Health care professionals' perception of Act (2013:407)

– the new health care services law for undocumented migrants

Master thesis in Medicine

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Abstract

Introduction: In July 2013 a new law was adopted in Sweden, *Lag (2013:407) om hälso- och sjukvård till vissa utlänningar som vistas i Sverige utan nödvändiga tillstånd* (or The Act), which states that undocumented migrants have the same right to health care services and dental care as asylum seekers. One of the most important measures to take, in order to ensure that these individuals receive the health care they are legally entitled to, is to make sure that health care professionals are well aware of the law. The aim of the study was to investigate how health care professionals in Sweden perceive The Act and the application thereof. We also wanted to investigate if there were any differences between various professions, area of work (type of unit), and between those reporting having dealt with undocumented migrants compared to those who had not.

Methods: A primarily quantitative web-based questionnaire was developed and used for this study. Our sample group consisted of health care professionals working in adult clinics in the Region Västra Götaland (VGR). Data were collected between November 2015 and January 2016. Multiple logistic regressions were used to analyze possible associations between independent variables, such as knowledge of The Act, and dependent variables, such as profession and type of unit. The same analytic method was used to find out if there were any differences between subgroups within the independent variables in relation to dependent variables.

Results: Our findings show that less than half of the participants knew The Act well, and that the demand for further education regarding this law is high, regardless of profession, area of work (type of unit) or if the participants had dealt with undocumented migrants or not in their work. The findings also show that participants who had been informed about The Act were significantly more likely to report to know The Act well, agree on that The Act had led to changes in how they perform their work and to be confident regarding guidelines at their workplace on undocumented migrants, compared to those who had not been informed about The Act. Furthermore, nurses were less likely to report to know The Act well and to have been informed about The Act, compared with other professions.

Conclusions: Four out of five of health care professionals in our study expressed a need for further education regarding The Act. Nurses, who in many health care units also work as front desk staff, lacked information and good knowledge of The Act to a larger extent, compared to other professions. This indicates a potential threat against patient security since this professional group is the first point to access treatment for undocumented migrants, as well as for other patient groups. One conclusion of the study is that the information and training about The Act has been insufficient. In order to ensure that the lawful right to care for this vulnerable group of undocumented migrants is provided, and to support health care professionals in their work, we suggest more efficient information from the region to the health care professionals as well as clear local guidelines.

1 Introduction

Asylum seekers and undocumented migrants over 18 years of age are not legally entitled to health care under the same conditions as the rest of the population in Sweden. Undocumented migrants are a particularly vulnerable group, not least from a health perspective (1). One of the most important measures to take, in order to ensure that this group of individuals receive the health care they are legally entitled to, is to make sure that health care professionals are well aware of the law governing this (2, 3), namely *Lag (2013:407) om hälso- och sjukvård till vissa utlänningar som vistas i Sverige utan nödvändiga tillstånd* (or The Act). Furthermore, current health care regulations in Sweden could create a potential health and safety issue for the health care professionals involved, not only because they have to decide whether an undocumented migrant has the right to care or not, but also because these particular laws are not fully consistent with the medical ethical principles that apply to health care professionals. The aim of this study is, thus, to investigate how health care professionals perceive The Act and the application thereof.

1.1 Definitions

There are different terms used to refer to people who are residing in countries without permission to stay. Some of these terms, which often is put together by a first word a) *illegal, irregular, extra-legal, unauthorized, clandestine* and a second word b) *immigrants, aliens*, *foreigners* may lead to misleading associations between migration and criminality (1, 4). In this study, we have chosen to use the term *undocumented migrants*, a reference to individuals who have either previously sought asylum in the country but have been refused, or persons residing in the country without having applied for asylum or remained in Sweden after their visas expired.

1.2 Migration in Europe and undocumented migrants in Sweden

In 2015 it was estimated that more than 215 million international migrants were living outside their country of origin (5). In Europe the number of third-country nationals (i.e. non-EU foreign national) who has applied for international protection in the EU plus Switzerland and Norway (EU+), has increased steadily from approximately 250,000 persons in 2010, to more than 650,000 in 2014. The trend was continuing in 2015; after eight months the number of applications had risen with approximately 60,000 compared with the previous year. Syria was in 2014 the country with the highest number of applications for international protection registered in the EU (6, 7).

Sweden was in 2014 the second ranked receiving country in Europe, with more than 80,000 applicants reported. When adjusting the figures relative to each country's population, Sweden was the country who received by far the most applicants, with more than 8,000 per million people living there (7, 8). The Swedish Migration Agency (Migrationsverket) estimated that between 140,000 and 190,000 people would seek asylum in Sweden in 2015 (9), and the Director General of the Swedish Migration Agency said that "the refugee situation is unprecedented in modern times, from both a European and Swedish perspective" (10). To reduce the number of people seeking asylum and being granted residence permit, the Swedish government decided on 24 November 2015 to change the asylum regulations to the minimum level in the EU (11).

The estimated number of undocumented migrants in EU was in 2008 between 1.9 and 3.8 million (12), and in Sweden between 10,000 and 50,000 in 2010 (1). Due to several factors, there is no reliable statistics for this group of people. One of the reasons is that the national as well as the international social, economic and political situation is constantly changing for these individuals, which leads to geographic

movement as well as changes in group composition. Another reason is that undocumented migrants have no recognized identity in Sweden since they lack personal code or other registration number. Naturally, due to the risk of being deported, this group of people arguably tries to avoid Swedish authorities and maybe even the public eye (1, 13). About 50% of the asylum seekers in Sweden are living in the counties containing Stockholm, Gothenburg and Skåne, and it is estimated that most of the undocumented migrants are living in these areas as well (13).

1.3 Human Rights and Medical ethics

Human rights are today defined in various international agreements, where one of the most known is The Universal Declaration of Human Rights which was adopted by the UN General Assembly on 10 December 1948 in the aftermath of the Second World War. The creation of the declaration was a result of the UN members' will to guarantee the rights of every individual everywhere. The declaration states in article 2 that "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status" (14).

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being" according to the WHO constitution from 1948 (15). The right to health has today been enshrined in numerous international and regional human rights treaties as well as national constitutions all over the world. These rights are mainly described in the International Covenant on Economic, Social and Cultural Rights (16). According to the General Comment 14, made by the UN Committee on Economic, Social and Cultural Rights, the right to health contains four elements: *Availability*, *Accessibility*, *Acceptability and Quality* (known as the *AAAQ framework*). This means, among other things, that health care services should be

available in sufficient quantity, and be of good quality with skilled medical personnel. Health care services should also be accessible to everyone without discrimination, and respectful of medical ethics and culturally appropriate (17).

The World Medical Association (WMA) was founded in 1947, the same year as the Nuremberg trials took place, where atrocities in which doctors had participated during the Hitler regime were revealed. In the beginning WMA's objects were primarily to promote closer ties among the physicians worldwide, and to create an organization which could support and guide doctors during difficult times (18). Since then WMA has formulated a broad range of ethical statements that the Swedish Medical Association (Sveriges Läkarförbund) has adopted (19). WMA states for example in the Declaration of Geneva (1948) that "the health of my patient will be my first consideration" (20), and in the Declaration of Lisbon on the rights of the patient (1981) that "every person is entitled without discrimination to appropriate medical care" (21).

1.4 General attitudes, health care regulations and their impact on migrants' health

Undocumented migrants are considered among the most vulnerable in Europe, partly due to their weak legal status (22). Undocumented migrants benefit from the right to health in differing degrees across the European Union, although all Member States have ratified the UN conventions, which include guaranteeing the right to health care for all (23). The European Union Agency for Fundamental Rights (FRA) writes in their report from 2011, wherein they analyze Sweden and nine other Member States of the European Union, that most European countries entitle undocumented migrants to emergency care only, and that this is not always granted cost free. Furthermore, even if undocumented migrants are granted full access to health care, practical

obstacles could prevent them from benefitting from it, and five such main obstacles were identified: 1) costs and reimbursements, 2) unawareness (among both health care users and health providers) of entitlements, 3) fear of being reported to the authorities, 4) discretionary power of public or health care authorities and 5) lack of quality and continuity of care (24).

