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The Right to Health Care for Irregular Migrants in Norway: Interpretation, Accessibility, and Gaps Between Needs and Rights

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ABSTRACT

Based on legal interpretation, interviews with rejected asylum seekers, and decisions from hospitals and the County Governor, this article examines the degree of compliance with the human right to health care for adult irregular migrants in Norway. The findings indicate that a certain minimum of health care services is accessible for most. However, economic concern represents a heavy burden. Fear of deportation, often considered a barrier to health care in earlier studies, represents a problem for those who evade deportation and lack information about health-care providers' duty of confidentiality. Unclear legislation leads to uncertainty among health personnel. This uncertainty produces, in some cases, an arbitrary practice. The article suggests that the most serious gaps between health-care needs, national legislation, and international human rights obligations appear to exist concerning the lack of rehabilitation rights after surgery, the lack of health care for patients suffering from serious mental health issues, and the high threshold for treatment of chronic diseases.

KEYWORDS

Irregular migrants; right to health; health care; accessibility; affordability; implementation gaps; arbitrary practice; barriers; ICESCR article 12; ECHR article 2; ECHR article 3; non-discrimination

Introduction

Numerous international treaties recognise the right to health,[1] interpreted as lying somewhere between the right to be *healthy* and the narrower scope of a right solely to *health care*.[2] Norway is an example of a strong welfare state, exceeding many of the core obligations related to the right to health. Critics have argued that the Nordic welfare model ties up material resources to ensure economic sustainability and equal protection for insiders, and as a result, excludes those defined as outsiders.[3] Simultaneously, Norway's promotion as a human rights-respecting nation makes

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[1]Universal Declaration of Human Rights (1948) art 25; European Social Charter (1961) art 11; Convention on the Rights of the Child (1989) art 24; Convention on the Elimination of All Forms of Discrimination against Women (1979) art 11.1(f) and art 12; International Convention on the Elimination of All Forms of Racial Discrimination (1965) art 5d (IV); Convention on the Rights of Persons with Disabilities (2006) art 25.

[2]Jonathan Wolff, 'The Content of the Human Right to Health'; Kimberley Brownlee, 'Do We Have a Right to the Political Determinants to Health?' both in Rowan Cruft, Matthew Liao and Massimo Renzo (eds), *Philosophical Foundations of Human Rights* (Oxford University Press 2015).

[3]Vanessa Barker, *Nordic Nationalism and Penal Order: Walling the Welfare State* (Routledge 2018) chs 2–3.

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the country an interesting subject of investigation concerning the degree to which irregular migrants are eligible for health services and included in Norway's health system.

In this article, the term 'irregular migrant'[4] (hereinafter IM or IMs for the plural) substitutes the legal term 'foreigner' who is 'unlawfully residing',[5] used in the Norwegian Immigration Act (hereinafter IMA). The judicial category takes effect when a foreign national does not leave the realm within a given time limit. The category may contain people who never had a residence permit (unregistered migrants, rejected asylum seekers, visa overstayers), who have had a temporary or permanent residence permit (if ceased or revoked,[6] or not renewed[7]) or Norwegian citizenship (if revoked[8]). Due to the heterogeneity of people referred to as IMs, time spent unlawfully in the country varies from one day to decades. Precise numbers are lacking; it is estimated that there might be around 18,100 IMs in Norway.[9] Unlawful presence is a legal basis for deportation,[10] expulsion,[11] detention,[12] and penalties.[13] Poor quality of life[14] makes IMs particularly vulnerable to health risks.[15] These health-care needs represent a legislative challenge when balancing migration management on the one hand, and the duty to provide health care on the other hand.[16] This article focuses on IMs' right to *health care*. Research identifies challenges related to IMs' use of health services from the perspective of patients[17]

[4]Alternative terms: undocumented, irregularised, illegalised, unauthorised, non-status, clandestine.

[5]Utlendingsloven [Immigration Act] 2008 (hereinafter IMA) does not contain a definition of *people* who are unlawfully present in the realm. As IMA is constructed as a permit system, it follows indirectly that a foreigner without a given permit to stay in the realm is 'unlawfully residing' (see ss 103, 105, 108).

[6]IMA ss 68–70 cf s 71(1); s 63 or s 37(1)(e).

[7]IMA s 61.

[8]Lov om norsk statsborgerskap [Act on Norwegian Citizenship] 2005, s 26 or s 26a cf IMA ch 8.

[9]Li-C Zhang, 'Developing Methods for Determining the Number of Unauthorized Foreigners in Norway' [2008] Statistics Norway <www.ssb.no/a/english/publikasjoner/pdf/doc_200811_en/doc_200811_en.pdf> accessed 4 September 2019. Zhang suggests that there might be between 10,500 and 32,000 IMs in Norway.

Sigmund B Mohn and others, 'Et marginalt problem? Asylsøkere, ulovlig opphold og kriminalitet' [Marginal problem? Asylum seekers, unlawful residency and crimes'] [2014] Oxford Research AS <www.udi.no/globalassets/global/forskning-fou_i/beskyttelse/et-marginalt-problem---endelig.pdf> accessed 5 November 2019.

The report revised Zhang's estimate, using new data from 2008–2011, resulting in an estimate of 20,900 (lowest estimate) and 56,000 (highest estimate) of IM present in 2010–2011. The report underlines that numbers are highly imprecise and concludes that the lowest estimate, 18,100, for the period of 2010, is the most plausible.

[10]IMA s 90(6) cf (7).

[11]IMA s 66 (2)(a) or (b).

[12]IMA ss 106–107.

[13]IMA s 108(2)(a).

[14]Trine Myhrvold and Milada C Småstuen, 'Undocumented Migrants' Life Situations: An Exploratory Analysis of Quality of Life and Living Conditions in a Sample of Undocumented Migrants Living in Norway' [2019] 28(11-12) Journal of Clinical Nursing <https://doi.org/10.1111/jocn.14743> accessed 15 September 2019.

[15]See for example Sotirios Tsiodras, 'Irregular Migrants: A Critical Care or a Public Health Emergency' (2014) 42 Intensive Care Medicine 252; Ines Keygnaert and others, 'Sexual and Reproductive Health of Migrants: Does the EU Care?' (2014) 114 Health Policy 215; Richard F Mollica and others, 'Mental Health in Complex Emergencies' (2004) 364 The Lancet 2058; Trine Myhrvold and Milada C Småstuen, 'The Mental Healthcare Needs of Undocumented Migrants: An Exploratory Analysis of Psychological Distress and Living Conditions Among Undocumented Migrants in Norway' (2017) 26 Journal of Clinical Nursing 825.

[16]Anna Lundberg and Mikael Spång, 'Deportability Status as Basis for Human Rights Claims: Irregularised Migrants' Right to Health Care in Sweden' (2017) 35 Nordic Journal of Human Rights 35.

