Central Asia, 1990–2004”, two migration systems have emerged in the Europe and Central Asia region since the collapse of the Soviet Union: 1) Flows from the former Soviet republics to Russia (map 2.2.1) 2) Flows from Central and Eastern Europe to Western Europe (map 2.2.2)

Map 2.2.1 Flows from the Soviet republics to Russia



Map 2.2.2. Flows from Central and Eastern Europe to Western Europe



Source: Data are from World Bank staff estimates for the period 2000-2003.

2.2.1 Migration in Europe

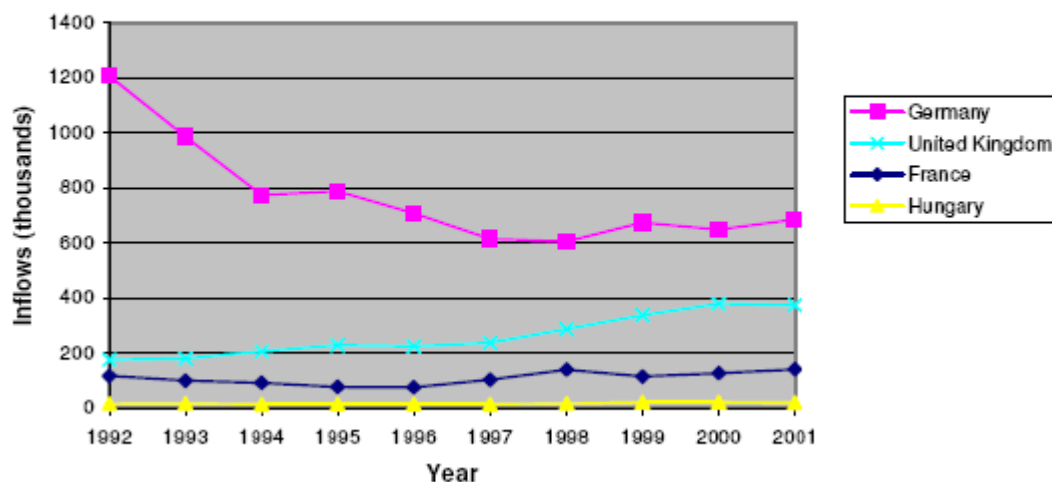
All European states are now net immigration countries. For more established host countries such as France, Germany, the United Kingdom (UK), Benelux countries, Austria, Switzerland, Sweden and Denmark, this has been the case since at least the 1960s. Despite a decline in migration after recruitment stops in 1973-74, immigration flows have been continuous, for the most part taking the form of family reunion, refugee flows and special labor migration. Most countries have experienced particularly high levels of immigration since the 1990s.

Austria, France, Germany, the Netherlands, Switzerland, the UK and Nordic countries are all examples of this trend. A notable exception is Germany, which has seen a decrease in flows since the early 1990s, although this can be attributed to the exceptionally high levels of influx in the early 1990s (OECD, 2007).

A second category of European countries became net receiving countries in the 1980s, in large part because of growing economic prosperity (Ireland, Spain, Portugal, Greece, Finland), as well as a redirection of migration flows following the introduction of more restrictive policies in north European receiving countries. These countries have also experienced increased immigration since the 1990s, with recent

inflow of labor migrants to Ireland, Italy and Portugal being particularly pronounced (Diagramm1).

Diagramm 1: Comparison of inflows of foreign population in selected European countries, 1992 - 2001
(source: OECD 2004)



Source: Global Commission on International Migration (GCIM, 2004)

Thirdly, in a similar development – but two decades later – a number of CEECs have now become host countries. After 1989, Estonia, Latvia, Lithuania, Romania, Poland, Czech Republic, Hungary and others former socialist countries on the EU's eastern borders became important transit countries for migrants attempting to enter more prosperous west European host countries. This pattern has persisted in the case of EU candidate countries and associated states in Southeast Europe. But for most of the countries that recently joined the EU, economic growth and political stability have rendered them countries of destination in their own right. Cyprus, Hungary, the Czech Republic, Slovakia and Slovenia have had positive net migration since 2001 (GCIM, 2004).

2.2.2 Migration in Norway

During 2006, the number of persons registered as living in Norway increased by almost 41,000. The number of persons who moved into Norway in 2006 was almost 24,000 higher than the number who left. The birth surplus led to an increase in

Norway's population by 17,300 people in 2006. In 2006, Poland, Afghanistan, Iraq, Lebanon and Somalia in particular stood out, either by attracting media attention or because of the number of applicants, or both (UDI, 2006). The immigrant population is now nearly 460 000. This group accounts for 9.7 per cent of Norway's population. Broken down by country, 56 000 are immigrants from other Nordic countries, 57 000 come from other countries in Western Europe and North America, 48 000 from the ten new EU-countries in East Europe, 52 000 from the rest of Eastern Europe, and 246 000 come from Turkey and countries in Asia, Africa and South America. (Statistisk sentralbyrå, 2008)

2.3 Types of immigrants

The number of permits granted does not, tell us how many foreign nationals arrive in Norway or who is staying here, for several reasons:

- Visitors who come to Norway from the EU and EEC for less than three months do not need a permit
- Some of those who have been granted a permit do not use it (for example, due to illness).
- Some applicants receive more than one first-issue permit, for example by applying for a family immigration permit after having first been granted a study or work permit.
- Citizens of the Nordic countries do not require a permit from, or to be registered by, the immigration authorities.
- EU nationals can stay in Norway as jobseekers for six months without a permit
- A visa granting entry into Norway may be issued by any country participating in the Schengen agreement. (UDI, 2006)

2.3.1 Illegal migration\undocumented migrants

2.3.1.1 Europe

According to the Europol's estimates, around 500 000 persons enter the European Union illegally every year. (W. Bruggeman EUROPOL 2002). Statistics published by EUROSTAT show that 38% of the 54 428 illegal immigrants apprehended in the European Community during the third quarter of 1999 had entered the EU through Italy, followed by France (23%) and Spain (18%). In 1998, 40 201 were apprehended after illegally entering Germany; 16 500 in the UK and about 91 000 in Italy (Delaunay and Tapinos 1998; Hilderink et al. 2003).

There are many different situations that can cause an individual to become undocumented. Migrants may be rejected asylum seekers, rejected candidates for family reunification, labor-migrants without residence permit (foreigners who lose their labor/annex residence permit after their work contract expires), students who have expired their study permit, tourists who have overstayed their tourist visa, embassy staff who have lost their diplomatic/consular status through dismissal or other circumstances, etc. (SOPEMI, 2007)

Many other distinctions can be made, for instance between migrants who willingly choose an irregular status, and those who have been forced to this situation. Indeed, many undocumented migrants do not intend to live irregularly, but are tempted, forced or trapped (IOM, 2005). Individuals who come to Europe with the intention of legally obtaining a residence permit are often discouraged by all the difficulties this brings about. For example, the fact that one is not allowed to work as long as any claim for a residence permit is pending, seems to tempt many people to give up their procedure, find a job in the informal labor market, and assume daily life as an undocumented migrant (IOM, 2005). Some people's asylum claims are rejected, but these individuals claim serious and well-founded fears of returning to their home country, and are forced to remain in the country illegally. In some countries in Europe no status is foreseen for people who wish to return but are no longer allowed

entry by their country of origin, ex. Ethiopia. Individuals who resort to trafficking organizations as a means to flee face a very particular situation. These include children who are sold to trafficking organizations, and women attracted by false promises of a bright future. They often find themselves in desperate situations. They did not choose a life in illegality and are unwilling and unable to cope with the very hard survival conditions

Jörg Alt (1999) distinguishes two main types of undocumented migrants: those who have decided to remain in Europe on a permanent basis, and those who keep their center of life in their country of origin while commuting to and from Europe regularly. Alt's research reveals that the biggest groups of undocumented migrants present in Germany are "undocumented refugees" and "undocumented workers"¹, and to a lesser extent individuals who come to Europe for family reunification. Undocumented refugees mainly consider their host country as their new center of life. It is not surprising that refugees consider the return to their country of origin impossible, as they do not see a perspective for the future. Accordingly, their fear of discovery and expulsion is very high and they make every effort to remain hidden and inconspicuous. Migrants who are in Europe due to family reunification usually plan to stay for an indefinite period of time. On the contrary, according to Alt, many of the undocumented workers still consider their center of life to be in their country of origin. Their motivations for migration are material needs. Many of them are married and have relatives who are still living in their home country. A common example is of individuals who have work in their country of origin but can barely earn a living. A considerable group of people migrates to Europe only temporarily to earn enough money to carry out a major undertaking, such as building a house. These migrants still have their center of life in their country of origin and therefore commute occasionally between their country of origin and their place of employment.

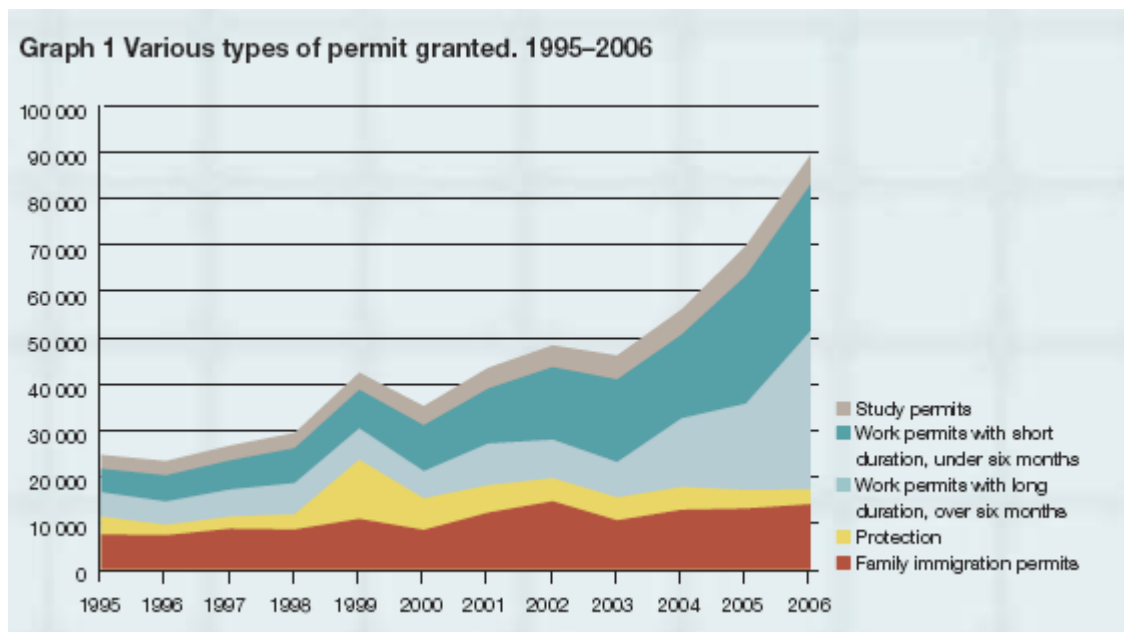
¹ The term "undocumented refugees" refers here to rejected asylum seekers (individuals who have applied for political asylum but who have been refused) as well as undocumented migrants who have not applied for asylum but who may face persecution upon return to their country of origin. The term "undocumented worker" refers to employed individuals who do not have a legal residence permit to reside in the country and/or do not have a legal working permit.