Larchancé came to similar conclusion in her study from 2012 where she identified undocumented migrants' obstacles in realizing health care rights in France (25). France is considered having one of the most generous health care systems in the world; in 1999 the law on "universal health coverage" came into force, which entitles all persons living in France, including foreigners, the same right to health care. However, Larchancé writes in her report that several factors such as social stigmatization, precarious living conditions including financial difficulties and the climate of fear and suspicion generated by stricter immigration policies, in practice, limit the access to health care. She is also referring to the French anthropologist Fassin who means that "it is their [the undocumented migrants] construction as an illegitimate social group which in fact both hinders their access to health care and produces ill health", and says in her findings that the notion of illegitimacy has a negative impact on people's sense of responsibility toward undocumented migrants, which is a particular serious matter when those people affected also include health care professionals (25).

In a report, by the humanitarian organization Doctors Without Borders in 2005 on undocumented migrants' health in Sweden, 65% of the respondents report that their physical health has been impaired during their stay as "non legal" in Sweden. The

same trend could be distinguished when the mental health of this group of people was examined: 64% of respondents reported that their mental health had deteriorated (26).

Migrants' health and their access to health depend more than anything on policies of entitlement and exclusion; on social, political, and economic structures. Since migrants have to adapt to (several) different medical systems and additionally often are not covered by these systems to the same extent as the nationals of a particular country, migration is accompanied by changes in therapeutic options as well as changes in risk of ill health. Health among migrants also varies according to gender, ethnicity, class and legal status (27).

1.5 The Act

The Swedish government decided on 28 January 2010 to appoint a special investigator with the task of submitting proposals on how the regulations regarding health care for asylum seekers and undocumented migrants could be made "more appropriate" than they were at the time (13). According to the Health and Medical Services Act (Hälso- och sjukvårdslagen (1982:763) 4 § and the Dental Act (Tandvårdslagen (1985:125) 6 §, undocumented migrants only had the right to receive unsubsidised urgent health and dental care. In other words, undocumented migrants carried full responsibility for their medical costs. These laws were also applied to undocumented migrant children, if they were not former asylum seekers, which gave them a different status, with the same right to health care as Swedish children (13).

Swedish regulations had been criticized by, among others, the former UN Special Rapporteur on the Right to the Highest Attainable Standard of Physical and Mental Health, Professor Paul Hunt. In the report Mission to Sweden from 2007, Hunt says

that he is “concerned that Swedish law and practice regarding the health care accessible to asylum seekers and undocumented foreign nationals is not consistent with international human rights law” (28).

Recommendations from the Swedish investigation, which were very much alike the ones Paul Hunt had suggested earlier, were published in the Swedish Government Official Report series (Statens Offentliga Utredningar, SOU) in 2011 and proposed changes to existing laws: care should be offered to asylum seekers and undocumented migrants regardless of age, “to the same extent and on the same terms as that offered residents” (13).

Before propositions of legislative amendments are submitted to the Parliament, it is normal procedure in Sweden that recommendations from investigations appointed by the Government, are sent out for consultation to concerned authorities, organizations, and other parties (29). However, this was never done in the case of The Act, nor did the government follow the recommendations made by the investigation in question. The Act was adopted in Sweden in July 2013, which states that undocumented migrants have the same right to health care services and dental care as asylum seekers (13). This means that undocumented migrants have the right to 1) subsidized health care and dental care that cannot be deferred, 2) maternal health care, 3) abortion care, 4) contraceptive advice 5) subsidized medicines prescribed in connection with these treatments and 6) a voluntary general health check-up (23). In other words, even though undocumented migrants’ and asylum seekers’ right to care is expanded, according to the new law, they are not entitled to care that can be deferred, and a difference still exists between these individuals and residents in Sweden. However,

each county or region has the right to provide health care to a greater extent than the law requires (30).

1.6 The introduction and perception of The Act

The county councils in Sweden had just one month, after the parliament decision, to prepare before The Act came into force in July 2013. Nevertheless, people who were interviewed about the introduction of The Act in a follow-up report made by The Swedish Agency for Public Management (Statskontoret), stated that the new regulatory framework was relatively easy to implement (31). Almost all county councils undertook some form of information campaign; however, the design and scope of information differed between the county councils. Two county councils did not organize any information campaigns since they believed that media had informed sufficiently about the new regulation, and there was therefore no need for further information. Already before The Act was introduced, more than half of the county councils in Sweden had decided that undocumented migrants had the right to receive more than just emergency care, and three had decided to give the same care to these individuals as residents in Sweden (31).

The National Board of Health and Welfare (Socialstyrelsen) and The Swedish Agency for Public Management both made the conclusion, in 2014 and 2015 respectively, that the County Councils' information, on the obligation to provide health care to undocumented migrants, is "difficult to access, inconsistent, and in many cases misleading" (31, 32). However, despite these conclusions, the overall assessment is that most undocumented migrants seeking care receive the care that they are entitled to (31).

The Swedish Red Cross and Doctors of the World each did a follow up of the first six months after the introduction of The Act. They reported that up to a quarter of the

individuals did not receive the treatment that they were entitled to. Both organizations claim that the reason for this was in most cases that health care professionals were not aware of The Act (2, 3).

Doctors of the World believed that the most important measure, to ensure that the new health care law is working in practice, was to ensure that the information about The Act reached out to all who worked in health care and that special efforts were made to inform the administrative personnel, since these professionals work at the entry point of the access to care and are often those who have first contact with undocumented migrants (2). This view was also shared by Jensen et al. in the study from 2011, where they suggest it be interesting in future studies to investigate how nurses and administrative personnel perceive access to health care for undocumented migrants (33).

1.7 'Care that cannot be deferred'

According to Swedish health regulations, the goal of health care is good health and care on equal terms for the entire population. Furthermore, health care should be provided with respect for the equal worth of all and for human dignity, on the basis of need and in accordance with science and empirical experience (34, 35).

In 1997 the Swedish Parliament decided on an ethical platform for priority-setting in the health care system. This platform is based on three ethical principles, ranked in the following order: the principle of Human Dignity, the principle of Needs and Solidarity, and the principle of Cost/Effectiveness. This means that all people should be treated equally regardless of age, sex, legal status or other personal characteristics or functions in society, that those with the greatest need for care should be given preference and that resources should be used where they render the greatest benefit.

These three principles should govern and inform all decision making at every level throughout the health care system (32).

The Act states that undocumented migrants have the right to *'care that cannot be deferred'.* The term "care that can be deferred" is used for the first time in Sweden in a proposition to the Swedish Parliament in 1982 (36), where it was referring to the care that patients temporarily staying in another county from where they were registered could receive once they were back in their county where they were living. The first time this concept is mentioned in a migration context is in the Management system for systematic quality work (SOSFS 1988: 8) in 1988. The National Board of Health and Welfare pointed out that "care that can be deferred" does not apply to asylum seekers, as these patients cannot be referred to their home county or country for treatment (32).

The same year as The Act was adopted, the Swedish government commissioned The National Board of Health and Welfare to provide official clarifications on the application of the concept *'care that cannot be deferred'*. In the investigation of this matter the National Board's first action was to organize a hearing with representatives from government authorities, metropolitan regions, non-governmental organizations (NGOs), professional associations and the Swedish Association of Local Authorities and Regions (Sveriges Kommuner och Landsting, SKL). All the major professional organizations and trade unions in the health care sector had after the Ministry memorandum in 2012 (37) already opposed the proposal to limit health care for undocumented solely to *'care that cannot be deferred'* (32).