[17]Norwegian studies: Synnøve Bendixsen, 'Vilkårlige rettigheter? Irregulære migranters tillit, sosiale kapital og kreative taktikker' ['Arbitrary Rights? Irregular Migrants' Trust, Social Capital, and Creative Tactics'] in Synnøve Bendixsen, Christine Jacobsen and Karl H Søvig (eds), *Eksepsjonell velferd? Irregulære Migranter i det norske velferdssamfunnet* [*Exceptional Welfare? Irregular Migrants in the Norwegian Welfare Society*] (Gyldendal 2015); Eli Kvamme and Siri Ytrehus, 'Barriers to Health Care Access Among Undocumented Migrant Women in Norway' (2015) 6(1) Society, Health & Vulnerability <www.tandfonline.com/doi/full/10.3402/shv.v6.28668> accessed 20 September 2019. Europe: Marjolein Winters and others, 'A Systematic Review on the Use of Healthcare Services by Undocumented Migrants in Europe' (2018) 18(1) BMC Health Services Research <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-2838-y#citeas> accessed 23 September 2019.

and health providers,[18] and in legislation.[19] This article examines the following questions:

- How is the right to health care set out in the most relevant international treaties implemented by Norway, and how are these obligations implemented for IMs in Norwegian legislation?
- To what extent is the right to health care accessible to IMs in practice?
- Are there any gaps between legislation and IMs' need for health care that might have implications for human rights obligations?

The article has a socio-legal approach to the research questions. It combines doctrinal methods with qualitative empirical evidence, to investigate the interrelation between legislation and practice. The article aims to evaluate the degree of compliance with human rights obligations related to the right to health care for adult IMs in Norway. The article does not provide an in-depth analysis of different subcategories of health-care rights but rather aims to point at potential issues related to international obligations from a Norwegian perspective.

The next section analyses the right to health for IMs set out in the most relevant international obligations and shows how these are implemented in Norwegian legislation. Section three presents the methods used to collect the empirical material. Section four presents findings from interviews, medical records, decisions from hospitals, and decisions from the Country Governor. The section examines how accessible the legislative rights are, how they are interpreted by health personnel, and whether legislation leaves a gap for untreated, serious health-care needs among IMs. Drawing on the findings, section five discusses the degree of compliance with the right to health care for IMs in Norway.

Legal Framework

ECHR

Section four presents findings from interviews, medical records, decisions from hospitals, and decisions from the Country Governor. The European Court of Human Rights (ECtHR) has found that although ECHR article 14 prohibits discrimination, a State may have legitimate reasons for curtailing the use of resource-hungry public services, such as health care, by immigrants residing unlawfully, who, as a rule, do not contribute to their

[18]Svein Aarseth and others, 'Paperless Migrants and Norwegian General Practitioners' [2016] 136(10) Tidsskrift for den Norske Laegeforening <http://pdfs.semanticscholar.org/d09f/3b0750a153bee02a2b988ce01c6a38d8ec33.pdf> accessed 20 October 2019; Marry-A Karlsen, 'Precarious Inclusion: Irregular Migration, Practices of Care, and State B/ordering in Norway' (PhD thesis, University of Bergen 2015); Natasja K Jensen and others, 'Providing Medical Care for Undocumented Migrants in Denmark: What are the Challenges for Health Professionals?' (2011) 11(154) BMC Health Services Research <https://link.springer.com/article/10.1186/1472-6963-11-154> accessed 15 October 2019.

[19]Norwegian context: Karl H Søvig, 'Tilgang til velferdstjenester for irregulære migranter etter det norske regelverket' [Access to Welfare services for Irregular Migrants in Norwegian Legislation]; Andrea Süssman, 'Dronning i grenseland?' [Liminal Queen?] both in Bendixsen, Jacobsen and Søvig (n 17); Henriette S Aasen, Alice Kjellevold and Paul Stephens, 'Undocumented Migrants' Access to Health Care Services in Europe' in Henriette S Aasen and others (eds), *Juridification and Social Citizenship in the Welfare State* (Edward Elgar 2014). European context: Dan Biswas and others, 'Access to Health Care for Undocumented Migrants from a Human Rights Perspective: A Comparative Study of Denmark, Sweden, and the Netherlands' (2012) 14 Health and Human Rights 49.

funding.[20] However, case law indicates that in serious cases, an issue might arise under article 2 (right to life) or article 3 (inhuman or degrading treatment). ECHR article 2.1 lays down a positive obligation on States to take appropriate steps to safeguard the lives of those within their jurisdiction.[21] Acts and omissions of the authorities in the field of health-care policy may engage responsibility under article 2.[22] An issue may arise where the authorities put an individual's life at risk through the refusal of health care available to the general population.[23] The threshold set out in case law is high.

ECHR Article 3 protects individuals from 'inhuman or degrading treatment'. ECtHR has considered whether an individual's health may invoke a shield to expulsion under article 3. The threshold of severity may be engaged in 'very exceptional circumstances'.[24] In the recent *Paposhvili v Belgium*,[25] the Grand Chamber clarified the term. The case concerned the deportation of a seriously ill Georgian national, facing deportation and a ban on re-entering Belgium for 10 years on public-interest grounds due to several criminal convictions. While in prison, he was diagnosed and treated for chronic lymphocytic, leukemia, hepatitis C, and tuberculosis. He argued that deportation would violate ECHR article 3, as necessary medical treatment was not accessible in Georgia. Using the term 'very exceptional circumstances' set out in earlier case law, the Grand Chamber concluded that deporting the applicant would represent a violation of article 3. The Grand Chamber clarified the content and threshold of this term, stating that an 'immediate risk of dying' is not required. The question is if 'substantial grounds' show that a person will face a 'real risk' of being exposed to a 'serious, rapid and irreversible decline' in state of health 'resulting in intense suffering' or to a 'significant reduction of life expectancy' due to the 'absence of appropriate treatment' or 'access to such treatment'.[26] Determining whether such a risk exists, the state shall assess whether the person in question will receive appropriate treatment when returned. A theoretical existence of a health system is not enough:

> The authorities must also consider the extent to which the individual in question will actually have access to this care and these facilities … The Court observes in that regard that it has previously questioned the accessibility of care … and referred to the need to consider the costs of medication and treatment, the existence of a social and family network, and the distance to be travelled in order to have access to the required care … [27]

This statement shows that the ECtHR pays attention to the accessibility of a theoretical right to health care. Affordability and physical access must be considered. People 'unlawfully residing' in Norway are required to leave the realm, and thus legally defined as deportable. *Paposhvili v Belgium* indicates that if such a person is seriously ill, and the absence of appropriate treatment in the country the person is expected to return to will result in a 'serious, rapid and irreversible' decline in state of health, leading to either 'intense suffering' or to a

[20] *Ponomaryovi v Bulgaria* App no 5335/05 (ECHR, 21 June 2011) [54].
[21] *LCB v the United Kingdom* App no 23413/94 (ECHR, 9 June 1998) [36]; *Oyal v Turkey* App no 4864/05 (ECHR, 31 March 2010) [53].
[22] *Powell v the United Kingdom* App no 45305/99 (ECHR, 4 May 2000).
[23] *Nitecki v Poland* App no 65653/01 (ECHR, 21 March 2002); *Pentiacova and others v Moldova* App no 14462/03 (ECHR, January 2005); *Hristozov and others v Bulgaria* App no 47039/11 and 358/12 (ECHR, 13 November 2012) [106]; *Cyprus v Turkey* App no 25781/94 (ECHR, 12 May 2014) [219].
[24] *D v The United Kingdom* App no 30240/96 (ECHR, 2 May 1997) [52]–[54]; *N v The United Kingdom* App no 26565/05 (ECHR, 27 May 2008) [42]–[47].
[25] App no 41738/10 (ECHR, 13 November 2016).
[26] Ibid. [183].
[27] Ibid. [190].