They are less afraid of discovery and deportation, and because of various reasons they achieve re-entry into Germany rather easily.

2.3.1.2 Undocumented immigrants in Norway

This thesis will focus on people who are staying in the country illegally (Graph 1, adapted from UDI annual report 2006):

- *Persons who have been granted visa or resident permit on false grounds.*
- *Persons who have been granted a valid visa or resident permit which has expired.*
- *Asylum seekers whose applications have been rejected finally and have not left the country.*
- *Persons who have entered the country without a permit and are not registered anywhere in the Norwegian system*



Source: UDI 2006

Whichever method of assessment is used, estimated numbers of irregular migrants are based on assumptions. The fact remains that irregular migration is, by its very definition, unquantified and, indeed, largely unquantifiable (GCIM, 2005).

Facts and figures concerning the extent of irregular migration in Norway, both entry and residence, are limited (SOPEMI, 2007). However, we know that the problem exists, particularly in the major cities with a relatively large proportion of immigrants and less social transparency.

Each year a significant number of asylum seekers, many of them having their application rejected, leave the reception centers without providing a forwarding address. Of those who left in 2006, 1 520 had not returned to a centre by November 2007, 25 % fewer than in 2005 (UDI, 2007). Some may have returned to their home country, some may have moved to a third country and some may have stayed in Norway illegally to make a living through work, criminal acts or supported by friends or relatives.

The police have arrested a number of undocumented migrants working illegally during coordinated controls of various businesses, especially on construction sites and in shops and restaurants. Some of these illegal workers are former asylum seekers, while others have come directly to work, neither applying for asylum nor for a work permit (SOPEMI, 2007).

Those apprehended are expelled if there are no legal obstacles, and 830 persons were arrested for staying illegally in Norway during 2006. 690 persons were rejected at the border or after entry in 2006, only slightly fewer than the previous year. There were almost 1400 expulsions, a small increase from 2005. Expulsions also include convicted criminals (SOPEMI, 2007). These data are summarized in Table 2.3.1.2.1

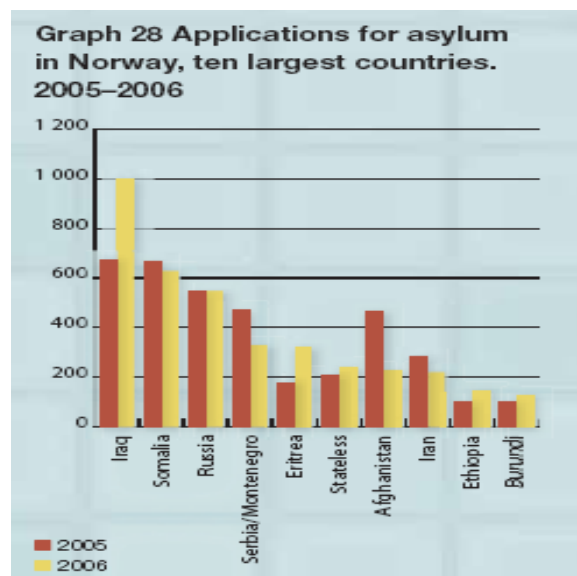
Table 2.3.1.2.1. Rejections and expulsions. 2001 - 2006

Sanction	2001	2002	2003	2004	2005	2006
Rejection –at entry	1619	1907	1712	1041	637	651
Rejection - later	219	102	137	108	70	38
Expulsions	(unav.)	(unav.)	1141	1260	1274	1379

Source: UDI

2300 foreigners were returned involuntarily from Norway by the police during 2006, a further reduction from 3000 in 2005. 56 % of them were asylum seekers, who were handled according to the Dublin procedure or former asylum seekers whose applications had been rejected. In the remaining group criminals and other categories are included. During the first nine months of 2007 the number returned involuntarily reached 1600 (UDI, 2006).

In 2006, the predominant group of asylum seekers in Norway came from Iraq, Somalia, Russia, Serbia, Eritrea, Afghanistan, Ethiopia and Burundi (see Graph 28. Source: UDI, 2006).



Source UDI, 2006

2.3.1.3 Working conditions for undocumented immigrants

“Migrant workers often do work which is considered dirty, dangerous, and degrading (the so-called “3-D jobs”). Moreover, given their precarious legal position in the country of destination, undocumented immigrant workers are highly vulnerable to abuse and exploitation by employers, migration agents and criminal gangs. Undocumented workers are exploited in all of the countries that make up the European Union” (PICUM, 2001)

Undocumented migrants may be forced, through necessity, to take up employment in unregulated and therefore potentially dangerous industries. Working in industries such as construction and agriculture are physical demanding jobs leaving one prone to injuries and musculoskeletal conditions. For women working as prostitutes there is an increased risk of contracting sexually transmitted diseases. As undocumented immigrants do not have a personal identification number, which is needed to work legally in Norway, they are bound to work illegally. This means that they are not insured in the case of a work accident.

For many people, this situation is hard to believe, as it reminds us of times long before a labor movement existed. The term “slavery” is often used to describe this situation.

2.3.1.4 Undocumented immigrants' housing conditions

To obtain housing, as well as other basic needs, undocumented migrants seem to highly depend on their network of social relations (at least if they have such a network). These networks may be made up of various individuals.

One type of social network is family or friends who reside in Norway and who help undocumented migrants upon arrival or in times when they don't have enough income to pay the rent. It is quite common for many undocumented migrants to stay with their family or friends who are legal residents in Norway.

The second type of network is made up of compatriots and/or people of the same cultural or religious background.

A small group of undocumented migrants, mostly rejected asylum seekers, depend on NGOs for accommodation or rent deposit. The undocumented immigrants who found accommodation on their own often received information in ethnic or religious places. It is also there that they can find flat mates to reduce costs (World Bank, 2006).

An aspect that characterizes undocumented migrants' housing is their residential mobility. Many are forced to live as nomads because of the uncertainty of their

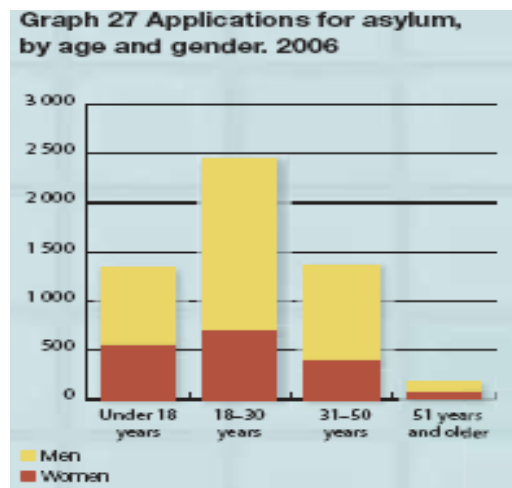
income and the illegality of their presence in Norway. People living with their family or friends often feel uncomfortable and conscious of being a burden. So they mostly try not to stay too long at one place, even if they are staying with family members.

Most undocumented migrants seem to live in districts of large cities where large numbers of foreigners live. This is due to both the cost of the accommodation and also to the fact that they are likely to stay unnoticed there. The problems they face looking for accommodation are multiple, especially when they have little financial means (PICUM, 2001).

2.3.1.5 Undocumented immigrants' need for health services

Since little information is available about undocumented immigrants in Norway, it is difficult to estimate the need for health services for this group. As persons without an identifiable personal registration number are left out of statistics on hospital admittances, use of medicine and so on, it becomes even harder to identify the undocumented immigrants' need for health services. Norway has universal health insurance covering everyone with a health insurance certificate. Undocumented immigrants in Norway are practically left uninsured as they are rejected the right to have such a certificate.

The undocumented immigrants in Norway could be divided into two main groups, the rejected asylum seekers staying in the country and those coming to work for a shorter period of time. Their health problems are presumably quite different as asylum seekers have typically fled from war and therefore in higher risk of having experienced severe physical and emotional distress, than those coming to work for a shorter period of time. Their need for health services might therefore be quite high. Especially the need for dealing with emotional distress has been confirmed to be high (SOPEMI, 2007). As most of the asylum seekers are young men (Graph 27. Source: UDI), this presumably applies to the rejected asylum seekers as well, who, because of these characteristics, probably have a smaller health need than if there were more women and more elderly in the population (PICUM, 2001).



Source: UDI 2006

Those coming to work could be traveling from some degree of relative poverty, which is likely to have influenced their health condition. On the other hand, there might also be a “healthy worker effect” (Holstein, Iversen & Kristensen, 1997), that those traveling to find work are those who are young and healthy enough to do so. Therefore, that group is presumably not in as great need for health services as they would be if they were a more fragile group, or the rejected asylum seekers.

2.3.2 Health and Human Right

2.3.2.1 *Universal right for health*

Among the human rights enshrined in a number of human rights documents is the right for health. The right to health is a short way of referring to a number of rights related directly and indirectly to health (Leary, 1994). The right to health is stated directly in international and regional human rights document such as the UDHR, the ICESCR (table 2.3.2.1.1), the Additional Protocol to the American Convention on Human Rights, the European Social Charter and furthermore in the Declaration of Alma-Ata and in the World Health Organization’s constitution (Center for the Study of Human Rights, 2001; OAS(a) 2003; WHO 2004; WHO 1978). A number of human rights are more indirectly related to health and thus reveals a complex relationship between health and the field of human rights. To illustrate this

relationship, the linkages of health and human rights are sometimes described as a three-tiered overlapping system comprising the following:

- Human rights violations resulting in ill-health
- Promotion or violation of human rights through health development and policies
- Reducing vulnerability to ill-health through human rights

(WHO, 2002; Mann et al, 1994)

First, violations of human rights such as harmful traditional practices, torture, slavery, or violence against women and children can have serious health consequences. Examples of rights relating to the second are the right to participation, freedom from discrimination, right to information, and right to privacy. For example, if a health practice or policy discriminates against a group of people it would constitute a human rights violation. Conversely, securing freedom from discrimination through a health policy would promote human rights. Second, the observance of a number of rights would have the potential to reduce vulnerability to ill-health. This would be, for example, the right to medical care, education, food, nutrition, and freedom from discrimination. The fields of public health and human rights thus become intertwined, while it is the two latter tiers, which explain ways of understanding the right to access to health care.

2.3.2.2 Situation in Europe

In 1950, in response to World War II and the political changes in Europe in the years after the war, the Council of Europe agreed on the European Convention on Human Rights and established simultaneously the European Court of Human Rights to secure enforcement of the convention. Individuals, non-governmental organizations, and member states alike can go directly to the court but only after exhaustion of domestic remedies.