After the hearing in 2013 a number of professional organizations made a consensus statement on the concept in question. In their statement they say that the concept of "care that can be deferred" should not be used in medical practice since all treatments are considered necessary (if there is not a question of a medical condition which in all probability will pass or heal by itself), emergency as well as elective treatment, although the latter one can be performed in a later, planned stage. In the organizations' opinion the formulation "can be deferred" implies a postponement in an uncertain future of a necessary treatment, which may never be carried out; "to introduce legal obstacles that prevent treatment at the right time and to the right patient may jeopardize the rights and security of the patients and should therefore not be accepted" (38). They also mean that a list of diagnoses, indicating treatment that could be postponed, is not useful since most diagnoses have varying progression and thus various treatments. In the recommendation part of the consensus statement the authors conclude that the concept of *'care that cannot be deferred'* could create worse and more arbitrary health care and suggest instead that this concept is interpreted according to the priority-setting principles accepted by the Swedish Parliament in 1997, "to discriminate/prioritize on the basis of criteria other than medical needs is unethical and therefore should the concept not be used" (32, 38). In their report from 2014, "Vård för papperslösa" (32), The National Board of Health and Welfare states that "the concept of '*care that cannot be deferred'* is not compatible with medical ethics, is not medically appropriate in health care and risk jeopardizing patient safety", and shares the health professions' opinion that it is not possible to specify diagnoses whose treatment can be deferred; it is instead the treating physician or dentist who should make the decision on whether treatment can be deferred or not, after having examined the patient, in each individual case.

1.8 Challenges for health care professionals in their meeting with undocumented migrants

The aim with the project "Best practice in Health Care Services for Immigrants in Europe" (EUGATE) was to identify on what constitutes best practice of health care for immigrants in Europe (39). One of the studies within this project was made by Priebe et. al. (40). The study investigated potential problems that health care professionals who provide care to migrants on a daily basis experience in their service. The study included health care professionals (physicians, nurses, psychologists, physiotherapists and social workers) from 16 different European countries (Sweden included), working in three different types of services (primary care, emergency care and service for mental illness). The majority of the respondents reported that treatment for migrants (i.e. labor immigrants, refugees, asylum seekers, victims of human trafficking and undocumented migrants) after the initial contact would not differ from that for non-migrant patients. However, there was an exception to this: participants stated that further treatment pathways for undocumented migrants and refugees were different from other migrants' or non-migrants' pathways. Eight problem areas for health care professionals were also identified in the study, presented in order of frequency: 1) Language barrier, 2) Difficulties in arranging care for migrants without health coverage, 3) Social deprivation and traumatic experiences, 4) Lack of familiarity with the health care system, 5) Different understanding of illness and treatment, 6) Cultural differences, 7) Negative attitudes among staff and patients, and 8) Lack of access to medical history. Regarding undocumented migrants, who in most cases are not entitled to mainstream health services, the authors said that "awareness of the legal situation may put practitioners into a dilemma" (40). One of the respondents who worked in primary care, said about migrants not being fully covered by health insurance: "…and doctors are in a situation with no good solution –

from an ethical point of view they should provide treatment, from a legal point of view, they shouldn't" (40).

Jensen et al. also performed a study within the EUGATE project (33). They noticed that there was a difference between emergency rescue (ER) physicians' and general practitioners' (GPs) experiences in Denmark. ER physicians expressed concerns about the lack of access to previous medical records and lack of contact persons, but thought in general that the treatment of undocumented migrants did not differ from the one given to anyone else. The GPs, on the other hand, were concerned about several factors when providing health care for these patients: administrative barriers, language issues, financial aspects, whether there was an obligation to inform the police or not (even though the participants had no intention to do so) and a concern on how to handle the situation in general.

In Sweden, health care professionals, who have to decide in each individual case whether the undocumented migrant is entitled to care or not, may experience stress in relation to these decisions, and feel uncertain about whether their assessments are the right ones. Physicians may even try to push away the problem by referring the patient to another physician (32). This indicates that current health care regulations in Sweden could create a potential health and safety issue for the health care professionals involved, not only because they have to make the decision to treat or not but also because these particular laws are not fully consistent with the medical ethical principles that apply to health care professionals.

1.9 Aim and objectives

The aim of this study is to investigate how health care professionals perceive The Act and the application thereof. We also want to identify what challenges, if any, health care professionals experience in their work with undocumented migrants. The research questions are:

- What knowledge do health care professionals have of The Act?
- Do health care professionals experience any changes as a result of The Act in how undocumented migrants are examined and treated?
- Do health care professionals experience any advantages and/or disadvantages with The Act in their daily work?
- Are there any differences, with regard to the above, between various professions, area of work (type of unit), and between those reporting having dealt with undocumented migrants compared with those who have not?

2 Method

2.1 Study design

For this study we used a primarily quantitative web-based questionnaire. (41, 42). Given the limited time frame to conduct this study and pragmatic challenges concerning access to contact details for health care professionals, we chose to collect data from a non-probability sample.

Since little or no research has been done regarding Swedish health care professionals and their perceptions of The Act, we have not had any template for the questionnaire. Instead we have constructed the questionnaire after a review of literature on undocumented migrants' access to health care and the possible challenges for health care professionals regarding this care, in Sweden and in Europe. Important references

in the creation and formulation of the survey questions have been Enskär et al. and Jensen et al (33, 43).

The questionnaire was written in Swedish and constructed in esMaker, a web-based survey and analysis tool. The questionnaire contained 37 questions and took approximately 10 minutes to answer (see Appendix 4). The questions enquired about knowledge and perception of the law, implementation of the law, possible changes at the work place, working conditions, need for further education and information, and sociodemographics. There was also a fictitious case with follow-up questions. However, the results from those questions will not be presented in this study due to pragmatic reasons. Most of the questions were forced-choice, but there were also open questions where we wanted to achieve a greater understanding of the respondents' answers.

2.2 Participants and data collection

Data were collected in Region Västra Götaland (VGR), which is Sweden's second largest county with more than 1.6 million inhabitants (44). The target group was defined as health care professionals (managers, physicians, nurses and front desk staff) working in adult clinics in Sweden. Potential participants were asked to participate by email (see Appendix 1). A total of 17,855 questionnaires were sent, of which 1,458 to managers (8.2%), 5 008 (28.0%) to physicians, 10 645 (59.6%) to nurses, 30 (0.2%) to front desk staff, and 714 (4.0 %) were sent to health care professionals whose specific professional titles were unknown to us. Since some of the potential participants had two titles, such as nurse and manager, and we classified them as either or (double titles including manager were classified as manager), these numbers must be seen as approximate. Based on the overall gender balance within

hospitals and health centers within VGR, we estimate that 76% of those we sent the questionnaire to were women and 24% were men.

Data were collected between November 2015 and January 2016. Contact details were obtained from the contact person for the VGR staff registry (Katalog i Väst; KIV) at each of the eight hospitals in the greater Gothenburg region as well as the public primary health care in VGR. We requested email addresses for all managers, physicians, nurses and front desk staff in all adult clinics. Potential participants who contacted us to inform that they did not want to participate in the study, received an answer from us. We replied that we wanted to collect responses and opinions from all health care professionals in the region, regardless of whether the respondent had dealt with undocumented migrants or not. However, we also informed that all participation was voluntary and that we of course respected the decision not to participate. The study was endorsed by the Director of Health Care in VGR who informed the managing directors of the eight hospitals and the public primary health care prior to the recruitment. Potential participants who, after having received the inviting email, chose to participate where informed more thoroughly about the study upon accessing the questionnaire (see Appendix 2).