'significant reduction of life expectancy', the person cannot be returned. Before deporting a seriously ill person, states are obliged to assess whether that person will have access to appropriate treatment upon return. Furthermore, the case indirectly indicates that rejecting appropriate health care to individuals *still present* in a member state in situations referred to as 'very exceptional circumstances', might engage responsibility under article 3.

ICESCR

The International Covenant of Social Economic and Cultural Rights of 1966 (ICESCR) provides a more explicit right to health. Article 12 establishes the right of 'everyone to the enjoyment of the highest attainable standard of physical and mental health'. The formulation 'everyone' indicates that the right applies to every person in a state's jurisdiction, independent of legal residency. 'Highest attainable standard' must be interpreted in the light of the ICESCR article 2.1. It sets out that each member state shall '… take steps … to the maximum of its available resources' to achieve '… progressively the full realization of the rights … by all appropriate means, including particularly the adoption of legislative measures'. The UN Committee of Economic, Social and Cultural Rights (CESCR) has stated that a state shall use '… the maximum of its available resources'[28] to ensure the right to health. All states have an obligation to offer essential primary health care as a minimum.[29] The obligation to fulfil a progressive realisation then varies, dependent on available resources.

The ICESCR article 12 must be read in the light of the non-discrimination principle set out in article 2.2. It contains a general obligation to '… guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to … other status'. However, the ICESCR article 4 opens for limiting the rights of the covenant if it is 'determined by law', 'compatible with the rights of the convention' and 'solely for the purpose of promoting welfare in a democratic society'. In 2000, the CESCR stated in its General Comment no 14 (GC14) that respecting the right to health requires refraining from '… limiting equal access for all persons, including … illegal immigrants, to preventive, curative and palliative health services' (s 34). The statement indicates that limiting health-care rights based on unlawful residency is incompatible with the Covenant.

Nevertheless, in its post-dated General Comment no 20 (2009), related specifically to the non-discrimination principle in article 2.2, the CESCR states that different treatment based on any prohibited ground is considered discriminatory '… unless the justification for differentiation is reasonable and objective'.[30] This includes an assessment of whether the '… aim and effects of the measures or omissions are legitimate, compatible with the nature of the Covenant rights and solely for the purpose of promoting the general welfare in a democratic society',[31] as also set out in the ICESCR article 4. Furthermore, there '… must be a clear and reasonable relationship of proportionality between the aim sought to be realized and the measures or omissions and their effects'.[32] This indicates that limiting

[28]Ibid. [47].
[29]CESCR 'General Comment no 3: The nature of States parties' obligations (art 2, para 1)' (1990) E/1991/23, para 10; CESCR 'General Comment no 14: The right to the highest attainable standard of health' (2000) E/C.12/2000/4, paras 43, 47.
[30]CESCR 'General Comment No 20: Non-discrimination in economic, social and cultural rights (art 2, para 2)' (2009) E/C.12/GC/20, para 13.
[31]Ibid.
[32]Ibid.

health-care rights based on residence status might be in line with the Covenant if satisfying these terms. However, everyone must be ensured a certain minimum of health-care rights.

As the ECtHR, the GC14 sets out that the right to health contains a notion of accessibility, with four dimensions: non-discrimination, physical accessibility, affordability, and information accessibility.[33] Affordability implies ensuring that services '… are affordable for all, including socially disadvantaged groups'. Information accessibility means '… the dissemination of appropriate information relating to … availability of services'.[34]

Norwegian legislation

The ECHR and the ICESCR: relevance and weight

The Norwegian Constitution section 92 states that the Norwegian authorities shall 'respect and ensure' human rights as they are expressed in the 'treaties … binding for Norway'. The section does not directly incorporate international treaties in the Constitution but is interpreted as a directive for governmental representatives to enforce human rights as implemented in Norwegian legislation.[35]

The Norwegian Human Rights Act directly implements the ICESCR and the ECHR.[36] Based on the principle of presumption, Norwegian legislation is assumed to be in coherence with international obligations. In the case of incoherence, the implemented treaty prevails over national legislation.[37] Sources from international enforcement bodies related to implemented treaties are relevant when interpreting national legislation.[38] Judgements from the ECtHR are legally binding. The ECtHR's competence to authoritatively interpret the ECHR obliges other member states to adopt to its case law (ECHR arts 19 and 32). For these reasons, case law from the ECtHR is in general given more weight than sources from other enforcement bodies.[39] General Comments of enforcement bodies such as the CESCR are considered a source of *relevance*. However, the *weight* of a concrete statement depends on its character. If a General Comment relates to a specific rule and conducts a consolidating review on a concrete interpretation issue, it might be given considerable weight.[40] A statement with the character of being a recommendation related to optimal practice is given limited weight.[41]

Norway is thus obliged to ensure that everyone within its jurisdiction receives a certain minimum of both somatic and mental health care. If everyone has access to a decent minimum of health care, limiting further resource-hungry health services to migrants unlawfully residing in the realm is justifiable. However, such differentiation is not in line with an *optimal* practice of the ICESCR. The ECtHR and CESCR stress that health-care rights must be accessible in practice. Refusing available health care to seriously ill individuals might, in very exceptional circumstances, raise an issue under the ECHR article 3 if resulting in an irreversible status in health and intense suffering. If an

[33]GC-2000-14-CESCR, E/C.12/2000/4, para 12.
[34]GC-2000-14-CESCR, E/C.12/2000/4, para 12b.
[35]HR-2016-2554 [64]–[70], [140].
[36]Menneskerettsloven [Human Rights Act] 1999, ss 2(1) and 2(2).
[37]Ibid., s 3 cf s 2.
[38]See e.g. HR-2019-2301-A; HR-2016-2262-A; HR-2015-206-A.
[39]Innst 186 S (2013–2014), p 20.
[40]HR-2015-206-A [64]–[65].
[41]Ibid; HR-2009-1932-A [44]; HR-2015-2524-P [152].

individual's life is put at risk by refusing essential health care available to the population generally, responsibility under the ECHR article 2 might be engaged. The next question is how these obligations are implemented in national legislation.

Norwegian health legislation and IMs

The Patient Rights Act[42] provides a basis for making exceptions to the healthcare rights set out in the Act's chapter two for non-permanent residents (s 1–2 (1)). IMs' health-care rights are implemented in the Royal Decree on health services for people without a permanent residence in the realm (RD 1255).[43] The Patients Act's preparatory work does not contain any assessment related to the reasonability or proportionality of the limitation. The consultation memorandum 2010 preceding the RD 1255, contains a brief assessment of human rights obligations. The Ministry sets out that differentiation based on a '… person's attachment to the state' is presumably in line with human rights obligations as long as everyone is ensured a certain minimum of health services.[44]

RD 1255 establishes that everyone has the right to be assessed by a specialist after a medical referral.[45] Furthermore, everyone has the right to 'emergency care' and to '… health care that is totally necessary and cannot be deferred'.[46] The rights cover specialist and primary health care and apply to somatic and mental health. The term 'emergency' is understood as a situation where a patient needs to be treated within 24 hours. The term 'help that cannot be deferred' is defined as situations where health care cannot be postponed without '… immediate risk of death, permanent severe disability, serious injury or severe pain'.[47] The consultation memorandum sets out that the medical assessment should be based on the assumption that the patient will leave the country within three weeks and use the health system in her/his home country. Health care that can be postponed for more than three weeks without escalating to a medical emergency is outside the scope of the right.[48]

Pregnant women are entitled to the same prenatal health care as authorised citizens, and to abortion.[49] 'Everyone' has the right to treatment of communicable diseases.[50] Prisoners have the right to health care that 'should not be postponed' until detention is over.[51] The 'mentally unstable' have the right to mental health care when '… representing a nearby danger to themselves or others'.[52] The content of the term 'mentally unstable' is not explained in the consultation memorandum. The wording 'representing' indicates a link to the term 'nearby danger',[53] and thus that representing such a danger is a criterion.