The European Convention on Human Rights contains only civil and political rights. The economic, social and cultural rights are covered in the European Social Charter,

which was signed somewhat later in 1961. The European Social Charter “would define the social objectives aimed at by Members and would guide the policy of the council in the social field” and is not enforced by a court (Robertson & Merrills, 1993). Instead, control of Member States is based on submission of reports by governments (ibid.; Council of Europe(a) n.d.). In 1998, the Additional Protocol to the European Social Charter Providing for a System of Collective Complaints came into force (Council of Europe(b), n.d.). The protocol makes it possible for certain listed organizations to lodge complaints to the European Committee of Social Rights based on which the Committee can come forward with recommendations (ibid.). The economic, social and cultural rights thus become susceptible to “quasi-judicial” review (Toebe, 1999).

The seven UN human rights conventions form the UN treaty body system: they set international standards for the protection and promotion of human rights (table 1.6.1.1.). These conventions are not part of customary law but states can subscribe to them by becoming a party to each treaty. Each state party has an obligation to take steps to ensure that everyone in the state can enjoy the rights set out in the treaty. Below the main international conventions on human rights are listed:

International Bill of Human Rights

- Universal Declaration of Human Rights (1948) - UDHR
- International Covenant on Civil and Political Rights (1966) - ICCPR
- International Covenant on Economic, Social and Cultural Rights (1966) - ICESCR

Other Core Human Rights Instruments (Thematic or Protecting Specific Groups)

- International Convention on the Elimination of All Forms of Racial Discrimination (1965) - ICERD
- Convention on the Elimination of All Forms of Discrimination Against Women (1979) - CEDAW

- Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) - CAT

- Convention on the Rights of the Child (1989) - CRC

- International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990) – ICRMW

Table 2.3.2.1.1 below summarizes the dates these conventions were ratified in the Scandinavian countries.

Table 2.3.2.1.1. Date of ratification of the seven UN human rights conventions by EU member states

Country	ICESCR	ICCPR	ICERD	CEDAW	CAT	CRC	ICRMW*
Denmark	03 Jan 76	23 Mar 76	08 Jan 72	21 May 83	26 Jun 87	18 Aug 91	
Finland	03 Jan 76	23 Mar 76	13 Aug 70	04 Oct 86	29 Sep 89	20 Jul 91	
Norway	03 Jan 76	23 Mar 76	05 Sep 70	03 Sep 81	26 Jun 87	07 Feb 91	
Sweden	03 Jan 76	23 Mar 76	05 Jan 72	03 Sep 81	26 Jun 87	02 Sep 90	

* The ICRMW has not been ratified by any EU member state.

2.3.2.3 Situation in Norway

According to Norwegian laws and regulations, undocumented immigrants in the need of immediate life saving care, have the right to use the Norwegian health care system. The following legal acts stipulate the use of the health care system by undocumented immigrants (translation and laws were taken from www.lovdata.no):

The Health Personnel Act

§ 7 Emergency health care

Health personnel shall immediately provide the health care they are capable of when it must be assumed that the health care is of vital importance.

Pursuant to the limitations laid down by the Patients Rights Act section 4-9, necessary health care shall be given, even if the patient is incapable of granting his

consent thereto, and even if the patients objects to the treatment. When in doubt as to whether the health care is of vital importance, health personnel shall perform the necessary examinations.

This duty does not apply to the extent that other qualified health personnel undertakes the responsibility to provide health care.

Chapter 2. § 4 Responsible conduct

Requirements to professional conduct for health personnel

Health personnel shall conduct their work in accordance with the requirements to professional responsibility and diligent care that can be expected based on their qualifications, the nature of their work and the situation in general.

Health personnel shall act in accordance with their professional qualifications, and assistance shall be obtained and patients shall be referred on to others if this is necessary and possible. If the patient's needs so indicate, the profession shall be performed through co-operation and inter-action with other qualified personnel.

Upon co-operation with other health personnel, the medical practitioner and the dentist shall make decisions in matters concerning medicine or dentistry respectively in relation to examinations or treatment of the individual patient.

The Ministry may in regulations determine that certain types of health care shall only be provided by personnel with special qualifications.

§21 General rule relating to the duty of confidentiality

Health personnel shall prevent others from gaining access to or knowledge of information relating to people's health or medical condition or other personal information that they get to know in their capacity as health personnel.

The Patients' Rights Act

Section 2-1. The right to necessary health care

The patient is entitled to emergency care. The patient is entitled to receive necessary health care from the municipal health service.

The patient is entitled to receive necessary health care from the specialist health service. This right only applies if the patient can be expected to benefit from the health care, and the costs are reasonable in relation to the effect of the measure. The specialist health service shall set a time limit within which, when justified for medical reasons, a person with such a right shall receive necessary health care.

The health service shall give any person who applies for or requires health care the health and treatment-related information he or she requires in order to safeguard his or her right.

If the regional health enterprise has not ensured that a patient who is entitled to necessary health care from the specialist health service receives such care within the time limit fixed pursuant to the second paragraph, the patient has the right to receive necessary health care immediately, if necessary from a private service provider or service provider outside the realm.

If the regional health enterprise cannot provide health care for a patient who is entitled to necessary health care, because there are no adequate medical services in the realm, the patient has the right to receive necessary health care from a service provider outside Norway within the time limit fixed pursuant to the second paragraph.

The King may issue regulations regarding what is to be regarded as health care to which the patient may be entitled.

The Ministry may issue further regulations regarding the determination of and information concerning the time limit mentioned in the second paragraph, and

regarding the organization of and payment for the services that the patient is entitled to receive from a private service provider or service provider outside the realm pursuant to the fourth paragraph.

Amended by the Act of 15 June 2001 No. 93 (in force from 1 January 2002 pursuant to the Decree of 14 December 2001 No. 1417), the Act of 12 December 2003 No. 110 (in force from 1 September 2004 pursuant to the Decree of 19 March 2004 No. 540).

The Mental Health Care Act

Section 1-1 Purpose

The purpose of this Act is to ensure that mental health care is applied and implemented in a satisfactory manner and in accordance with the fundamental principles of the rule of law. The purpose is also to ensure that the measures described in the Act are grounded on the needs of the patient and respect for human dignity.

Section 1-2 Mental health care

The term “mental health care” shall mean the examination and treatment by specialized health services of persons suffering from mental illness, and the nursing and care that this requires.

The term “compulsory observation” shall mean such examination, nursing and care as is mentioned the first paragraph, with a view to establishing whether the conditions for compulsory mental health care are present without consent as provided for in chapter 4 of the Act relating to Patients’ Rights.

The term “compulsory mental health care” shall mean such examination, treatment, nursing and care as are mentioned in the first paragraph without consent as provided for in chapter 4 of the Act relating to Patients’ Rights. Amended by Act No. 45 of 30 June 2006 (entry into force 1 Jan. 2007 as per Resolution No. 1422 of 15 Dec. 2006)

Municipal health Services

2-1 (Right to health services)

Everyone has the right to necessary medical aid in his municipality of residence or in the municipality where he is staying

Act relating to the strengthening of the status of human rights in Norwegian law

(The Human Rights Act)

Section 1. The purpose of the Act is to strengthen the status of human rights in Norwegian law.

Section 2. The following conventions shall have the force of Norwegian law insofar as they are binding for Norway: 2. The International Covenant of 16 December 1966 on Economic, Social and Cultural Rights.

The Norwegian legislation gives undocumented immigrants the right to obtain emergency health care. This is reflected in the Health Personnel Act, Mental Health Care Act, Patient's Rights Act and Municipal Health Act. However, the interpretation of the terms "emergency help" and "compulsory observation" is unclear from the legislation and hard to understand by both undocumented immigrants and health personnel. It often results in an ethical dilemma for the health personnel in that they do not know exactly what is included in the notions of emergency help and compulsory observation. Furthermore, it is not explained in the Law who is supposed to cover the medical costs in that case.

3. Research question, data and methodology

Having discussed the various aspects of migration and the situation with undocumented immigrants and their rights to health, we are now going to focus our attention on the subject of the experiences of some general practitioners (GPs) in dealing with this group of patients in Norway.

The previous presentation indicated that undocumented immigrants may have more health problems than the general population; while at the same time have a more limited access to the health care system. In practice, they even have less access to health care than international and national regulation would grant them. In many cases, GPs provide most of the health care the immigrants receive. It is then of interest to explore the opinions and experiences of both registered and non-registered GPs (leger avtale- og avtaleløse)² in geographic areas with many undocumented immigrants.

3.1 Research question and study objectives

The aim of the empirical analyses is to explore whether GPs offer consultations to undocumented immigrants or refer them to other physicians, to see what type of health problems immigrants have, and to estimate how often such patients pay cash

² Registered GPs have an agreement with the municipality government. They offer services to inhabitants named on a list (typically 1,000-2,000 inhabitants). They are paid a per-capita fee by the municipality and additionally collect patient co-payments and service-fees from the National Health Insurance. The patient co-payments are regulated (at maximum NOK 130 for day time visit, NOK 295 for a night home visit). Non-registered GPs do not collect per-capita fees or service fees. Their income stems entirely from patient co-payments, and these may be considerably higher than those of registered GPs

for the medical services. In particular we aim to address the following research questions:

1. Do GPs who see more “non-western” patients also see undocumented immigrants more often?
2. What are the usual problems undocumented immigrants contact GPs for?
3. Do non-registered GPs see more patients with undocumented immigrant status, than registered GPs do?
4. Why did undocumented immigrants choose to come to particular doctors, according to GPs’ opinion?
5. Is it more difficult for GPs with low perceived competence to refer undocumented immigrants to specialist/hospital?
6. Does the location of the GPs’ office matter for how many undocumented immigrants seek his/her help?

3.2 Data

In November 2007, the Norwegian Medical Association, in cooperation with representatives of the municipalities of Oslo, Drammen and Lier, undertook a questionnaire survey of registered and non-registered GPs the fore mentioned municipalities. The study was an integral part of a project conducted by the Norwegian Medical Association. The project shall result in a status report on the current stance of the health services for non-western immigrants in Norway. Non-western immigrants are defined as immigrants from the following countries: Albania, Bosnia-Herzegovina, Bulgaria, Estonia, Belarus, Croatia, Latvia, Lithuania, Macedonia, Moldova, Poland, Romania, Russia, Serbia-Montenegro, Slovakia, Slovenia, the Czech Republic, Ukraine and Hungary, as well as the immigrants from Asia, Africa, South and Central America. The survey was implemented electronically by using the QuestBack system (www.questback.com) (Appendix 1). This system is e-mail based, and respondents reply via a web browser.

The study encompassed all GPs in the register of the Norwegian Medical Association, and working in the three municipalities (Table 3.2.1). The register distinguished between registered GPs (n=531)(Table 3.2.1) and non- registered GPs (n=49). The latter were those who did not have contract with the local municipalities and had a private practice in these municipalities.