2.3 Dependent/Outcome variables

2.3.1. Knowledge of The Act

Knowledge of The Act was measured with questions enquiring about how well participants knew The Act (question [Q] 2), whether they had been informed about The Act since its introduction (Q3 and Q4), whether they considered there to be a need for further education regarding The Act (Q6 and Q7) and what they believed '*care that cannot be deferred*' to mean (Q16). The participants could answer how well they knew The Act on an ordinal scale from "1) Very well" to "5) Not well at all". Data were dichotomized into *well* (very well, well, pretty well) and *not well* (not well,

not well at all) to facilitate further analyses. To Q4, Q7 and Q16 respondents could indicate more than one answer. To be able to differentiate between respondents having been informed by the employer (VGR=1or local manager=2) and those having been informed by others (university=3, various courses=4, trade unions=5, NGOs=6, media=7, colleague=8, own interest=9, and other=10), Q4 answers were transformed so that only one alternative (1-10) were attached to each respondent. The order (1-10) were treated as a hierarchy, so that the answer with the lowest number remained in the data set. This means that if a respondent had indicated for example VGR=1, media=7 and colleague=8 as informants, we classified the respondent as having answered only VGR.

2.3.2. Health care professionals' experiences of changes in how undocumented migrants are examined and treated

To examine if health care professionals had experienced any changes in how undocumented migrants are examined and treated we asked participants whether they considered The Act to have led to any changes in how they perform their work (Q8). The participants could answer the question on an ordinal scale from "1) No change" to "4) Big change", and also "I do not know". Data were dichotomized into *No/I do not know* (no change, I do not know) and *Yes* (small change, moderate change, big change) to facilitate further analyses. We also asked participants to describe experienced changes with an open-answer question (Q9); however, for pragmatic reasons, the analysis of the qualitative data in this study are not presented here.

2.3.3. Health care professionals' experiences of advantages and/or disadvantages with The Act

Whether health care professionals experienced any advantages and/or disadvantages with The Act in their daily work was investigated with questions about their confidence in guidelines at their workplace regarding undocumented migrants (Q10);

uncertainties at their workplace regarding undocumented migrants (Q11 and Q12); whether they believe that those affected by the law, that is, undocumented individuals, are aware of The Act and their rights to health care (Q15); whether they believe there is care that can be deferred (Q17); and whether they perceive discrepancies in the health and medical legislation in Sweden (Q18 and Q19). The participants could answer how well they agreed to be confident regarding guidelines at their workplace (Q10) on an ordinal scale from “1) very well” to “5) not well at all” but also indicate that their workplace did not have such guidelines. Data were dichotomized into *Well* (very well, well, pretty well) and *Not well* (not well, not well at all, no internal guidelines) to facilitate further analyses. The question regarding whether there had been any uncertainties at workplace regarding undocumented migrants (Q11) could be answered with “Yes” or “No”, and with the subsequent multiple-choice question (Q12), participants were asked to indicate uncertainties that had occurred at their workplace. The participants could answer how well they agreed with a statement that those affected by The Act, that is, undocumented individuals, are aware of The Act and their rights to health care on an ordinal scale from “1) very well” to “5) not well at all”, and also “Do not know”. Data were dichotomized into *Well* (very well, well, pretty well), *Not well* (not well, not well at all) and *Do not know* to facilitate further analyses. The question regarding whether there is ‘*care that can be deferred’* (Q17) could be answered with “Yes, for example…”, “Yes, but it must be assessed case by case” and “No”. However, for pragmatic reasons, the analysis of the qualitative data in this study are not presented here.

The question regarding whether participants perceive discrepancies in the health and medical legislation in Sweden (Q18) could be answered with “Yes”, “No” or “Do not

know", and with the subsequent multiple-choice question (Q19), participants were asked to indicate what kind of consequences that discrepancies in health and medical legislation possibly could lead to.

2.4 Independent/ Explanatory variables

The respondents were classified according to 1) *profession*, with the following subcategories: manager, physician, psychologist, midwife and nurse; 2) *work place (type of unit),* with the following subcategories: emergency care, primary care, psychiatric care and "other health care"; and 3) *if they had dealt with undocumented migrants or not*. We also wanted to investigate if there were any associations between *having been informed about The Act or not*, *knowing The Act well or not* and the following dependent variables: need for further education regarding The Act (Q6), changes in how health care professionals perform their work (Q8), confidence about the guidelines regarding undocumented migrants that are applied at the workplace (Q10), uncertainties at the workplace regarding undocumented migrants' health care (Q11). The possible association between *having been informed about The Act* and *knowing The Act well* was also of interest, and the participants were, on the basis of the above, classified according to this.

2.5 Statistical analyses

Data were analyzed using SPSS version 21. Descriptive analyses were used to present sociodemographic results. To facilitate analysis, continuous data, such as years of work experience or age, were converted into categorical variables. Descriptive analyses were also used to present the results of questions 4, 7, 12, 16 and 19 (see Appendix 2), which all were multiple-choice questions. Multiple logistic regressions were used to analyze possible associations between independent variables and dependent variables. Profession, type of unit, whether one had dealt with

undocumented migrants or not, whether one had been informed about The Act or not, whether one knew The Act well or not, work experience and gender were considered relevant confounders and therefore adjusted for. Each table shows the impact of each of the independent variables on the dependent variable. The results are shown as odds ratios (OR), with a 95% confidence interval (CI). P-values less than 0.05 were considered as statistically significant.

2.6 Ethics

Before commencing the questionnaire, participants were informed about the study and then asked to give written informed consent (see Appendix 3). Participation was anonymous and voluntarily, and participants did not receive any payment. The study was reviewed and approved in accordance with Angered Hospital's policy on Research Ethics (Angereds Närsjukhus forskningsetiska riktlinjer) (Ref: ANS 82-2014).

3 Results

3.1 Response rate

A total of 1,568 completed questionnaires were returned, representing a response rate of 8.8%. Respondents who reported working in pediatric units (*n*=8), miscellaneous professions (*n*=16) and front desk staff (*n*=4) were excluded – the latter two categories due to small numbers. The remaining 1,540 respondents (response rate = 8.6%) reported being managers, physicians, psychologists, midwives and nurses (see Table 1).

3.2 Sociodemographic variables

The sociodemographic characteristics of the sample are presented in Table 1. The majority of the respondents were women (72.5%). Just over half were nurses (52.2%) and nearly a third were physicians (32.5%). Most of the respondents worked in

emergency care units (51.6%). In the category "other health care", which was the second biggest group (23.5%), many different health care units were represented, such as intensive care; gynecology; internal medicine; surgery; skin; and Ear, Nose and Throat (ENT). More than half (60.0%) reported having had dealt with undocumented migrants in their work. The median age of the respondents was 42 years, and the median work experience in years was 15.

Table 1 **Sociodemographic characteristics of the respondents**

	Descriptive statistic			
			N	**%**
Total of respondents			1 540	100
Gender				
Female			1 116	72.5
Male			406	26.3
Other			1	0.1
Missing			17	1.1
Occupation				
Line manager			103	6.7
Physician			501	32.5
Psychologist			51	3.3
Midwife			74	4.8
Nurse			804	52.2
Missing			7	0.5
Type of unit				
Emergency care			795	51.6
Primary care			184	11.9
Psychiatric care			186	12.1
Other health care			362	23.5
Missing			13	0.9
Dealt with u.m.*				
Yes			924	60.0
No			438	28.4
Do not know			172	11.2
Missing			6	0.4
	MED	***Quart***	***Min***	***Max***
Age (years)	42	33 - 54	21	82
Work experience (years)	15	6 – 30	0	57

* undocumented migrants (u.m.)

3.3 Knowledge of The Act

Nearly 46% (CI 42.1 – 49.0) of the participants reported that they knew The Act *well* (5.1% very well, 12.7% well, 28.1% pretty well) (0,3% missing). The results indicate

significant associations between knowledge of The Act and profession, type of unit, whether one has dealt with undocumented migrants or not and whether one has been informed about the Act or not. As seen in Table 2, the results also indicate significant differences within the groups. Nurses were significantly less likely to report knowing The Act well compared with others*;* following professions showed a significantly higher likelihood ratio: line managers (OR 2.15, CI 1.28 – 3.61), physician (OR 1.52, CI 1.14 – 2.02), psychologist (OR 2.01, CI 1.02 – 4.34). Participants in both the psychiatric care and “other health care” were significantly less likely to report knowing The Act well compared with others. Participants in following units showed a significantly higher ratio of knowing The Act well compared with participants in the psychiatric care: emergency care (OR 1.95, CI 1.29 – 2.95), primary care (OR 2.72, CI 1.61 – 4.57), and participants in the primary care showed a significantly higher ratio of knowing The Act well compared with “other health care” (OR 1.64, CI 1.05 – 2.55). Participants who had dealt with undocumented migrants showed a significantly higher ratio of knowing The Act well (OR 2.92, CI 2.26 – 3.77) compared with those who had not. Participants who had been informed about The Act showed a significantly higher ratio of knowing it *well* (OR 6.26, CI 4.89 – 8.01) compared with those who had not been informed.