[42]Lov om pasient- og brukerrettigheter [Patient Rights Act] 1999.
[43]Forskrift om helse- og omsorgsrettigheter til personer uten fast opphold i riket [Royal Decree on health- and care services for people without permanent residence in the realm] 2011.
[44]Ministry of Health and Care Services, 'Høring - Endring av prioriteringsforskriften - Helsehjelp til personer som oppholder seg ulovlig i landet' ['Hearing - Changes in the Priority Regulation - Health care to people who are unlawfully residing in the realm'] (2010), para 6.
[45]RD 1255, s 1 cf Patient Rights Act, s 2–2(1).
[46]RD 1255, ss 3 and 5(1)(a).
[47]RD 1255, s 5(1)(a).
[48]Ministry of Health and Care Services (n 44), para 6.
[49]RD 1255, s 5(1)(b) and (c).
[50]Ibid., s 5(1)(d) cf Smittevernloven [Act on Communicable Diseases] 1994, s 6-1.
[51]RD 1255, s 5(1)(a).
[52]Ibid.
[53]The wording of the term is the same as in Lov om etablering og gjennomføring av psykisk helsevern [Act on Mental Health Care] 1999, ss 3–3.3(b). See also Ministry of Health and Care Services (n 44), para 6.4.

The main rule is that IMs pay the full price for health services and goods.[54] In case of a medical emergency, advance payment is not required, and payment after treatment is reimbursed by rules for monetary claims.[55] If the patient cannot pay, the health institution covers the expenses.[56]

IMs are protected by health personnels' duty of confidentiality in the same way as authorised citizens[57] and enjoy the same rights to appeal a medical decision.[58]

Related to human rights obligations, national legislation raises two main concerns: first, how payment for health services is practised, and whether this practice makes health care economically accessible. Second, whether practice related to 'totally necessary' health care ensures everyone a certain minimum of mental and somatic health care and does not leave anyone in a situation that constitutes inhuman or degrading treatment. These questions are examined after presenting the methods.

Empirical Material: Methods

Decisions from the Country Governor and hospitals

To understand how the above-mentioned legislation is interpreted and practised, the article analyses 32 health decisions involving IMs. The cases are dated from 2011 to 2019.

The County Governor[59] (CG) is the state's representative in local counties. Related to health services, the CG functions as the *appellate instance*. A patient who believes that one is not receiving the health care services to which one is entitled may appeal to the healthcare provider that made the decision, often a hospital (see Figure 1). If the responsible agency upholds its decision, the appeal is forwarded to the CGs for a final assessment. The CG also functions as the supervisory authority for welfare issues falling within the municipalities' remit. A patient can request the CG to assess whether health personnel have violated their professional duties[60] in a concrete case. In particularly grave offences, the CG forwards the case to the Board of Health Supervision.[61]

There are thus two kinds of cases – both visualised in Figure 1: (1) *Appeals* regarding the content of a decision,[62] and (2) *Requests* to assess health personnel.[63]

To access cases involving IMs, I cooperated with the Health Centre for Undocumented Migrants (HCUM).[64] The HCUM is run by the Church City Mission[65] and the Red Cross, and is based on health providers' voluntary work. They provide free health care to IMs two days a week. Sometimes, the HCUM represents its patients in appealing. After receiving the reference number to these cases, I forwarded a request for access to the CG Oslo/

[54]Lov om spesialisthelsetjenesten [Specialist Health Care Act] 1999, s 5-3(1),(4) cf Circulations I-2017-3, para 4 and I-2011-5, para 3; See also Specialist Health Care Act, s 5-3(3),(4) cf I-2017-3, para 7: Exception for patients in forced mental health protection. In these cases, the state covers treatment.
[55]Specialist Health Care Act, s 5-3(1) cf (4) cf I-2017-3, paras 4,9; Ministry of Health and Care Services (n 44), para 6.7.1.
[56]Ibid.
[57]Lov om helsepersonell [Act on Health Personnel] 1999, s 3 cf Patient Rights Act, s 3-6.
[58]Patient Rights Act, ch 7.
[59]Fylkesmannen [County Governor].
[60]Act on Health Personnel, s 4 and ch 5 are relevant for this article.
[61]Helsetilsynsloven [Act on Health Supervision] 2017.
[62]Patient Rights Act, s 7-2.
[63]Ibid., s 7-4.
[64]Helsesenteret for papirløse migranter [Health Centre for Undocumented Migrants].
[65]Kirkens Bymisjon [Church City Mission].

Figure 1. Visualisation and presentation of cases (28). *Legetjenester A/S [Medical Services A/S) delivers health services at Trandum. Both cases were somatic. **Community Mental Health Centre (8 cases); Somatic specialists (17 cases). ***Duty of Confidentiality (2 cases); Professional Accountability (2 cases). ****Professional Accountability.

Viken. The CG then provided anonymised versions of the cases. Some appeals are not forwarded to the appellate instance as the responsible agency – the health-care provider – changes its decision after assessing the appeal. I got anonymised versions of 10 such cases directly from the HCUM. The HCUM also gave me four anonymised medical decisions in cases that had not been appealed, as the patient in question had disappeared. These decisions were included in the analysis, as they to a certain degree make examples of hospital practice. These four medical decisions are not included in Figure 1.

Interviews

To assess experienced access to existing health-care rights, and potential gaps between formal rights and health-care needs, the article analyses 25 interviews with IMs conducted between May 2018 and October 2019. All informants were rejected asylum seekers. Demographic information was collected (Figure 1). The project is approved by the Norwegian Centre for Research Data (Table 1).

The participants were recruited from mainly three arenas: face-to-face at two meeting arenas in Oslo, and through a refugee service agency in southern Norway. The aim of recruiting participants from outside Oslo was to reflect potential geographical differences

Table 1. Demographic characteristics of participants (*N*=25).

DEMOGRAPHIC INFORMATION	*N*=25
GENDER	
Women	13
Men	12
AGE	
22–30	6
31–40	12
41–50	4
51–66	3
COUNTRY	
Eritrea	9
Iran	11
Iraq	1
Nigeria	1
Ethiopia	3
LIVING SITUATION	
Asylum centre	12
Family	3
Friends/partner	5
Own apartment	3
Tent or similar	2
YEARS IN NORWAY	
3–6	3
7–12	18
12–20	4

among participants. Based on the assumption that people who had lived in Norway for a longer period had developed health issues and thus used or needed the public health system, I aimed to recruit informants who had lived at least three years in Norway, preferably longer. This choice, combined with the recruitment strategy used, may explain why Iranians and Eritreans are over-represented. Eritreans cannot be deported by force, and the same is the case for Iranians without a passport. Consequently, many IMs with these nationalities do not actively evade deportation by hiding and are thus easier to get in contact with. One bias is therefore that the empirical material mainly reflects the narratives of IMs who were not hiding. To reduce bias, I recruited some participants who were hiding, through other arenas. How the factor hiding/not hiding influence access to health services, is explained in the result section.