Table 3.2.1 Number of survey respondents

	Registered GPs (avtaleleger)	Registered GPs with e-mail	Unregistered GPs ("avtaleløse")	Unregistered GPs with e-mail
Oslo	467	358	49	34
Drammen	46	25	0	0
Lier	18	11	0	0
Total	531	394	49	34

On the 29th of November 2007 all doctors with an e-mail address were approached by e-mail and asked to fill in a questionnaire. A reminder was sent once on 7th of December. In this process, a number of respondents withdrew from the survey (by sending a separate mail), while others just didn't reply. Also, some e-mail messages were returned because of incorrect e-mail addresses. For respondents who did not have e-mail address (n=188) or the e-mail address were incorrect, the questionnaire was sent by ordinary mail. In total, there were 392 e-mail-addresses and 188 post-addresses on the list of potential respondents.

The questionnaire was sent for 580 respondents (Table 3.2.1.). In total, 215 out of 580 GPs (38%) returned a completed questionnaire, after being approached twice (Table 3.2.2.) The response rate varied from 34% in Oslo to 56% in Drammen and Lier, and it was 36 % among registered GPs and 47 % among unregistered ones.

Table 3.2.2. Number of responses and response rate by municipality

Municipalities	Number of responses	Response rate
Oslo	179	34%
Drammen	26	56%
Lier	10	56%
Total	215	38%

The questionnaire contained 14 questions and additionally allowed for free text comments at the end. Some of the questions were closed-ended ones with multiple choices, while others were Likert-scale questions with choices ranging from “every day” to “never”. The questionnaire contained questions on GPs’ contact with undocumented immigrants, on GP characteristics (geographical location), and on GPs’ experience with undocumented immigrants. Regarding contacts with undocumented migrants, GPs were asked “How often do you see patients without legal status in Norway?” GPs who never saw undocumented immigrants (59% of those who responded to the questionnaire) did not fill out the rest of the questionnaire. The complete list of the survey questions is displayed in the Appendix (Appendix 2, 3).

3.3 Statistical methods

All variables in the dataset were categorical, but some of them (e.g. “how often do you see unregistered immigrants”) represented an underlying continuous variable. The data were analyzed by means of frequency tables and contingency tables (cross-tables). Differences between groups were tested by means of Pearson’s chi-square test, a G-test or the Fisher’s exact test.

The analyses of the data were performed in Excel and SPSS (Statistical Package for the Social Sciences).

4. Results

In total 60% of the GPs saw patients with non-western background daily, 21% weekly while 7% saw such patients seldom or never (Table 4.1).

Table 4.1 “How often do you see patients with a non-western background?” (n=210)*

	Frequency	Percent
Daily	128	60.9
Weekly	46	21.9
Monthly	20	9.5
Seldom and never	16	7.6
Total	210	99.9

*210 valid responses among 215 respondents

At the same time, 8.4% of the respondents saw patients without legal status in Norway daily, weekly or monthly, while 34% seldom saw such patients (Table 4.2)

Table 4.2 “How often do you see patient without any legal status in Norway?”(n=212)*

	Frequency	Percent
Daily, weekly and monthly	18	8.5
Seldom	73	34.4
Never	121	57.0
Total	212	99.9

*212 valid responses among 215 respondents

While 12% of the GPs who saw non-western patients daily also saw non-registered immigrants monthly or more often, the proportion was zero for GPs who only saw

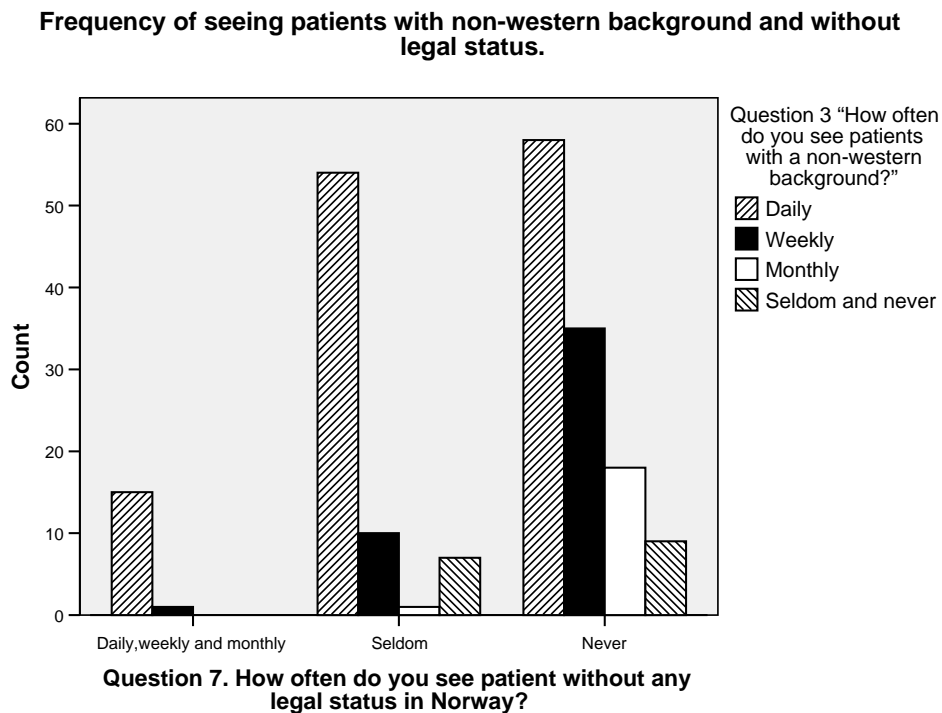
non-western immigrants monthly or more seldom (Table 4.3)(Figure 4.1)($\chi^2=27.4$, $p<0.001$).

Table 4.3. The number of GPs according to how often they saw “non-western” and how often they saw undocumented immigrants (n=208)*

Frequency of seeing patients without legal status	Frequency (percent) of seeing patients with non-western background									
	Daily		Weekly		Monthly		Seldom and never		Total	
	n	%	N	%	n	%	n	%	N	%
Daily, weekly and monthly	15	11.8	1	2.2	0	0	0	0	16	7.7
Seldom	54	42.5	10	21.7	1	5.3	7	43.7	72	34.6
Never	58	45.7	35	76.1	18	94.7	9	56.2	120	57.7
Total	127	100	46	100	19	100	16	100	208	100

*208 valid responses among 215 respondents

Figure 4.1. The number of GPs, classified by how often they saw “non-western” and undocumented immigrants



The largest percentage of undocumented immigrants sought GPs for somatic sickness (50%), 31% had mental illness, while 5.8% sought for help with resident permit (Table 4.4)

Table 4.4 What kind of problem did your last patient without legal status have? (N=86)*

	Frequency	Percent
Infections	11	12.8
Other somatic sickness	32	37.2
Mental illness	27	31.4
Help with residence permit	5	5.8
Other reasons	11	12.8
Total	86	100

*129 of the respondents never saw undocumented immigrants

Our third research question was: Do non-registered GPs see more patients with undocumented immigrant status, than registered GPs do? In total 23% of non-registered GPs saw undocumented immigrants monthly or more often, while only 7% of registered GPs saw such patients with the same frequency. (Table 4.5) ($\chi^2=6.8$, $p=0.032$).

Table 4.5. The number of registered/non- registered GPs according to frequency of seeing patients without legal status. (n=212)*

Frequency/percent of seeing patients without legal status	GP's status					
	Registered		Non-registered		Total	
	N	%	n	%	n	%
Daily, weekly and monthly	13	6.8	5	22.7	18	8.5
Seldom	68	35.8	5	22.7	73	34.4
Never	109	57.4	12	54.5	121	57.1
Total	190	100.0	22	99.9	212	100.0

*212 valid responses among 215 respondents

The fourth research question was: Why did undocumented immigrants choose to come to particular doctors, according to GPs' opinion? In total, 90% of the GPs said that they had been recommended to undocumented immigrants by their other patients or somebody else. In 13% of the cases, undocumented immigrants contacted their former GPs. (Table 4.6)

Table 4.6. Why did undocumented immigrants choose to come to particular doctors, according to GPs' opinion? (n=89)*

	Frequency	Percent
Patients knew the doctor as their former GP (when they were asylum seekers)	12	13.5
Patients knew the doctor, as he worked in the center for asylum seekers	2	2.2
Patients did not know the doctor	35	39.3
The doctor was recommended by another patient	45	50.6
The doctor was recommended by somebody else	35	39.3
Total number of answers	129**	100.0

***89 valid responses among 215 respondents**

(**more than one option was possible)

In order to address the fifth research question, we analyzed the association between the perceived level of medical competence and perceived difficulty with referring patients to higher levels of care (Table 4.7). In total 75% of GPs with high level of competence reported that it was problematic for them to refer a patient while 40% of those with low competence considered that it was un-problematic ($\chi^2=14.33$, $p=0.111$).

Table 4.7. Level of GP's self perceived competence according to level of difficulty in referring patient to a specialist/hospital. (n=82)*

Difficulty for GPs to transfer a patient to the specialist/hospital.	Level of GP's competence									
	Low		Average		Above average		High		Total	
	n	%	n	%	n	%	n	%	n	%
It is non-problematic to transfer a patient to the specialist/hospital	4	40.0	18	43.9	13	48.1	1	25.0	36	43.9
Patients are transferred by using the public system	0	0.0	2	4.9	0	0.0	0	0.0	2	2.4
Patients are not transferred to the specialist/hospital	4	40.0	4	9.7	1	3.7	0	0.0	9	11.0
Transfer of a patient is problematic	2	20.0	17	41.5	13	48.1	3	75.0	35	42.7
Total	10		41		27		4		82	100.0

*82 valid responses among 215 respondents

For the last research question, we tested the association between location of GP's office (municipality) and the frequency of seeing patients without legal status (Table 4.8). While 10% of GPS in Oslo and Lier saw such patients monthly or more frequent, the proportion 0% for Drammen ($\chi^2=4.037, p=0.401$).

Table 4.8. The frequency of undocumented immigrant visits according to municipality (n=212*)

Location of GP's office	Daily, weekly or monthly		Seldom		Never		Total	
	n	%	N	%	n	%	n	%
Drammen	0	0.0	10	40.0	15	60.0	25	100.0
Lier	1	10.0	5	50.0	4	40.0	10	100.0
Oslo	17	9.6	58	32.8	102	57.6	177	100.0
Total	18	8.5	73	34.4	121	57.1	212	100.0

*212 valid responses among 215 respondents

In about one third of the cases (31%) the GP does not receive any payment, while for the others the GP charges the patient in or the relative/other person in full, or charges NAV. (Table 4.9).

