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Fleeing from responsibility

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Medical assistance for a large group of people living in Norway is arbitrarily and poorly organised. Soon, the problems will be even bigger.

Photo: Sturlason

Some time ago, a sick man came to a doctor's surgery in Bergen. The examination that followed showed that he had cancer. He was referred first to one hospital, then to another. The referral was rejected by both hospitals. His appeal against the rejection led nowhere. Gradually, the man's condition worsened.

This man had no papers that were recognised by Norwegian authorities. He had lived for years in Bergen, where he had received regular medical assistance at the Health Centre for Paperless Migrants. Because the hospitals considered that he was not entitled to treatment for his cancer, he could not be admitted until his condition had become acute. The man died shortly after (1).

This man was one of at least 2 400 paperless migrants in Norway (2). These are people who have no documents entitling them to legal residence, and are often not recognised as citizens by any state. There is international consensus that people like these are entitled to medical assistance, but in contrast to countries such as Sweden, the UK and the Netherlands, Norway has no established healthcare option for paperless migrants (3). In Norway, it is restricted to the specialised health service and only in cases requiring immediate intervention (4). Beyond this, they must rely on voluntary efforts. In two cities in Norway, such medical assistance is provided at secret addresses (5, 6). The doctors are unpaid, and donations provide the money for necessary drugs.

The United Nations has reacted to these conditions, and as recently as in 2020 Norway was criticised for breach of human rights by not providing medical assistance to paperless migrants on par with the general population (7). Norway was given a two-year deadline to report on the implementation of necessary amendments to its service provision (7).

Paperless migrants are not the only vulnerable group to rely on voluntary organisations for medical assistance. People who for various reasons are not on a GP's list, such as family immigrants, resettled refugees and others with a residence or work permit, also have a substantial need for help, but there is little structure to their follow-up. Many have symptoms of post-traumatic stress, sleeping disorders, pain or other mental or somatic symptoms (8). Local authorities are responsible for provision of medical assistance to these people (9).

The health authorities in Oslo recently sent out a question to GPs asking whether any would consider being on a list of doctors who offer medical assistance to this group, but with no compensation or other professional support. This list, which was previously quite long, has now dwindled to three doctors (10).

I have been on that list myself. The pressure was high, with 5–15 consultations every day. The patients had little understanding of health matters, poor Norwegian language skills and a considerable need for coordinated services. Most of them needed an interpreter, many had trouble finding their way to the address, and they were unstable payers. After four months I realised that it was no longer possible for us to help, even though we wanted to. This was not only due to my own situation, but also because the other personnel at the medical centre were overburdened.

> ***«It is not right to base medical assistance for the weakest members of society on the altruism of selected doctors»***

A large number of expected refugees means that the number of patients for these doctors will certainly not diminish in the years to come. It is in principle alarming that the municipal responsibility for ensuring medical assistance to people who are legally resident, but have no GP, is restricted to asking them to attend the daytime A&E clinic. Waiting times there are often long, and the continuity of follow-up is poor. It is even worse that people risk deterioration of their health, at worst death, because there is no system in place to help them.

We need a review of the provision of health care to these groups, and this needs to be systematised and structured. This help should ideally be provided by clinicians who have the experience and qualifications to understand their background and complex needs. It should be local authorities' responsibility to ensure continuity in the follow-up of *everybody's* health problems.

It is not right to base medical assistance for the weakest members of society on the altruism of selected doctors. In January 2022, the Storting received a private members' bill to amend the legislation on universal access to primary health care (3). This may compel the government to reassess this matter.

It is sad that someone has to die before the authorities are held accountable for the responsibility they have so far fled from.

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