All informants were provided information about the study from a written information sheet, either read to them or given to them. To ensure anonymity, I only got their oral consent. None of the participants were compensated.

The interview guide was semi-structured, aiming to maintain openness related to the wording and the order of questions. The guide was discussed with a clinical psychologist with experience as a volunteer at the HCUM. I conducted a pilot interview with a participant experienced with similar studies. The aim was to receive feedback regarding the interview situation and the suitability of the questions. The guide was slightly changed after the feedback from the two above-mentioned people. The interviews lasted 60 to 160 minutes. Most happened face-to-face. Two were conducted by telephone. State-authorised interpreters were used in 11 interviews, 3 were conducted in English, the rest in Norwegian. Most interviews happened at OsloMet, eight in the participant's home, and one in a cafeteria. The interviews were audio-recorded and transcribed verbatim. All transcripts were verified once. The verbatim material was imported into NVivo for analysis.

Data analysis

The material was analysed using thematic content analysis to identify patterns within the data.[66] Codes were developed with the legal framework in mind, typical for a deductive analytic approach.[67] Some codes, such as 'economic barrier', 'information', 'use of emergency room' were developed *a priori*. Other codes emerged inductively during the analytic process, such as 'lack of rehabilitation'. The cases from hospitals and the CG were analysed after the interviews. I started by organising the cases into different legal aspects. In the next phase, the cases were analysed in relation to the interviews. In a final phase, themes capturing the interrelation between the empirical data and the legal framework were developed.

All participants is used below when applying to all participants. *Most participants* is used to refer to more than half. *Some participants* is used to refer to less than half, but more than three participants, and *a minimum* is used to refer to two. All the names are invented. Cases from the CG and hospitals are referred to in the text as 'decision', 'case', or 'appeal' from either 'the hospital' or 'the CG'.

Findings

Three main themes capture patterns from the empirical material, and interrelations between the judicial and the empirical material: (1) Accessibility (2) Arbitrary practice (3) Most serious gaps between need and rights. Each theme has corresponding subthemes.

Accessibility

Affordability

The conditions of those informants who had experienced medical emergencies had made them practically unable to pay before receiving help. None of these informants had been billed after treatment. Simultaneously, in one decision from a public hospital, a woman was billed 42,000 NOK for giving birth. The bill was revoked by the hospital after an appeal. The general impression is that hospitals cover expenses in emergency cases, but that exceptions occur.

Surprisingly, most informants had paid 200–350 NOK for specialist assessments or assessments in the emergency room. This means that for health-care rights covered by the RD 1255 they did not pay the full price, as legislation indicates, but patient's contribution, as authorised citizens pay. For most participants, economy did not represent a total barrier in the sense that they avoided seeking essential help. However, payment represented a considerable, heavy burden. Most participants said things like Semira from Eritrea: 'It's not easy to go to the emergency room when you don't have money and you have to pay 300 NOK, it's a lot.' Some participants avoided required medical assessments due to the economic burden. Zehra, an elder woman from Eritrea, explained:

> I have a lot of health problems and used to go to monthly appointments at the hospital, but since I do not have enough money to pay, I have not gone to the last appointments. Anyways, if I go, they also prescribe medication that I can't pay for, so it's no point going there.

[66] Virginia Braun and Victoria Clarke, 'Using Thematic Analysis in Psychology' (2006) 3 Qualitative Research in Psychology 77.
[67] Ibid. 12.

The economic burden became even more precarious for the participants depending on medications. Miriam from Eritrea, whose narrative was similar to those depending on medications, described her economic frustration:

> I need regular medication for high blood pressure and for metabolism and it's very expensive … it's hard, without any income, how can life go on? To doctor, to medication and then to food, clothes, electricity …

For IMs, working in Norway is criminalised.[68] IMs are not entitled to economic support,[69] but those living in asylum centres receive 1930 NOK per month.[70] Any extra expense thus has a big impact on the little money they have. Amlak expressed his economic burden when needing medication after surgery:

> I had an accident and was hospitalised for a while. When I was sent home, the doctor wrote me a prescription for different medicine. It was very, very expensive, some 200 NOK some 300 NOK and so on. I had to take medicine four times a day, if not I could not sleep. The asylum centre did not cover the medicine I needed. I was running out of money. I had no money for food, nor medicine. I suffered, I was hungry, I was without medicine, out of painkillers, when I think of it, I still have nightmares

According to participants who lived in asylum centres, they could apply for a refund if they had a prescription for necessary medication. However, they explained that due to a regulation change in 2018, such reimbursements were not provided any more. As Amlak's narrative indicates, the inability to cover medicine can lead to suffering and trauma. Amlak explained that he saw a psychologist at the HCUM regularly after the episode, due to his emotional responses to the event.

As intended by the legislature, economy represented a 'total' barrier to health care falling outside the scope of the RD 1255. Some participants who had been assessed by a specialist explained how the process then proceeded no further as they could not pay for surgery. As written in a medical record after assessing a woman with pelvic pain and a very large uterine fibroid – common benign tumours in women of reproductive age, where size and rapid expansion are considered factors of increasing risk:[71]

> The patient does not have a legal residency and does not have the right to economically covered health services … The patient must be informed that a policlinic consultation will cost about 1000 kr., and 6000 per day if she is hospitalized. In case of surgery to remove the uterus, the patient will need to stay 3–4 nights at the hospital.

Some informants used tactics[72] to avoid paying for less serious health issues. Those who lived in or near Oslo and knew about the HCUM, went there to get free health care. Consequently, there was a geographical difference between the participants' ability to receive free health care. Providing humanitarian assistance to foreigners unlawfully residing in the realm is legitimate unless the intention has been to help the foreign to '… evade the

[68]IMA, s 108(2)(a) cf s 55(1).
[69]Forskrift om sosiale tjenester for personer uten fast bopel i Norge, [Royal Decree on social services for people without a permanent residence in Norway] 2011, s 4.
[70]UDI 2008-035V1, para 4.2.
[71]Valerie Shavell and others, 'Adverse Obstetric Outcomes Associated With Sonographically Identified Large Uterine Fibroids' (2012) 97 Fertility and sterility 107.
[72]See also Synnøve Bendixsen, 'The Politicised Biology of Irregular Migrants' (2018) 8 Nordic Journal of Migration Research 167.

obligation to leave the realm' and '… the assistance has made it more difficult for the authorities to implement removal of the foreign national'.[73] The exception creates a legal space for voluntary organisations such as the HCUM to provide free health care. Private institutions or general practitioners (GPs), not funded by the state, may also provide free health care. Two informants had arrangements with a GP, who treated them regularly without any cost. This finding correlates with a study of Norwegian GPs, showing that 23% of Norwegian GPs have helped IMs and that 70% of those who had treated these patients would continue to do so.[74]

Information accessibility

Lacking information has been considered a barrier to health care for IMs.[75] Not surprisingly, all participants were unsure about the content of health-care rights they had in Norway. However, most participants knew they could go to the emergency room. In line with other studies,[76] their threshold for using the emergency room varied from 'nearly dead' to a sore throat.