Table 4.9 Payment/reimbursement (n=87*)

	Frequency	Percent
Patient pays the honorarium in full	14	16.1
Relative/other person pays the honorarium in full	11	12.6
GP sends the bill to NAV, and the patient pays a co-payment	35	40.2
GP does not get paid	27	31.0
Total	87	99.9

*87 valid responses among 215 respondents

The questionnaire ended with free-text comments. We received 167 comments (78% of the respondents). Some GPs commented that they did not know whether or not the patients were undocumented. "I never know whether the patient is legally or illegally in Norway. And I do not ask about this. I treat the patient anyway, whether or not he

has a social security number.”³ For some respondents it was difficult to answer the questionnaire. They noted that some of the questions did not include enough response alternatives. “I would like to see an answer option that says that I do not know whether the patient is legal or not. Some questions were difficult to answer because there were no categories that could be natural to mark.”⁴ “I did not think about these issues before; there were not enough response alternatives.”⁵

³ ”Det er ikke alltid jeg vet om pasienten er lovlig eller ulovlig i Norge. Og jeg bruker ikke e spørre om det. Jeg behandler selv om jeg ikke har personnummer.”

⁴ “Her burde være kategorier i forhold til om man faktisk ikke vet om de er her pe lovlig vis. En del av spørsmålene var vanskelige å svare på da de ikke hadde kategorier som var naturlige å krysse i.”

⁵ Har aldri tenkt på problemstillingen før nå, savner noen svaralternativer”

5. Discussion

The results of the survey indicate that GPs see undocumented immigrants relatively seldom, that the patients choose their GP on the basis of previous knowledge or “word of mouth”, that somatic diseases were most frequently seen, that a considerable proportion of GPs consider it difficult to refer patients to secondary care and one third of the patients pay the GPs in full out of pocket. These findings, however, should be seen against the limitations of the study.

The questionnaire design was not optimal. Unfortunately, the response rate was low with no opportunity to analyze selection bias because the survey was anonymous. Another potential problem was the absence of a pilot study, which usually precede the actual survey and may improve the wording of the questionnaire. Sensitive questions, such as the nationality, age and gender of the respondents, were not included. Nor was there any information on the nationality of the immigrants, the number of immigrant consultations or the diagnoses of the patients. Such questions might be essential for gaining better insight. The use of open questions, allowing the respondents to give a detailed explanation, rather than limiting their choice to a number of pre-determined options, would have further increased the information content of the survey. Actually, we believe that open questions would better reflect the difficulty and the complex character of the questions asked.

The limitations of the study should be seen against the general problem of undertaking studies of undocumented immigrants. There does not exist any solid statistics on the number of such immigrants in Norway (or elsewhere), and doctors do not know whether immigrants they see really are registered. Despite the apparent low quality of the questionnaire, an obvious positive result of the survey was that it drew attention to this topic and opened the door for further research. As a matter of fact, this was the only research known to us that attempted to investigate the problem of undocumented immigration in Norway and the access of such immigrants to the health care services. According to the GPs who took part in the survey, many of the

undocumented immigrants whom they saw had either a mental illness or an infection. The severity of such diseases makes it a particular problem both for the patients themselves and the society as a whole.

The fact that we received many free text comments at the end of the questionnaire indicates that the doctors considered the issue to be important. Some of the comments underscore design problems such as inability of GPs to know whether or not the patient was an undocumented immigrant. Some GPs might consider it unethical to ask a patient such a question directly. At the same time, GPs were not given clear guidelines as to whom to consider an undocumented immigrant. For this reason some GPs gave hypothetical responses, explaining what they would do if they met such a patient.

Our findings indicate that the GPs, who had more patients with a non-western background, also had more contacts with undocumented immigrants. Apart from the obvious reason that the majority of undocumented immigrants must be of non-western origin, we suppose that another explanation of this finding can be that undocumented immigrants choose their GPs upon recommendation of their friends and acquaintances, who are very likely to be of non-western origin themselves.

Judging by the GPs' response and the interest, reflected in their comments, it would be promising to extend this survey by including other municipalities in the study. Our hope is that the new extended survey will answer some of those research questions that failed to be answered in this study. Also, we believe that more focus should be given to unregistered GPs, since they appear to be more likely to have contact with undocumented immigrants, according to our data. The latter finding can perhaps be explained by a supposition that unregistered GPs were easier to be accessed by undocumented immigrants.

Regardless of the fact that undocumented immigrants do have rights to health care in Norway, they nevertheless face barriers in practice. Our study has revealed that GPs also face certain difficulties in treating undocumented immigrants.

National representative information about contacts of health care providers with illegal immigrants is not available. Information on the health status of illegal immigrants is also very limited. Our study confirms previous findings, namely that “reported health problems of undocumented immigrants mainly concern acute ones such as traumas, infections, sexually transmitted diseases, and mental disorders. They are often related to very poor living and working conditions, as well as to fear” (Torres, 2000).

Access to health care is one of the most urgent problems faced by undocumented migrants. The legislation on “urgent medical care” that is applied in Norway is rather complicated, not always known by either GPs or undocumented migrants, and often not sufficient (for example, it does not cover psychological assistance). According to other research, undocumented migrants are often reluctant to visit a doctor or go to a hospital and will rather resort to informal strategies, such as borrowing papers from documented residents, paying the full price of medical services, negotiating with doctors and consulting at organizations delivering free medical assistance.

Based on other countries’ experience, as well as our own findings, we can identify the following barriers to access to health care system for undocumented immigrants in Norway. All undocumented immigrants do not have a personal identity number, without which they completely lack access to the social security system. Another major barrier is the fear of being reported to the authorities and expelled from Norway. This fact prevents undocumented migrants from requesting medical assistance even in the most serious cases. Besides, undocumented immigrants face practical barriers when getting in contact with health care providers. Such barriers include the lack of information, language difficulties, financial problems, as well as the difficulty to be sent to a specialist and a hospital.

5.1 Policy implications

Possible consequences of not solving the above-mentioned problems may include a risk for public health, and the creation of a “second-class human being”.

According to our findings, since the undocumented immigrants more often choose to contact unregistered GPs (since they do not require the patient to have a social security number), then, as an alternative, we could offer volunteer doctors to work with non-governmental organizations (NGOs). As can be seen from the Swedish experience, NGOs, in particular the Swedish Red Cross brought together a team of volunteer doctors and nurses who provide health care support at a “secret” clinic in Stockholm city center every Wednesday. The clinic is financed by private donations (PICUM, 2007).

Additionally, we have found that undocumented immigrants often prefer to contact GPs who have more experience in dealing with patients of non-western origin. Therefore, the creation of church-based refugee centers that organize medical consultations at their facilities could be helpful. In 2006, Swedish NGOs started a project to provide direct assistance to undocumented migrants. It was in fact a project formerly carried out by MSF Sweden. Between 2004 and 2007, the project has received and treated 750 patients and provided around 2000 consultations. A network of about one hundred persons with a medical background works for this project (PICUM, 2007). This gives an indication of the need for medical care among undocumented immigrants also in Norway.

We also believe that it would be useful to provide the GPs with information describing the problems covered in the survey. Perhaps, the NMA (Norwegian Medical Association) can formulate some policy implications and give relevant recommendations to its members regarding the rights of the undocumented immigrants, as well as the GPs. In our opinion, the best solution to the problem of undocumented immigrants and their access to the health care system is to involve NGOs and volunteer doctors, who actually want to work with this group of patients.

6. Conclusion

The aim of this thesis was to shed light on the problems in providing health care to undocumented immigrants in Norway, as well as on the experiences of Norwegian GPs in dealing with this group of patients. For this purpose we analyzed survey data obtained from the Norwegian Medical Association.

The results of this study indicate that there is a need to organize better health care services for undocumented immigrants. This would be in the interest of both the immigrants and society in general.

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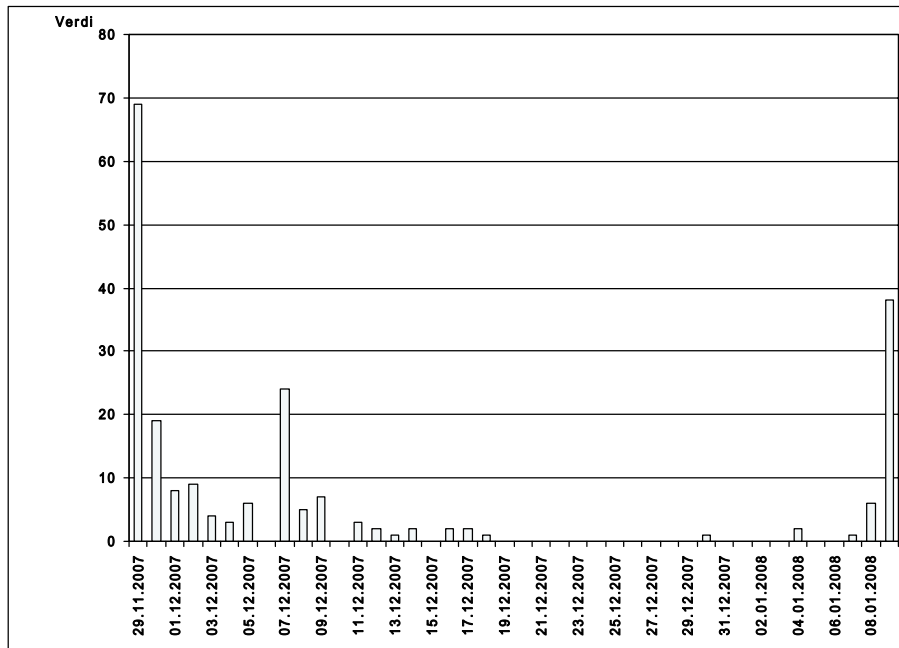
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Appendix 1. Questback presentation.