Table 2 “**I know The Act *well”***

	Multiple logistic regression		
Covariates	**p-value**	**Odds Ratio**	**CI**
Profession			
Line manager vs Physician	0.210	1.418	0.821 - 2.449
Line manager vs Psychologist	0.955	1.025	0.438 - 2.400
Line manager vs Midwife	0.187	1.647	0.785 - 3.455
Line manager vs Nurse	0.004	2.151	1.281 - 3.613
Physician vs Psychologist	0.389	0.723	0.345 - 1.513
Physician vs Midwife	0.626	1.161	0.636 - 2.119
Physician vs Nurse	0.004	1.517	1.138 - 2.021
Psychologist vs Midwife	0.307	1.607	0.647 - 3.989
Psychologist vs Nurse	0.045	2.009	1.015 - 4.340

Midwife vs Nurse	0.362	1.306	0.735 - 2.320
Type of unit			
Emergency vs Primary care	0.108	0.718	0.479 - 1.075
Emergency vs Psychiatric care	0.002	1.949	1.287 - 2.951
Emergency vs Other health care	0.290	1.175	0.871 - 1.586
Primary vs Psychiatric care	0.000	2.715	1.612 - 4.572
Primary vs Other health care	0.029	1.638	1.051 - 2.551
Psychiatric vs Other health care	0.029	0.603	0.383 - 0.950
Dealt with undocumented migrants			
Yes vs No / I do not know	0.000	2.918	2.257 - 3.772
Informed about The Act			
Yes vs No	0.000	6.259	4.894 - 8.006

43.2% (CI 39.4 – 47.0) of the participants answered that they had been informed about The Act (0,5% missing). The results indicate significant associations between having been informed about The Act and profession, type of unit, whether one has dealt with undocumented migrants or not and whether one knowing The Act well or not. As seen in Table 3, the results also indicate significant differences within the groups. Both psychologists and nurses were significantly less likely to report having been informed about The Act compared with other professions; line managers showed a significant higher likelihood ratio compared with the psychologists (OR 2.37 CI 1.05 – 5.36), and following professions showed a significant higher likelihood ratio compared with the nurses: line managers (OR 2.74, CI 1.65 – 4.56), physician (1.61, CI 1.21 – 2.14). Participants both in the emergency care and in the “other health care” were distinguished by their lower odds for having been informed about The Act compared with participants in the other units. Participants in the emergency care showed significant lower likelihood ratio compared with participants in the following units: primary care (OR 0.46, CI 0.31 – 0.68), psychiatric care (OR 0.63, CI 0.43 – 0.94). Participants in the following units showed significant higher likelihood ratio compared with participants in the “other health care”: emergency care (OR 1.40, CI 1.03 – 1.89), primary care (OR 3.06, CI 1.98 – 4.73), psychiatric care (OR 2.21, CI

1.43 – 3.42). Participants who had dealt with undocumented migrants showed a significant higher likelihood ratio for having been informed about The Act (OR 1.57, CI 1.21 – 2.04) compared with those who had not. Participants who had stated that they knew The Act well showed significant higher likelihood ratio for having been informed about The Act (OR 6.27, CI 4.90 – 8.02).

Table 3 "**I have been informed about The Act**"

	Multiple logistic regression		
Covariates	**p-value**	**Odds Ratio**	**CI**
Profession			
Line manager vs Physician	0.051	1.706	0.997 – 2.919
Line manager vs Psychologist	0.039	2.366	1.045 – 5.356
Line manager vs Midwife	0.077	1.932	0.930 – 4.011
Line manager vs Nurse	0.000	2.742	1.650 – 4.556
Physician vs Psychologist	0.364	1.387	0.684 – 2.810
Physician vs Midwife	0.682	1.133	0.624 – 2.055
Physician vs Nurse	0.001	1.607	1.210 – 2.136
Psychologist vs Midwife	0.652	0.817	0.339 – 1.967
Psychologist vs Nurse	0.676	1.159	0.580 – 2.318
Midwife vs Nurse	0.229	1.419	0.803 – 2.510
Type of unit			
Emergency vs Primary care	0.000	0.457	0.308 – 0.678
Emergency vs Psychiatric care	0.023	0.634	0.427 – 0.940
Emergency vs Other health care	0.030	1.398	1.034 – 1.892
Primary vs Psychiatric care	0.201	1.386	0.841 – 2.287
Primary vs Other health care	0.000	3.059	1.979 – 4. 728
Psychiatric vs Other health care	0.000	2.206	1.425 – 3.416
Served undocumented migrants			
Yes vs No / I do not know	0.001	1.569	1.210 – 2.035
Knowledge of The Act			
Well vs Not well	0.000	6.270	4.902 – 8.020

As seen in Table 4, 29.2% (CI 25.0 – 33.4) of all participants reported that they had been informed about The Act by their employer (i.e. VGR or the local manager at their work), and 14.0% reported that they had been informed about the same by others (i.e. university, various courses, trade unions, NGOs, media, colleagues, own interest, other).

Table 4 "**I have been informed about The Act by:**"

Answer options	Descriptive statistics	
	N	**%***
Employer	*450*	*29.2*
VGR	236	15.3
Local manager	214	13.9
Other	*215*	*14.0*
University	30	1.9
Various courses	9	0.6
Trade unions	7	0.5
NGOs (Incl. Rosengrenska)	57	3.7
Media	63	4.1
Colleague	14	0.9
Own interest	14	0.9
Other	21	1.4

*% of all respondents

80.1% (CI 77.9 – 82.3) of the respondents considered that there was a need for further education regarding The Act (0.2% missing). The results indicate that there are significant associations between whether one considers there to be a need for further education regarding The Act and whether one has been informed about The Act or not. There are also significant associations between the dependent variable and whether one knows The Act well or not. However, no significant associations were seen between the dependent variable and profession, type of unit or whether one have dealt with undocumented migrants or not. As seen in Table 5, the results indicate significant differences within some of the groups. Physicians showed a significant lower likelihood ratio for consider there to be a need for further education (OR 0.33, CI 0.11 – 0.98) compared with psychologists. No significant differences were seen between different type of units, or between those having dealt with undocumented migrants, and those who had not. Participants who did not know The Act well showed significant higher likelihood ratio for consider there to be a need for further education (OR 1.70, CI 1.24 – 2.32) compared with those who did know The Act well. Participants who had not been informed about The Act showed significant higher

likelihood ratio for consider there to be a need of further education (OR 1.67, CI 1.23 – 2.27) compared with those who had been informed.