A minimum of the participants believed that lacking an ID represented a barrier to use the emergency room. When asking Layla from Iran whether she believed she could go to the emergency room, she said: 'No, no, if I'm sick I cannot go to the emergency room, everywhere in Europe you need an ID and I do not have one.' When asking what she would do if she got sick, she answered, 'I would just have stayed home or borrowed medicine from friends'. Having an ID is not a requirement to access the emergency room. Thus, the self-exclusion Layla expressed was not a result of legislation but rather of misinformation. However, two appeals to the emergency room show that rejecting patients based on their lack of ID do occur. Both cases concern patients rejected by medical secretaries due to their lack of ID. Responding to the appeal, the emergency room apologised, agreeing that such practice was incompatible with the regulatory framework. Although not reflecting general practice, events like these two might explain Layla's self-exclusion, as many of the participants relied on information and stories from other IMs. Many informants explained having an embodied experience of being 'illegals', vulnerable to rejection or negative responses from the authorities. Some suffered from depression and anxiety. These factors may explain that hearing stories like the two above, cause self-exclusion for some.

Fear of deportation, found to be a barrier to health services in earlier studies,[77] depends on whether one is hiding from the authorities. As most participants in this study did not hide their address from the authorities, fear of being deported was not a barrier for them. Most of the participants did not associate the health system with the police or the immigration authorities. As Anes said: 'The doctors must accept you, they don't reject you because you don't have a residence permit. That is not how it works.' However, fear of

[73] IMA, s 108(6).
[74] Aarseth and others (n 18).
[75] Bendixsen, 'Arbitrary Rights?' (n 17); Aniek Woodward, Natasha Howard and Ivan Wolffers, 'Health and Access to Care for Undocumented Migrants Living in the European Union: A Scoping Review' (2013) 29(7) Health Policy and Planning <https://doi.org/10.1093/heapol/czt061> accessed 20 October 2019; Karen Hacker and others, 'Barriers to Health Care for Undocumented Immigrants: A Literature Review' (2015) 8 Risk Management Health Policy 175.
[76] Ibid.
[77] Ibid.

deportation did represent a barrier for those informants who were afraid of the police or who were hiding. Navid from Iran explained:

> I was living in a tent outside of Oslo during the winter. It was very cold, and my prostate was hurting a lot when I peed. I was bleeding, but I was very afraid of going to the doctor. I was too scared to go to the emergency room because maybe they could send the police after me.

Health providers have an obligation to maintain the confidentiality of patient information, including their migration status,[78] different from certain other European countries.[79] Norwegian health legislation is thus designed to avoid that patients, such as Navid, fear seeking health care. Mary, a Nigerian woman, was hiding from the police. When she became pregnant, she did not know where to go for help. She explained that she would have just stayed home, maybe gone to the hospital to give birth, if it had not been for her friend who informed her about a voluntary centre. The centre put her in contact with the HCUM, which helped her to get an appointment at a public hospital. At this point, Mary had been pregnant for about 19 weeks. She said that: 'You feel you are helpless but there are people out there that can help, but when you don't know them you are just there.' She further explained: 'I was afraid to go to the hospital because they might call the cops.' Understanding that the health personnel would not report her, she got more relaxed and went to her next appointments. Her story shows that having information about the duty of confidentiality may eliminate fear of deportation as a barrier to health care. Secondly, her narrative shows that even though pregnant IMs have the right to prenatal care, such rights may be hard to access as these women do not have a GP.

Arbitrary practice

As found in earlier studies,[80] the confusion participants expressed related to their health rights was also present among health personnel. As was written in a medical record after assessing a patient with spinal stenosis – a narrowing of the spaces within the spine that may cause pressure on the nerves –:

> He is an illegal asylum seeker … Normally this patient would be put on a waiting list for surgery, but I am unsure if he has these rights in Norway. Our legal advisers must decide, I cannot do it. This is not a medical emergency, but a chronic condition and the patient would be better after surgery.

This record indicates that unclear legislation related to the content of IMs' health rights, can lead to time-consuming paperwork.[81] The uncertainty the record exemplifies seemed to produce an arbitrary practice, resulting in both positive differentiation and limiting of rights.

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[78]Act on Health Personnel, s 21.

[79]Elisabetta De Vito and others, 'Public Health Aspects of Migrant Health: A Review of the Evidence on Health Status for Undocumented Migrants in the European Region' [2015] Health Evidence network synthesis report 42 <http://dlc.dlib.indiana.edu/dlc/bitstream/handle/10535/9938/WHO-HEN-Report-A5-3-Undocumented_FINAL-rev1.pdf?sequence=1&isAllowed=y> accessed 20 October 2019.

[80]Dan Biswas and others, 'Access to Healthcare and Alternative Health-Seeking Strategies Among Undocumented Migrants in Denmark' (2012) 11(1) BMC Public Health <https://doi.org/10.1186/1471-2458-11-560> accessed 21 October 2019.

[81]Winters and others (n 17).

Positive differentiation

Some participants had received more public health care than the RD 1255 indicates. Joanna from Iran had surgical treatment to remove an anal fissure without paying. Afsar from the same country underwent surgery for a less serious condition without any cost. Simultaneously, two informants suffered from severe chronic pain. Both were assessed by a specialist after a referral from the HCUM. In both cases, the specialist concluded that their conditions qualified for surgery. However, surgery was rejected due to their legal status. Decisions from the CG show that rejecting operation for conditions as *hip coxarthrosis* (a chronic disorder characterised by degeneration of the hip joint. In this case; the patient suffered 'strong pain and falls due to reduced function'), *large uterine fibroids* (two cases with tumours about 15×10 cm) or *ruptured eardrum* (small hole in the eardrum that might lead to hearing loss. The patient suffered hearing loss and pain) – with positive surgical indications – was in line with the RD 1255. The positive differentiation Afsar and Joanna experienced can be explained as 'structural compensation'.[82] The term refers to the use of alternative structures to compensate for exclusion in mainstream services. Since 2010, the HCUM has cooperated with Diakonhjemmet.[83] This hospital is a private foundation. Joanna and Afsar were treated there, after referrals from the HCUM.

The surgical treatment Joanna and Afsar received was related to humanitarian aid,[84] depending on voluntary or private initiatives. Positive differentiation also happened within the public health system. One informant had received continuing treatment in a Community Mental Health Centre.[85] Furthermore, a decision from a hospital—A Community Mental Health Centre—shows that a woman was admitted continuing treatment after an appeal. Simultaneously, in all cases where the CG assessed appeals related to refused treatment in Community Mental Health Centres, the appellate instance found that such treatment is not covered by the RD 1255. Furthermore, some participants had not been billed after treatment in public hospitals. Others were billed and some experienced increasing debt collection claims. Such positive differentiation can be explained by 'functional ignorance'.[86] The strategy refers to health personnel ignoring questions about legal status in encounters with IMs. Health personnel working in public hospitals are bound by legislation on prioritisation of patients and use of resources,[87] here under the RD 1255. However, the unclear concepts 'health care that is totally necessary' and 'mentally unstable', and vague regulations related to IMs' payment for health services, can explain how some practiSe a milder interpretation to act more in line with their ethical guidelines.