Svarlogg

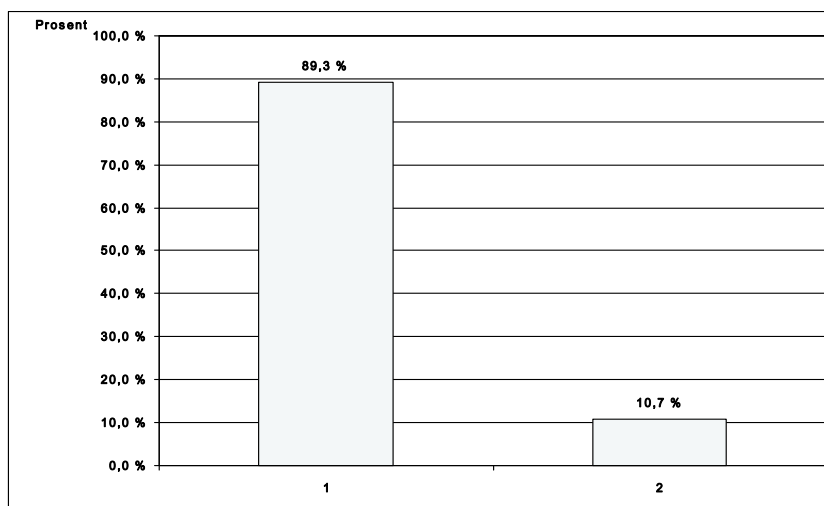


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www.questback.com

Kartlegging av legetjenester til udokumenterte innvandrere

1

1. Er du fastlege?



1	Ja
2	Nei

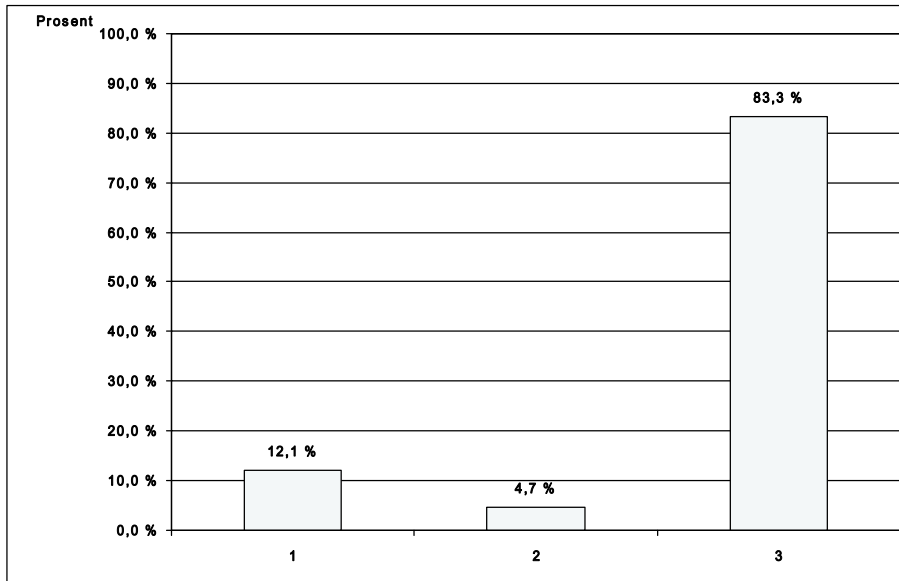
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Kartlegging av legetjenester til udokumenterte innvandrere

2

2. Min kontorkommune er:



1	Drammen
2	Lier
3	Oslo

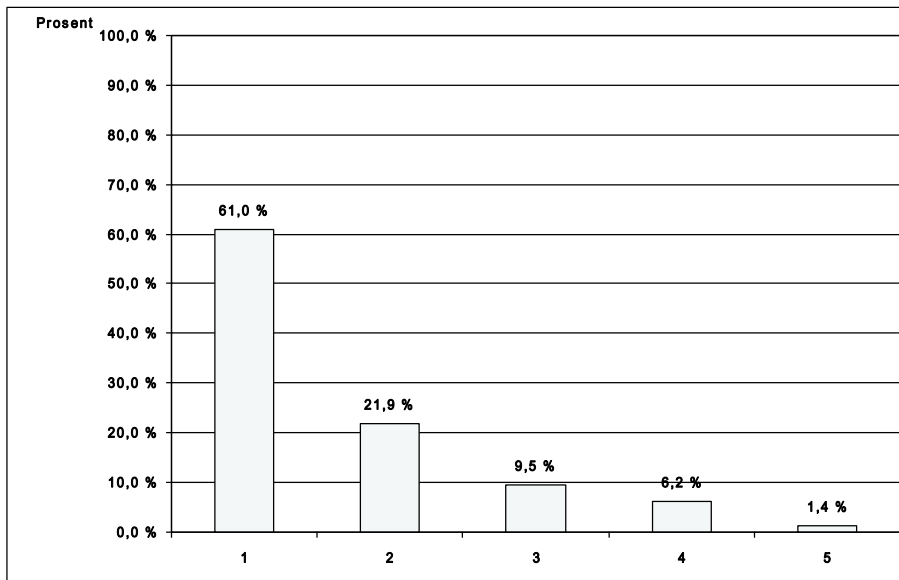
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www.questback.com

Kartlegging av legetjenester til udokumenterte innvandrere

3

3. Hvor ofte ser du listepasienter med ikke-vestlig bakgrunn? (Se definisjonen ovenfor.)



1	Daglig
2	Ukentlig
3	Månedlig
4	Sjeldnere
5	Aldri

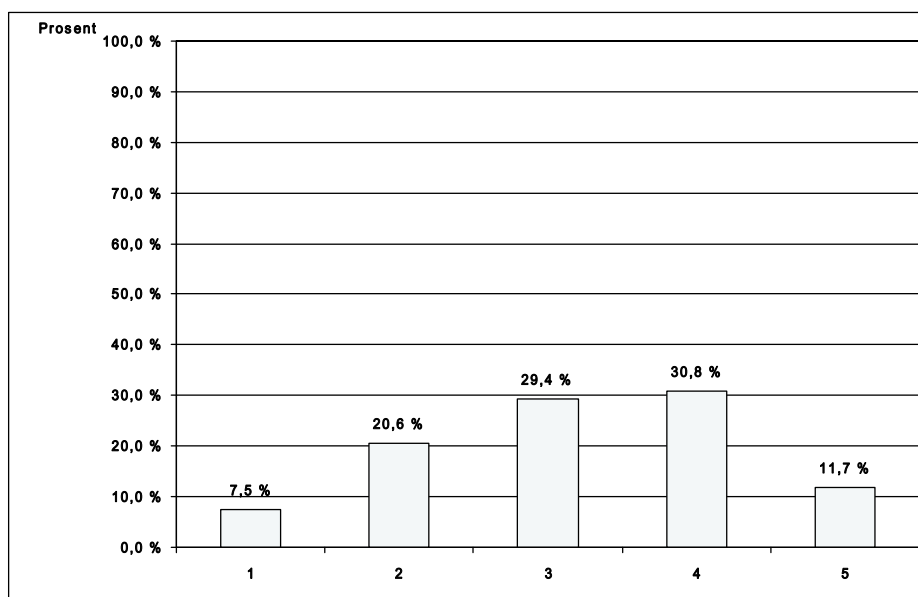
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www.questback.com

Kartlegging av legetjenester til udokumenterte innvandrere

4

4. Hvor ofte benytter du tolk?



1	Daglig
2	Ukentlig
3	Månedlig
4	Sjeldnere
5	Aldri

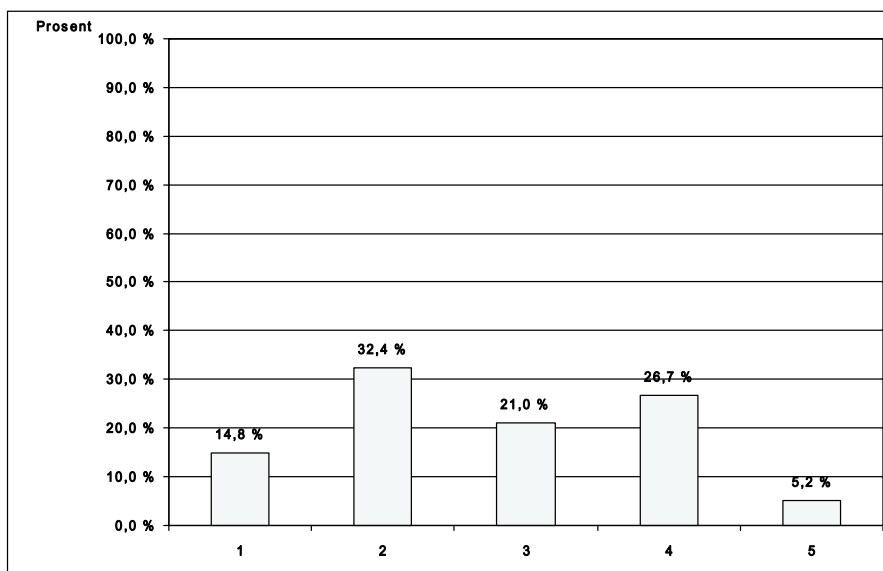
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Kartlegging av legetjenester til udokumenterte innvandrere

5

5. Hvor ofte ser du pasienter som ikke er listepasienter? (Gjelder alle pasienter.)



1	Daglig
2	Ukentlig
3	Månedlig
4	Sjeldnere
5	Aldri

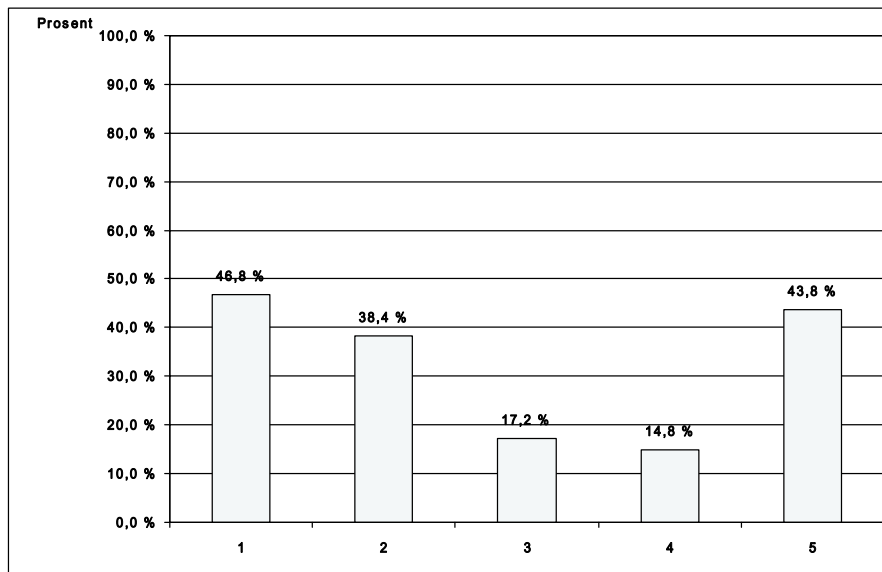
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Kartlegging av legetjenester til udokumenterte innvandrere

6

6. Hva gjør du hvis en udokumentert innvandrер søker behandling? (Flere alternativer er mulig.)



1	Jeg behandler kun alvorlig sykdom, øyeblikkelig hjelp (Helsepersonellovens § 7.)
2	Jeg henviser til legevakt
3	Jeg behandler allmennfarlig smittsom sykdom. (Smittevernloven § 3-5.)
4	Jeg tar imot svangerskapsrelaterte problemer
5	Jeg tar imot uavhengig av alvorlighetsgrad