Table 5 "**I need further education regarding The Act**"

	Multiple logistic regression		
Covariates	**p-value**	**Odds ratio**	**CI**
Profession			
Line manager vs Physician	0.382	1.276	0.738 - 2.207
Line manager vs Psychologist	0.147	0.420	0.130 - 1.358
Line manager vs Midwife	0.425	0.724	0.327 - 1.601
Line manager vs Nurse	0.839	0.947	0.558 - 1.606
Physician vs Psychologist	0.046	0.329	0.111 - 0.981
Physician vs Midwife	0.101	0.567	0.288 - 1.118
Physician vs Nurse	0.061	0.742	0.543 - 1.014
Psychologist vs Midwife	0.394	1.722	0.493 - 6.013
Psychologist vs Nurse	0.144	2.252	0.757 - 6.697
Midwife vs Nurse			
Type of unit			
Emergency vs Primary care	0.215	1.291	0.862 - 1.932
Emergency vs Psychiatric care	0.691	0.910	0.570 - 1.451
Emergency vs Other health care	0.441	1.141	0.816 - 1.594
Primary vs Psychiatric care	0.220	0.705	0.403 - 1.233
Primary vs Other health care	0.594	0.884	0.561 - 1.392
Psychiatric vs Other health care	0.384	1.254	0.753 - 2.089
Served undocumented migrants			
No / I do not know vs Yes	0.297	1.176	0.867 - 1.596
Knowledge of The Act			
Not well vs Well	0.001	1.698	1.241 - 2.324
Informed about The Act			
No vs Yes	0.001	1.670	1.229 - 2.268

Table 6 shows what kind of information participants who had indicated there to be a need for further education regarding The Act requested – in order of frequency. The most common answer options were: "Where do I turn when I have questions regarding undocumented migrants", "The law in general", Guidelines at my work place", "Interpretation of *'care that cannot be deferred'*".

Table 6 **"I need more information about"**

	Descriptive statistic		
Answer options	***N***	**%**	**CI**
	889	57.7	54.5 - 60.9

Where do I turn when I have questions regarding undocumented migrants			
The law in general	840	54.5	51.1 - 57.9
Guidelines at my work place regarding undocumented migrants	770	50.0	46.5 - 53.5
Interpretation of *'care that cannot be deferred'*	754	49.0	45.4 - 52.6
Differences between Swedish nationals, undocumented migrants and asylum seekers	733	47.6	44.0 - 51.2
The rights to provide more comprehensive health care than the law prescribes	727	47.2	43.6 - 50.8
How to proceed when an undocumented migrant is not able to pay the patient fee	716	46.5	42.8 - 50.2
Who is responsible for the undocumented migrants' patient fee costs	641	41.6	37.8 - 45.4
Professional secrecy regarding undocumented migrants	640	41.6	37.8 - 45.4
Who is responsible for that undocumented migrants have access to the health care that is prescribed by law	640	41.6	37.8 - 45.4
Whether I have the right to refer undocumented migrants or not	569	36.9	32.9 - 40.9
Patient fees for undocumented migrants	522	33.9	29.8 - 38.0
Sign prescriptions for undocumented migrants	447	29.0	24.8 - 33.2
Other	51	3.3	1.6 - 8.2

85.8% (CI 83.9 – 87.7) of the participants stated that there is "care that can be deferred"; however, 68.1% (CI 65.3 – 70.9) report that this must be assessed case by case, and 10,6% state that there is no "care that can be deferred" (3,6 % missing). Table 7 shows the results of how participants have defined the concept '*care that cannot be deferred'* – in order of frequency. The most common answer options were: "Emergency care", "Care and treatment of diseases and injuries where even a slight delay can have serious consequences for the patient", "Care that is given to prevent a

more serious state of illness or disease”, and “Care that is given to prevent more extensive care and treatment of a specific disease”.

Table 7 “**My definition of the concept** *‘care that cannot be deferred’”*

Answer options	Descriptive statistic		
	n	**%***	**CI**
Emergency care	1152	73.8	71.3 - 76.3
Care and treatment of diseases and injuries where even a slight delay can have serious consequences for the patient	902	57.8	54.6 - 61.0
Care that is given to prevent a more serious state of illness or disease	759	48.7	45.1 - 52.3
Care that is given to prevent more extensive care and treatment of a specific disease	617	39.6	35.7 - 43.5
Care to reduce the use of costlier emergency treatment measures	446	28.6	24.4 - 32.8
Care as a consequence of previous care	377	24.2	19.9 - 28.5
Do not know	140	9.0	4.3 - 13.7
Any type of health care	113	7.2	2.4 - 12.0
Cannot be defined	96	6.2	1.4 - 11.0

*% of all respondents

3.4 Has The Act led to any changes in how health care professionals perform their work

27.1% (CI 22.8 – 31.4) of the participants stated that The Act had led to changes in how they perform their work (small change 23.6%, moderate change 3.1%, Big change 0.5%) (0.2% missing). The results indicate significant associations between considering that The Act has led to changes and type of unit, whether one has dealt with undocumented migrants or not, whether one knows The Act well or not and whether one has been informed about The Act or not. As seen in Table 8, the results also indicate significant differences within the groups. The psychologists were distinguished by their lower odds for considering that The Act had led to changes in

how they perform their work compared with all other professions. Following professions showed a significant higher likelihood ratio: line managers (OR 4.31 CI 1.44 – 12.87), physicians (4.21, CI 1.53 – 11.62). The psychologist showed significant lower likelihood ratio compared with following professions: midwifes (OR 0.31, CI 0.10 – 0.95), nurses (OR 0.26, CI 0.10 – 0.72). Participants both in the emergency care and in the “other health care” were distinguished by their lower odds for considering that The Act had led to changes in how they perform their work compared with participants in other units. Participants in the emergency care showed significant lower likelihood ratio compared with participants in the following units: primary care (OR 0.40, CI 0.27 – 0.57), psychiatric care (OR 0.63, CI 0.41 – 0.96). Participants in the following units showed significant higher likelihood ratio compared with participants in the “other health care”: emergency care (OR 1.97, CI 1.29 – 3.01). Participants who had dealt with undocumented migrants showed a significant higher likelihood ratio for considering that The Act had led to changes in how they perform their work compared (OR 2.63, CI 1.95 – 3.55) compared with those who had not dealt with undocumented migrants. Participants who knew The Act well showed significant higher likelihood ratio for considering that The Act had led to changes in how they perform their work (OR 2.29 CI 1.71 – 3.05) compared with those who did not know The Act well. Participants who had been informed about The Act showed significant higher likelihood for considering that The Act had led to changes in how they perform their work (OR 1.82, CI 1.38 – 2.41) compared with those who had been informed.

Table 8 “**The Act has led to changes in how I perform my work”**

	Multiple logistic regression		
Covariates	p-value	Odds Ratio	CI
Profession			

Line manager vs Physician	0.930	1.024	0.607 - 1.727
Line manager vs Psychologist	0.009	4.311	1.444 - 12.871
Line manager vs Midwife	0.435	1.320	0.658 - 2.649
Line manager vs Nurse	0.623	1.134	0.688 - 1.808
Physician vs Psychologist	0.005	4.211	1.526 - 11.619
Physician vs Midwife	0.387	1.289	0.725 - 2.294
Physician vs Nurse	0.500	1.107	0.823 - 1.490
Psychologist vs Midwife	0.040	0.306	0.099 - 0.947
Psychologist vs Nurse	0.010	0.263	0.096 - 0.723
Midwife vs Nurse	0.589	0.859	0.495 - 1.492
Type of unit			
Emergency vs Primary care	0.000	0.395	0.273 - 0.573
Emergency vs Psychiatric care	0.031	0.629	0.412 - 0.959
Emergency vs Other health care	0.125	0.779	0.566 - 1.072
Primary vs Psychiatric care	0.071	1.591	0.960 - 2.635
Primary vs Other health care	0.002	1.970	1.292 - 3.005
Psychiatric vs Other health care	0.369	1.239	0.777 - 1.974
Served undocumented migrants			
Yes vs No / I do not know	0.000	2.632	1.951 - 3.551
Knowledge of The Act			
Well vs Not well	0.000	2.285	1.713 - 3.046
Informed about The Act			
Yes vs No	0.000	1.820	1.375 - 2.409

3.5 Advantages and/or disadvantages with The Act

42.1% (CI 38.3 – 45.9) of the participants agreed to be confident with regard to guidelines at their workplace concerning undocumented migrants (very well 5.9%, well 12.5%, pretty well 23.7%). The results indicate significant associations between agreeing to be confident regarding guidelines at workplace concerning undocumented migrants and having dealt with undocumented migrants or not, knowing The Act well or not, and having been informed about The Act or not. However, no significant associations were seen between the dependent variable and profession or type of unit. As seen in Table 9, the results also indicate significant differences within some of the groups. However, no significant differences were seen between different professions, or between different type of units. Participants who had dealt with undocumented migrants showed a significant higher likelihood ratio for agree to be confident regarding guidelines at their workplace regarding undocumented migrants (OR 2.74,

CI 2.08 – 3.62) compared with those who had not dealt with undocumented migrants. Participants who knew The Act well showed significant higher likelihood ratio for agree to be confident regarding guidelines at their workplace regarding undocumented migrants (OR 6.03, CI 4.59 – 7.92) compared with those who did not know The Act well. Participants who had been informed about The Act showed significant higher likelihood for agree to be confident regarding guidelines at their workplace regarding undocumented migrants (OR 2.50, CI 1.91 – 3.29) compared with those who had been informed.