Limiting rights

The same lack of clarity that may cause positive differentiation, can produce reluctance to act or a stricter interpretation than the legislative intent.[88] An example already mentioned

[82]Karlsen (n 18); Ursula K Trummer, Sonja N Zezula and Birgit Metzler, 'Access to Health Care for Undocumented Migrants in the EU' (2010) 16(1) Eurohealth <www.iom.int/jahia/webdav/shared/shared/mainsite/activities/health/Eurohealth-vol16no1-2010.pdf#page=16> accessed 20 October 2019.
[83]Health Centre for Undocumented Migrants, Annual Report (2018) p 9 <https://kirkensbymisjon.no/content/uploads/2018/06/Årsmelding-Helsesenteret-2018.pdf> accessed 6 September 2019.
[84]Karlsen (n 18) and Trummer and others (n 82).
[85]In this article, Community Mental Health Centre is a translation for the Norwegian term Distriktspsykiatrisk senter (DPS).
[86]Biswas and others (n 82).
[87]Act on Health Personnel, s 6.
[88]Karlsen (n 18).

is the two men rejected in the emergency room due to their lack of ID. Two appeals to the CG concern specialists not assessing referred patients due to the patient's legal status. In both cases, the CG found that rejecting first assessments violates the RD 1255. These four cases seem to be linked to uncertainty among certain health personnel in concrete cases.

Other cases reveal a general, limiting practice. One example is an appeal related to a woman who was denied abortion as she could not pay in advance. The hospital's practice at that time was that abortion was not considered 'totally necessary' health care. IMs applying for abortion were thus rejected on a regular basis. The CG interpreted abortion as 'totally necessary' and found that advance payment could not be demanded. The case led to new routines in abortion cases. Another example is a case where a patient with chronic hepatitis C was denied treatment. In its decision, the clinic wrote: 'Practice is that patients are offered treatment only if they are members of the Norwegian insurance scheme unless their condition is seriously life-threatening.' Patients were routinely rejected on this basis. The RD 1255 specifies that everyone is entitled to treatment of communicable diseases. The CG found that hepatitis C is a communicable disease and that the clinic had denied treatment on the wrong legal basis. The case led to new routines. Both examples show how the right to appeal may function as an important corrective to limiting practice.

Uncertainty among health personnel may also lead to delayed care.[89] One case concerns a woman with cancer, referred from the HCUM to a public hospital. The case documents indicate that uncertainty related to the content of her health rights led to postponed assessment from a relevant specialist. When assessed, the prognosis indicated that she needed radiotherapy. She was given a CT scan and an epicrisis to use in her home country. She did not return to get treatment. As her cancer developed to a situation of 'help that cannot be deferred' due to 'strong pain', she was offered alleviated treatment in Norway and died shortly after. Although the CG concluded that there had not been a violation of professional accountability in the case as health personnel had acted in line with the RD 1255, the case illustrates a consequence of correct interpretation of the regulatory framework.

Most serious gaps between needs and rights

Serious mental health problems

Most participants had problems sleeping, with appetite or headache. Some suffered from anxiety or depression. For most of the participants, mental health issues seemed to be related to their precarious migration status. Some participants experienced serious mental illness. Some described suicide attempts, or thoughts of taking their life, including how. Helen from Eritrea was suffering from severe depression. She explained being picked up by the police on the street and hospitalised due to her mental illness. She spent two weeks there. Her first encounter with the doctor was positive. He said that she would get help – psychiatric rehabilitation and physiotherapy. When the doctor found out that she did not have a legal residency, she was informed that she could not receive the help described. Sahid from Iran suffered from severe anxiety after traumatic episodes in his home country. When hospitalised several weeks in a public hospital for emergent

[89] Jensen and others (n 18).

surgery, he needed his own room as he could not sleep with the lights off. The hospital discharge team referred him to a Community Mental Health Centre. The Centre rejected the application due to his status. He explained:

> I have problems with nightmares … Every day, thinking: Now I am back in jail in Iran. I cannot sleep with the lights off, thinking the walls will come and take me, push me, that people will come and get me. I sit up at nights, waiting, looking out the window. Once, I heard the police outside and crushed the glass in my hand … I am often very scared … scared of talking … When I take the metro, I change it three, four times, thinking people sitting there will come and get me.

Victims of torture or human trafficking suffering from mental health issues are not offered rehabilitation. One example is a woman who had been tortured and raped in her home country. According to the case documents, she suffered from post-traumatic stress disorder (PTSD), severe depression, and dissociative disorder. After a suicide attempt, she spent some days under forced observation. The CG concluded that denying continuing care in a Community Mental health centre was in line with the RD 1255 as she no longer represented a 'nearby danger' to herself or others. Another case regards a person suffering from severe depression and trauma. He had been jailed in his home country. His application for continuing care in a Community Mental Health Centre was rejected due to his migration status. Later, his condition escalated, and he was placed in a psychiatric urgent care centre for some days before he was left on his own. A decision from a hospital concerns a female victim of human trafficking, diagnosed with PTSD and severe depression. After an assessment, she did not receive more help due to her migration status.

Four decisions from the CG reveal that the appellate instance interprets the RD 1255 as covering mental health care only in emergent situations. The cases concern rejections from Community Mental Health Centres after referrals from the HCUM. In three of the cases, the patients had been diagnosed with serious depression and PTSD. In all cases, the CG assessed whether the patient in question represented a 'nearby danger to themselves or others'. The wording indicates a high threshold. Representing such a danger provides a legal basis for emergent psychiatric care. Consequently, the CG concluded that rejecting these patients was in line with the RD 1255.

Lack of rehabilitation rights after an emergency or help that is 'totally necessary'

The problem with lack of rehabilitation overlaps with some of the situations described above, related to mentally ill patients. The same issues applied to the participants who had undergone emergent surgery. Not receiving rehabilitation is in line with the RD 1255. For some, it led to serious suffering. Sayed from Iran had a major surgery when he was still an asylum seeker. He thus had the right to necessary rehabilitation – home nurse care, medication, wheelchair, physiotherapy, etc. After a few days, his asylum application was rejected, and all rights to rehabilitation stopped. He was also removed from his GP's practice list. He explained: 'I needed strong medication as the nerves in my back were damaged. Then I suddenly lost all the medication and help from one day to another. I just sat home and cried in pain.' Bijan was hospitalised for an acute stroke and underwent heart surgery. He explained how a social worker came to him on the day of discharge to inform him of the rights one normally has in these situations, but that they did not

apply to him due to his status. Consequently, he did not receive rehabilitation or follow-up appointments.

High threshold for 'health care that is totally necessary'

As indicated above, decisions from the CG reveal that the threshold related to 'totally necessary' health care is interpreted strictly. Chronically ill patients with indications for surgery are referred to use the health system in their home countries. Another example is a man with chronic alcoholic abuse. He had been hospitalised several times for emergency situations such as pancreatitis, intoxication, and other somatic symptoms related to his abuse. His application for rehabilitation and detoxification was rejected, and the CG concluded that the decision was in line with the RD 1255. Rejecting surgery or treatment of chronic diseases is not in line with an *optimal practice* of the ICESR recommended by the CESCR. However, treatment of many chronic diseases extends a 'certain minimum' scope, and rejection cannot be defined as a *violation* of the ICESCR or the ECHR. Nevertheless, a strict interpretation of the term 'totally necessary' can lead to situations that, in some cases, might raise issues under human rights obligations. Two cases concern the treatment of cancer. One case concerns treatment for diabetes. The patients were not given treatment, as their condition would not develop to a medical emergency within three weeks. Such strict practice is problematic, as inadequate treatment over time is health-harming and might lead to situations where life is at risk.