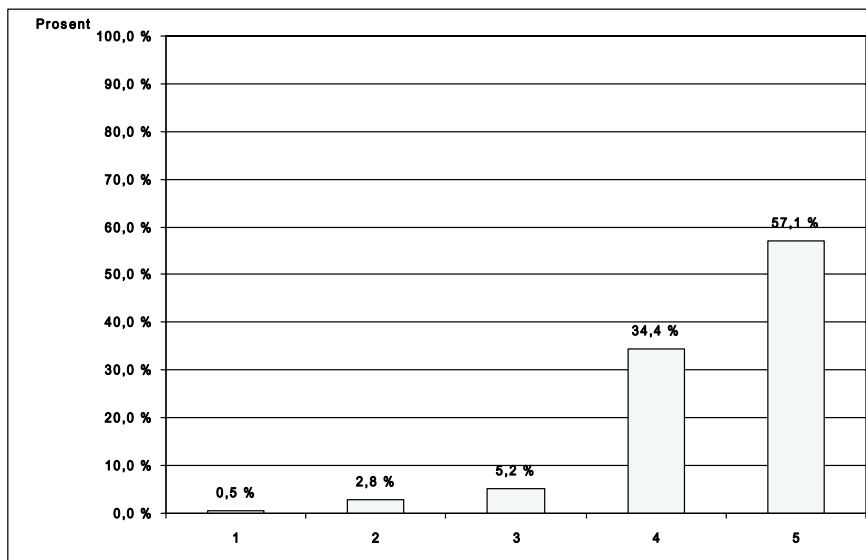
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Kartlegging av legetjenester til udokumenterte Innvandrere

7

7. Hvor ofte ser du pasienter som ikke har lovlig opphold i Norge?



1	Daglig
2	Ukentlig
3	Månedlig
4	Sjeldnere
5	Aldri

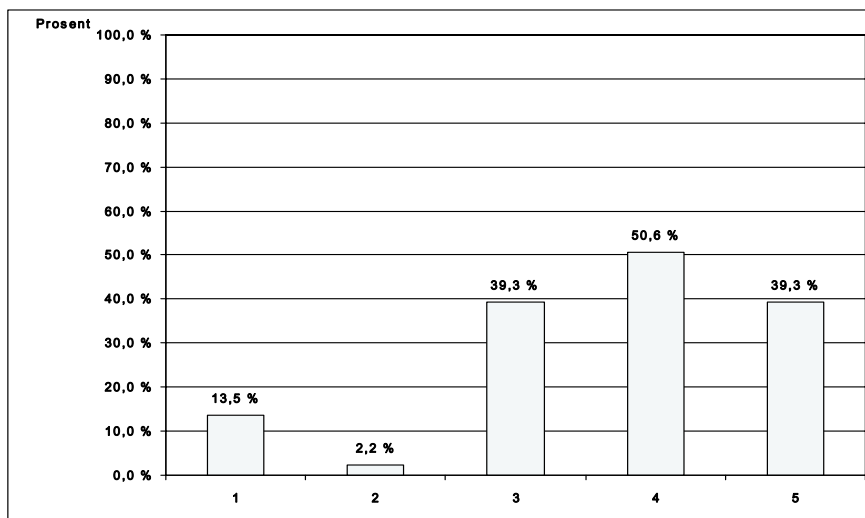
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Kartlegging av legetjenester til udokumenterte Innvandrere

8

8. Hvorledes kom de i kontakt med deg? (Flere alternativer er mulig.)



1	Har vært fastlege for vedkommende
2	Har vært lege på asylmottak
3	Ny pasient / direkte kontakt
4	En annen pasient formidlet kontakt
5	Andre formidlet kontakt

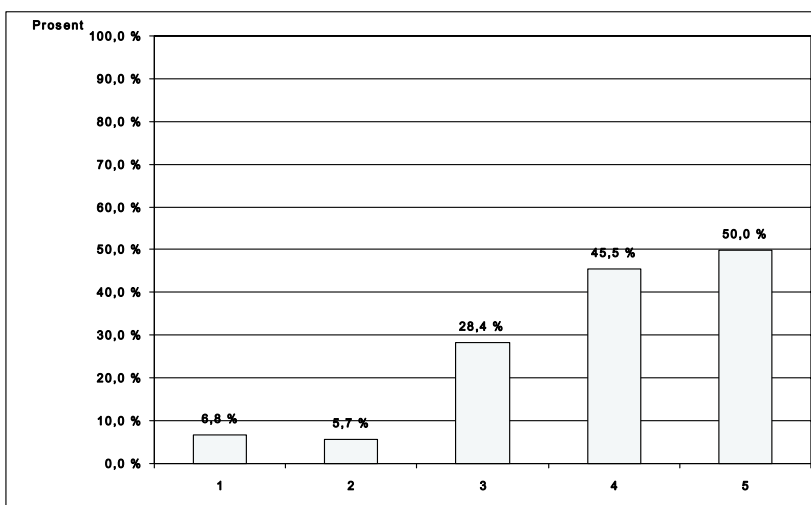
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Kartlegging av legetjenester til uokumenterte innvandrere

9

9. Hvorfor mener du at du ble oppsøkt? (Flere alternativer er mulig)



1	Min etnisk/språklige bakgrunn som lege
2	Har jobbet med flyktninger
3	Tilgjengelighet
4	Legekantoret har mange ikke-vestlige pasienter
5	Andre årsaker

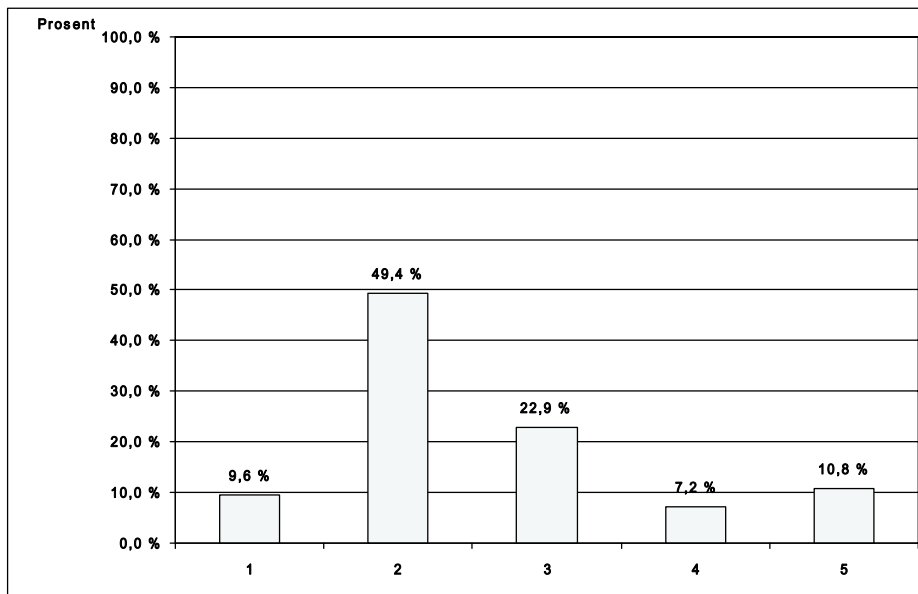
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Kartlegging av legetjenester til uokumenterte innvandrere

10

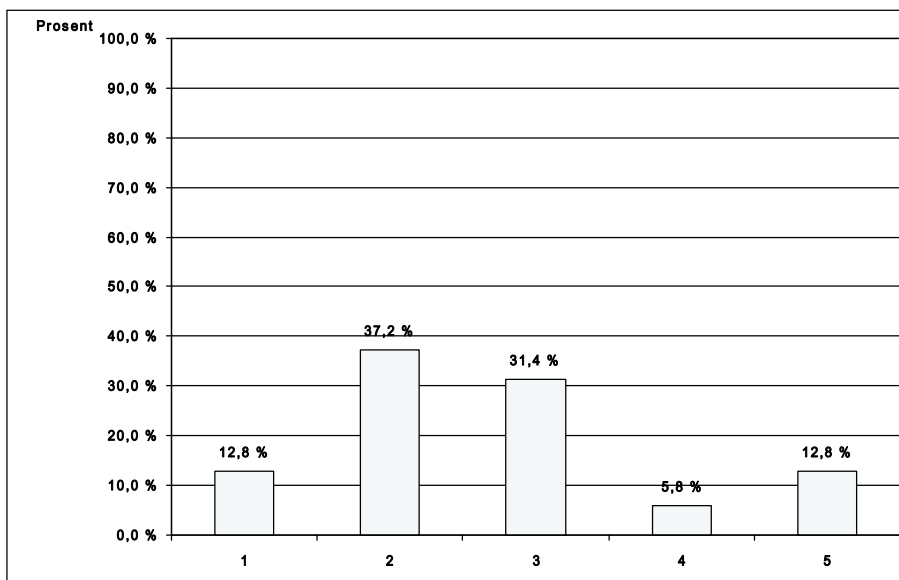
10. Gjelder problemet for pasient uten lovlig opphold oftest:



1	Infeksjonssykdom/seks uelt overført sykdom
2	Annen somatisk sykdom
3	Psykisk lidelse
4	Hjelp til oppholdstillatelse
5	Andre grunner

	N
Denne undersøkelsen	83

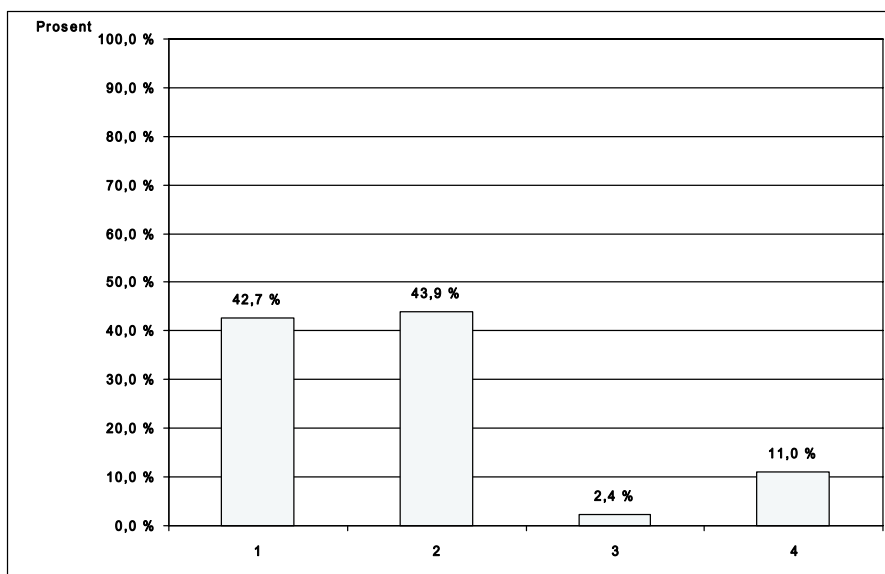
11. Hva gjaldt problemet for siste pasient uten lovlig opphold?