Table 9 "**I feel confident about the guidelines that are applied at my work**"

	Multiple logistic regression		
Covariates	**p-value**	**Odds Ratio**	**CI**
Profession			
Line manager vs Physician	0.929	1.026	0.588 - 1.789
Line manager vs Psychologist	0.822	1.109	0.451 - 2.725
Line manager vs Midwife	0.684	0.854	0.401 - 1.821
Line manager vs Nurse	0.946	1.018	0.599 - 1.731
Physician vs Psychologist	0.847	1.081	0.490 - 2.383
Physician vs Midwife	0.565	0.833	0.447 - 1.552
Physician vs Nurse	0.963	0.993	0.733 - 1.344
Psychologist vs Midwife	0.594	0.771	0.296 - 2.009
Psychologist vs Nurse	0.831	0.919	0.422 - 2.001
Midwife vs Nurse	0.564	1.192	0.657 - 2.163
Type of unit			
Emergency vs Primary care	0.569	1.126	0.748 - 1.696
Emergency vs Psychiatric care	0.585	1.128	0.732 - 1.738
Emergency vs Other health care	0.552	1.103	0.799 - 1.522
Primary vs Psychiatric care	0.996	1.001	0.586 - 1.711
Primary vs Other health care	0.928	0.979	0.619 - 1.549
Psychiatric vs Other health care	0.927	0.978	0.606 - 1.577
Served undocumented migrants			
Yes vs No / I do not know	0.000	2.741	2.077 - 3.618
Informed about The Act			
Yes vs No	0.000	2.503	1.907 - 3.286
Knowledge of The Act			
Well vs Not well	0.000	6.032	4.594 - 7.920

37.7% (CI 33.8 – 41.6) of the participants stated that there had been uncertainties at their workplace regarding undocumented migrants' health care (2.5% missing). The

results indicate significant associations between having experienced uncertainties at workplace regarding undocumented migrants' health care and type of unit and whether one has dealt with undocumented migrants or not. However, no significant associations were seen between the dependent variable and profession, knowing The Act well or not, or having been informed about The Act or not. As seen in Table 10, the results also indicate significant differences within some of the groups. Managers showed a significant higher likelihood ratio for having experienced uncertainties at workplace regarding undocumented migrants' health care (OR 1.63 CI 1.01 – 2.64) compared with nurses. Participants in the Emergency care and in the Primary care both showed a significant higher likelihood ratio for having experienced uncertainties at workplace regarding undocumented migrants' health care (OR 1.44, CI 1.08 – 1.93 and OR 1.79, CI 1.19 – 2.70 respectively) compared with participants in the "Other health care". Participants who had dealt with undocumented migrants showed a significant higher likelihood ratio for having experienced uncertainties at workplace regarding undocumented migrants' health care (OR 4.94, CI 3.76 – 6.49) compared with those who had not dealt with undocumented migrants. No significant differences were seen between those who knew The Act well, compared with those who did not know The Act well, or between those who had been informed about The Act compared with those who had not been informed about The Act.

Table 10 **Uncertainties at work regarding undocumented migrants' health care**

	Multiple logistic regressions		
Covariates	**p-value**	**Odds Ratio**	**CI**
Occupation			
Line manager vs Physician	0.337	1.280	0.773 - 2.117
Line manager vs Psychologist	0.209	1.719	0.738 - 4.000
Line manager vs Midwife	0.653	1.164	0.600 - 2.261
Line manager vs Nurse	0.048	1.629	1.005 - 2.638
Physician vs Psychologist	0.441	1.343	0.635 - 2.842
Physician vs Midwife	0.732	0.910	0.530 - 1.563

Physician vs Nurse	0.084	1.273	0.968 - 1.673
Psychologist vs Midwife	0.389	0.677	0.279 - 1.642
Psychologist vs Nurse	0.887	0.948	0.452 - 1.989
Midwife vs Nurse	0.203	1.399	0.384 - 2.346
Type of unit			
Emergency vs Primary care	0.242	0.805	0.560 - 1.158
Emergency vs Psychiatric care	0.370	1.199	0.807 - 1.782
Emergency vs Other health care	0.014	1.442	1.075 - 1.933
Primary vs Psychiatric care	0.108	1.489	0.917 - 2.417
Primary vs Other health care	0.005	1.790	1.187 - 2.700
Psychiatric vs Other health care	0.411	1.203	0.774 - 1.867
Served undocumented migrants			
Yes vs No / I do not know	0.000	4.943	3.764 - 6.491
Knowledge of The Act			
Well vs Not well	0.354	0.881	0.674 - 1.152
Informed about The Act			
Yes vs No	0.428	1.113	0.854 - 1.451

Table 11 shows what kind of uncertainties participants indicated had occurred at their workplace regarding undocumented migrants' health care – in order of frequency. The most common answer options were: "Responsibility of costs", "Follow-up care", "Administration", "Whether the patient has the right to health care or not".

Table 11 "**Following uncertainties have occurred at my work place**"

Answer options	Descriptive statistic		
	n	**%***	**CI**
Responsibility of costs	363	23.6	19.2 - 28.0
Follow-up care	327	21.2	16.8 - 25.6
Administration	303	19.7	15.2 - 24.2
Whether the patient has the right to health care or not	300	19.5	15.0 - 24.0
Referral management	171	11.1	6.4 - 15.8
Follow-up visit	166	10.8	6.1 - 15.5
Patient safety	85	5.5	0.7 - 10.3
Other	71	4.6	0.3 - 9.5

*% of all respondents

Diagram 1 shows the difference between professions regarding what kind of uncertainties that have occurred at the workplace regarding undocumented migrants' care.