Discussion and Concluding Comments

The objective of this article has been to examine the degree of compliance with human rights obligations related to health care for adult IMs living in Norway. A certain minimum of health-care rights is implemented in national legislation. One important aspect has been to assess how accessible these rights are. The findings indicate that emergency health care is generally provided without cost. Patients often paid the patient's contribution—200–400 NOK—for assessments from specialists or the emergency room. Most participants used the public health system despite the economic burden it represents. Somewhat different from what has been suggested in legal-dogmatic research,[90] the article finds that a certain minimum of health services seem to be economically accessible for IMs in Norway. The reason is that health personnel charge a patient's contribution for minimum services, and not the full price as legislation indicates. However, patients depending on medication are in an extremely precarious economic situation. Treatment of many chronic diseases is economically inaccessible, as most of these conditions do not fall within the scope of 'totally necessary' health care. The material analysed indicates that hospitals thus inform the patient that they will charge the full price before providing treatment. As IMs are not entitled to work or receive economic social support, treatment of these diseases becomes unaffordable.

The duty of confidentiality is a crucial legislative tool for minimising fear of deportation as a barrier to health services. Problems arise when someone hiding from the authorities lacks information regarding the duty of confidentiality, and thus awareness of it among IMs is important. Some experienced a subjective fear, despite having such knowledge.

[90] Aasen and others (n 19).

Fear of deportation is not related to the health legislation per se. It is an example of how migrant-specific policies – the duty to leave the realm – influence health status, as indicated in earlier research.[91]

The study reveals a considerable degree of variation at the level of practice among health providers. Patients were billed differently; from full payment, to patient's contribution, to no payment at all. The interpretation of 'health care that is totally necessary' varies. The CG interprets the term strictly. As earlier research indicates,[92] unclear legislation might lead to an arbitrary practice. Positive differentiation illustrates the problematic relation between the high threshold for receiving necessary health care set out in legislation and professionals' ethical guidelines. Positive differentiation is not a problem related to human rights obligations. The problem is when uncertainty leads to denied or postponed treatment of a decent minimum of health care. The findings indicate that such limiting practice happens. It can partly be solved by better information and routines among health providers. The term 'health care that is totally necessary' entered Norwegian health legislation with the RD 1255 in 2011. Making general guidelines to address all potential blurry lines seems to be difficult and would not necessarily solve the uncertainty practitioners experience in concrete cases. This study shows that the voluntary effort of the HCUM plays an essential role by representing patients in complaints. According to the HCUM, their patients would never have appealed on their own initiative. Making hospitals aware of potentially limiting practice, is not only important in individual cases but also for future practice. Furthermore, the HCUM plays an important role by referring IMs to specialists for assessments they are legally entitled to, but have difficulties accessing due to their lack of a GP. Similar findings have been established elsewhere in Europe.[93]

The material reveals unmet health-care needs among IMs in Norway that might raise issues related to human rights obligations. The ECHR article 3 might be engaged if 'absence of appropriate treatment' or 'access to such treatment' will lead to 'serious, rapid and irreversible decline' in state of health 'resulting in intense suffering'.[94] Before deporting such a seriously ill individual, or before rejecting health services based on the assumption that the person in question will return to her/his home country, the state must consider whether that person, when returned, will '… actually have access to this care and these facilities'.[95] In an above-mentioned case, a woman with cancer was rejected radiotherapy, and referred to use the health system in her home country. No assessment was done on whether she would have access to treatment. She was not treated in time and died. Different to the other patients and participants of this study, the woman was an EEA national. EEA nationals are in another legal position than are third-country nationals, as return often is easier and re-entering Norway is legal.[96] Presuming that she would have access to appropriate care might thus have been reasonable. Her EU citizenship makes it hard to argue that referring her to use the health system in her home country could engage the responsibility of the Norwegian authorities under the ECHR article 3 or

[91]Sol P Juárez and others, 'Effects of Non-Health-Targeted Policies on Migrant Health: A Systematic Review and Meta-Analysis' (2019) 7 The Lancet Global Health 420.

[92]Karlsen (n 18); Maria A Schoevers, 'Hiding and Seeking: Health Problems and Problems in Accessing Health Care of Undocumented Female Immigrants in the Netherlands' (2011) (PhD thesis, Radboud University 2011).

[93]Woodward and others (n 75).

[94]*Paposhvili v Belgium* (n 25) [183].

[95]Ibid. [190].

[96]IMA, ss 109–11.

2. However, it is worth stressing that the interpretation of RD 1255 done by the CG in that case, indicates that rejecting cancer treatment at an early stage is in line with the regulatory framework. Such an interpretation could lead to cases that might engage responsibility under ECHR articles 2 and 3.

Rejecting available health care to victims of torture suffering from serious mental illness or trauma might meet the threshold of severity in the ECHR article 3. There is no case law from the ECtHR directly applicable related to the rejection of mental health care to deportable individuals. Rejecting health care will seldom lead to an 'irreversible' decline in health status, as set out in *Paposhvili v Belgium*. It can be argued that the ECHR article 3 must be interpreted in light of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 10 December 1984, article 14, and that States thus have a responsibility to offer rehabilitation to such victims.[97]

Practice from hospitals and the CG shows that the scope of 'totally necessary' health care is based on the assumption that the patient will leave the realm within three weeks and use the health system in her/his home country. The assumption is not applicable when patients need medication and rehabilitation immediately after surgery. Migration management, such as encouraging voluntary return, is not a necessary or reasonable ground for limiting rehabilitation rights after emergent surgery. Lack of rehabilitation and access to necessary medication might, in some cases, fall within the scope of the ECHR article 3.

The high threshold related to 'totally necessary' health care might have unintended economic consequences. Many of the participants in this study had lived in Norway for 10 to 20 years. Providing preventive health care as opposed to treating a condition only when it becomes an emergency, is found to be cost-saving for health systems.[98] Providing health care at an earlier stage, for example for chronic diseases, would also be more in line with an optimal practice of the ICESCR article 12.

The right to health care cannot be understood in a vacuum. There are many underlying determinants of the right to health. Examples are food, clothing and housing, social security, and safety.[99] WHO's Health in All Policies[100] advocates for consideration of the health implications of public policies across all sectors. Migrant-specific policies, in this case, return policies, influence determinants of health. Exclusion from work affects living conditions, access to adequate food, and the ability to pay for medication and preventive health services. The threat of deportation has negative effects on mental health. Restrictive migration policies not only cause health harms but also undermine human rights in a broader perspective.[101]

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[97] Case C-353/16 MP v Secretary of State for the Home Department [2018] ECLI:EU:C: 2018:276.
[98] European Union Agency for Fundamental Rights, 'Cost of Exclusion from Healthcare: The Case of Migrants in an Irregular Situation' (2015).
[99] Wolff (n 2); Brownlee (n 2).
[100] World Health Organisation, Helsinki statement on health in all policies: framework for country action (2014 Geneva).
[101] Juárez and others (n 91).

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