1	Infeksjonssykdom/seks uelt overført sykdom
2	Annen somatisk sykdom
3	Psykisk lidelse
4	Hjelp til oppholdstillatelse
5	Andre grunner

	N
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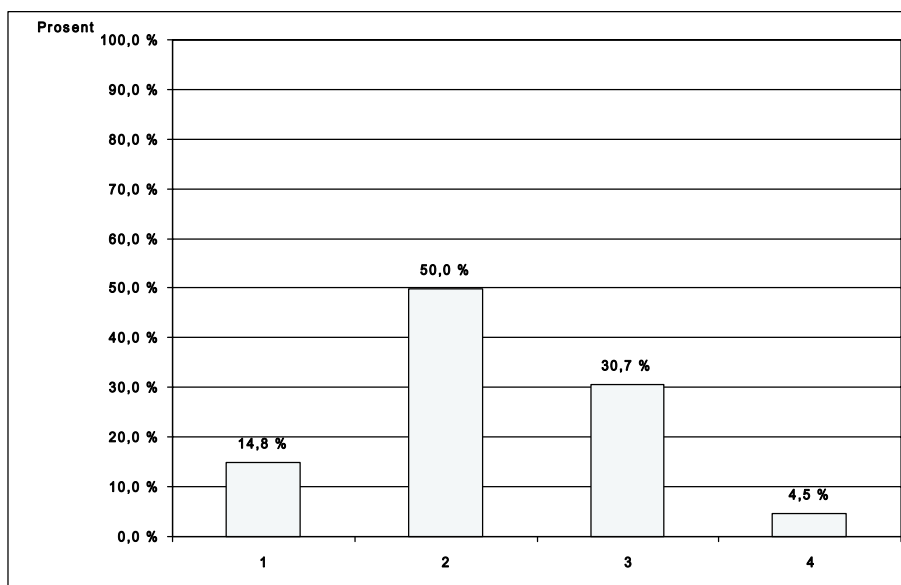
12. Ved behov, hvor lett er det å henviser til spesialist/sykehus?



1	Det oppleves som problematisk
2	Det er uproblematisk
3	Jeg henviser utenom det offentlige systemet
4	Jeg henviser ikke

	N
Denne undersøkelsen	82

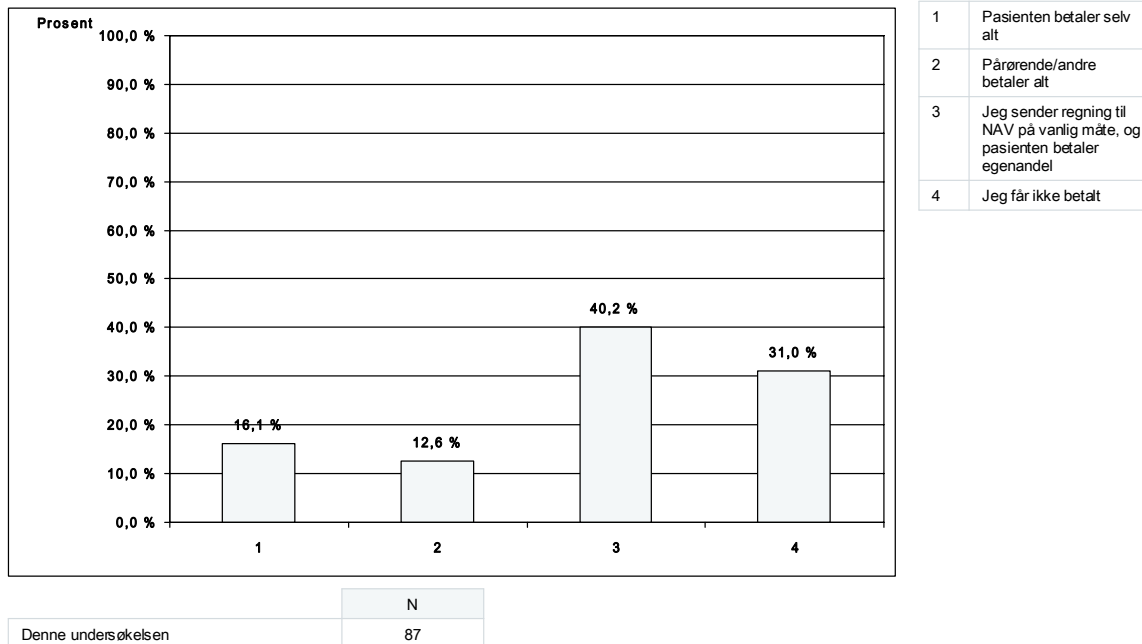
13. Hvorledes vurderer du din kompetanse overfor disse pasientgruppene?



1	Lav
2	Middels
3	Over middels
4	Høy

	N
Denne undersøkelsen	88

14. Betaling



1	Pasienten betaler selv alt
2	Pårørende/andre betaler alt
3	Jeg sender regning til NAV på vanlig måte, og pasienten betaler egenandel
4	Jeg får ikke betalt

Appendix 2. Questionnaire (Original version)

Legetjenester til udokumenterte innvandrere (Undocumented migrants)

QUESTBACK-UNDERSØKELSE

Den norske legeforening skal neste år lage en statusrapport om ikke-vestlige innvandrere. Definisjoner: *Ikke-vestlige innvandrere* har bakgrunn fra land i Asia med Tyrkia, Afrika, Sør og Mellom-Amerika og Øst-Europa.

Øst-Europa omfatter følgende land: Albania, Bosnia-Hercegovina, Bulgaria, Estland, Hviterussland, Kroatia, Latvia, Litauen, Makedonia, Moldova, Polen, Romania, Russland, Serbia og Montenegro, Slovakia, Slovenia, Tsjekkia, Ukraina og Ungarn. En gruppe som vi vet lite om, er de som ikke har offisiell oppholdsstatus i Norge. Vi vet lite om hvilke helsetjenester de benytter og omfanget. Svein Aarseth og Trygve Kongshavn vil derfor gjennomføre en kartlegging på området. Denne spørreundersøkelsen foregår via epost og sendes fastleger og andre allmennleger i Oslo, Drammen og Lier med kjent epostadresse. Svarene behandles anonymt av Questback.

1. Er du fast lege?

1. Ja
2. Nei

2. Min kontorkommune er:

1. Drammen
2. Lier
3. Oslo

3. Hvor ofte ser du listepasienter med ikke-vestlig bakgrunn?

1. Daglig
2. Ukentlig
3. Månedlig
4. Sjeldnere
5. Aldri

4. Hvor ofte benytter du tolk

1. Daglig
2. Ukentlig
3. Månedlig
4. Sjeldnere
5. Aldri

5. Hvor ofte ser du pasienter som ikke er listepasienter

1. Daglig
2. Ukentlig
3. Månedlig
4. Sjeldnere
5. Aldri

6. Hvorledes stiller du deg til å behandle ”udokumenterte personer”. (Flere alternativer er mulig)

1. Jeg behandler kun alvorlig sykdom , øyeblikkelig hjelp (Helsepersonellovens § 7)
2. Jeg henviser til legevakt
3. Jeg behandler allmennfarlig smittsom sykdom. (Smittevernloven §3-5)
4. Jeg tar imot svangerskapsrelaterte problemer
5. Jeg tar imot uavhengig av alvorlighetsgrad.

Resten av spørsmålene gjelder personer som ikke har lovlig opphold i Norge.

7. Hvor ofte ser du pasienter som ikke har lovlig opphold i Norge

1. Daglig
2. Ukentlig
3. Månedlig
4. Sjeldnere
5. Aldri

Dersom svaret på siste spørsmål var aldri, kan du avslutte her.

8. Hvorledes kom de i kontakt med deg? (Flere alternativer er mulig)

1. Har vært fastlege for vedkommende
2. Har vært lege på asylmottak
3. Ny pasient /Direkte kontakt
4. En annen pasient formidlet kontakt
5. Andre formidlet kontakt

9. Hvorfor mener du at du ble oppsøkt? (Flere alternativer er mulig)

1. Etnisk/språklig bakgrunn
2. Har jobbet med flyktninger
5. Tilgjengelighet
6. Andre årsaker

10. Gjelder problemet for pasient uten lovlig opphold oftest:

1. Infeksjonssykdom
2. Annen somatisk sykdom

3. Psykisk lidelse
4. Hjelp til oppholdstillatelse
5. Andre grunner

11. Hva gjaldt problemet for siste pasient uten lovlig opphold

1. Infeksjonssykdom
2. Annen somatisk sykdom
3. Psykisk lidelse
4. Hjelp til oppholdstillatelse
5. Andre grunner

12. Hvor lett er det å henvise til spesialist/sykehus?

1. Det er uproblematisk
2. Jeg henviser utenom det offentlige systemet
3. Jeg henviser ikke

13. Hvorledes vurderer du din kompetanse overfor disse pasientgruppene?

1. Lav
2. Middels
3. Over middel
4. Høy

14. Betaling.

1. Pasienten betaler selv
2. Pårørende/andre betaler
3. Jeg sender regning til NAV på vanlig måte
4. Jeg får ikke betalt

Appendix 3. Questionnaire (English version; translation by author)

1. Are you a GP?

1. Yes
2. No

2. My office is located in the following municipality:

1. Drammen
2. Lier
3. Oslo

3. How often do you see patients with a non-western background?

1. Daily
2. Weekly
3. Monthly
4. Seldom
5. Never

4. How often do you use help of an interpreter?

1. Daily
2. Weekly
3. Monthly
4. Seldom
5. Never

5. How often do you see patients who are not in your list?

1. Daily
2. Weekly
3. Monthly
4. Seldom
5. Never

6. What is your attitude when it comes to providing medical treatment to undocumented persons?

1. I only give treatment to serious sickness, emergency cases (Helsepersonelloven § 7)
2. I refer to the emergency room
3. I treat contagious diseases (Smittevernloven §3-5)
4. I treat pregnancy related problems
5. I give treatment independently of the seriousness of the sickness

The rest of questions apply to persons who do not have any legal status in Norway

7. How often do you see patient without any legal status in Norway?

1. Daily
2. Weekly
3. Monthly
4. Seldom
5. Never

If you answered “never” in the last question, you do not need to continue.

8. In what way did patient without any legal status in Norway get in touch with you (more than one option is possible)?

1. I was their GP
2. I was a doctor in a reception center for asylum seekers
3. New patient/Direct contact
4. One of my patients recommended me.
5. Somebody else recommended me.

9. Why do you think they visited you (more than one option is possible)?

1. Ethnic/language background
2. Have been working with refugees
3. Availability
4. I have many patients with the non-western background
5. Other reasons

10. What kind of problem is typical for patients without the legal status?

1. Infectious diseases

2. Other somatic sickness
3. Mental illness
4. Help with residence permit
5. Other reasons

11. What kind of problem did your last patient without legal status have?

1. Infectious diseases
2. Other somatic sickness
3. Mental illness
4. Help with residence permit
5. Other reasons

12. In case of need, how easy is it for you to send a patient to the specialist/hospital?

1. This is considered non-problematic
2. I do relegate by using public system
3. I do not relegate
4. This is considered problematic

13. How competent are you in providing medical services to this group of patients?

1. Low
2. Average
3. Above average
4. High

14. Payment/reimbursement

1. Patient paying him\herself
2. Relative/other person paying
3. I send the bill to NAV, as usual, and the patient pays his part of the bill.
4. I don't get paid