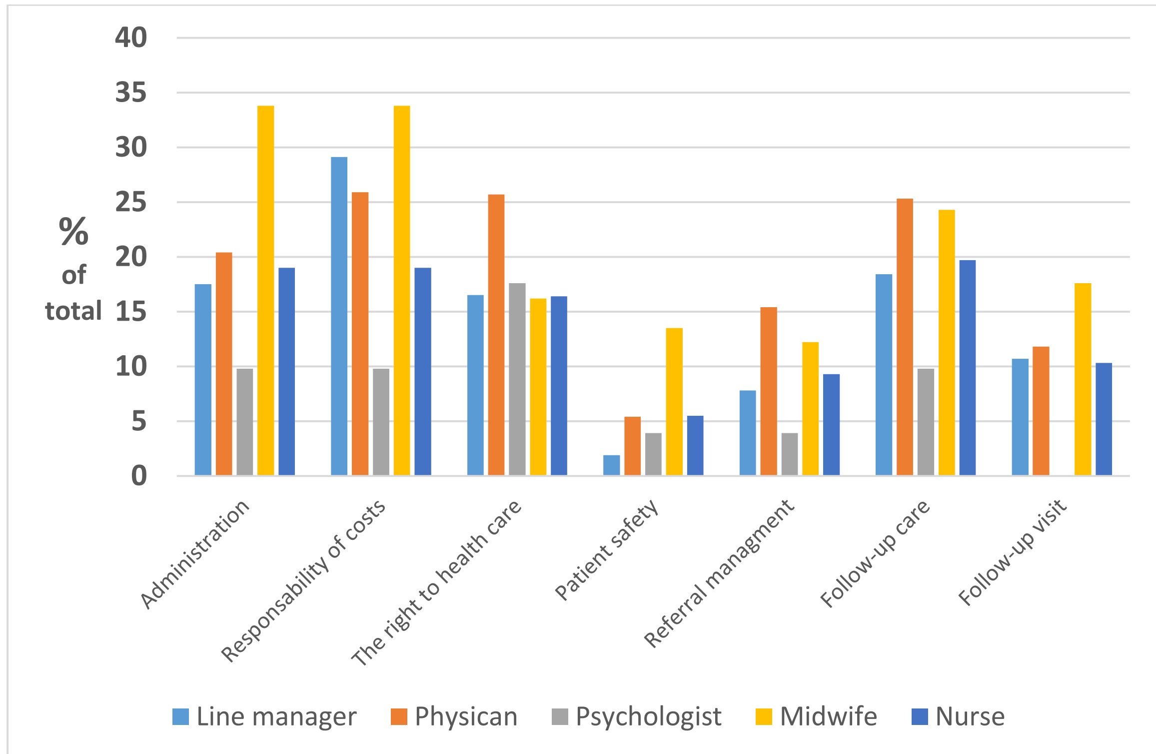

Diagram 1. The diagram shows the percentage of all respondents.

Diagram 2 shows the differences between type of units regarding what kind of uncertainties that have occured at the workplace regarding undocumented migrants' health care.

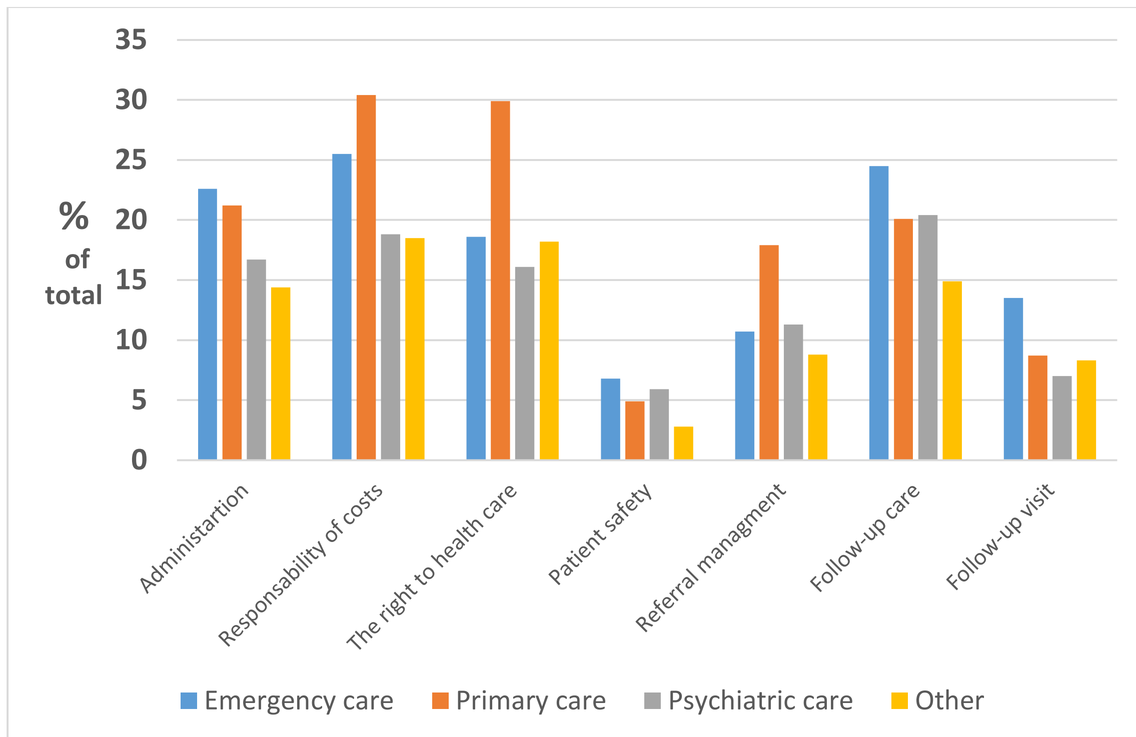

Diagram 2. The diagram shows the percentage of all respondents.

5,4% of the respondents reported that there are no discrepancies between different laws governing health care in Sweden, with regard to undocumented migrants' health care, 21,3% reported that there are so, and 72,3% did not know (1.0% missing). Table 12 shows what kind of consequences participants indicated these discrepancies could lead to – in order of frequency. The most common answer options were: "That care is not provided with respect for the equal worth of all", "The patient's need of continuity and safety in the health care is not met", "The patient with the greatest need of care is not given priority"

Table 12 **"Discrepancies could lead to"**

	Descriptive statistic		
Answer options	***N***	**%***	**CI**
That care is not provided with respect for the equal worth of all	916	59.5	56.3 - 62.7
That the patient's need of continuity and safety in the health care is not met	794	51.6	48.1 - 55.1
	761	49.4	45.8 - 53.0

That the patient with the greatest need of care is not given priority			
That the Swedish health care system does not function in a way that promote health or prevent diseases	666	43.2	39.4 - 47.0
That health care professionals cannot plan, direct or control activities in a way that leads to the requirement of good health care is maintained	602	39.1	35.2 - 43.0
Other	108	7.0	2.2 - 11.8

*% of all respondents

To the statement, "those affected by the law, that is, undocumented individuals, are aware of The Act and their rights to health care", 9.4% (CI 4.6 – 14.1) of the participants stated that they agreed *well,* 44.3% (CI 40.6 – 48.0) stated *not well,* and 45.9 % (CI 42.2 – 49.6) stated *do not know* (0.5% missing).

4 Discussion

4.1 Summary of findings

This study set out to investigate how health care professionals perceive *Lag (2013:407) om hälso-och sjukvård till visa utlänningar som vistas I Sverige utan nödvändiga tillstånd* (or The Act) and the application thereof. We also wanted to see if there were any differences, with regard to the above, between various professions, type of units, and between those reporting having dealt with undocumented migrants compared to those who had not. To investigate this, a web-based questionnaire was sent to health care professionals working in adult clinics in the Region Västra Götaland (VGR). Our findings show that less than half of the participants knew The Act well, and that the demand for further education regarding this law was high, regardless of profession, area of work (type of unit) or if the respondents had dealt with undocumented migrants or not in their work. Participants who had not been informed about, or did not know The Act well showed significant higher likelihood

ratios for requesting further education. The participants foremost lacked information about: “where to turn with questions regarding undocumented migrants”, “the law in general”, “guidelines at the work place”, and “how to interpret the concept of *‘care that cannot be deferred’”*. The latter was also demonstrated here by the participants’ rather limited knowledge of what is to be included in the concept ‘*care that cannot be deferred’* (according to the National Board of Health and Welfare). According to the findings from our study, participants who had been informed about The Act were significantly more likely to know The Act well, agree on that The Act had led to changes in how they perform their work and to be confident regarding guidelines at their workplace on undocumented migrants, compared to those who had not been informed about The Act. Nurses were less likely to report to know The Act well and to have been informed about The Act, compared with other professions. Furthermore, particularly health care professionals working in emergency or primary care experienced problems concerning undocumented migrants.

4.2 Knowledge of The Act

A majority of the respondents reported that they did not know The Act well, and less than a third reported that they had been informed about the same by their employer (VGR or local manager). We believe that this is a particular serious matter since earlier reports (2, 3) claim that the main reason, for undocumented migrants not receiving the care they are legally entitled to, are that health care professionals are not aware of The Act. As mentioned above, nurses were less likely to report to know The Act well and to have been informed about The Act, compared to other professions. This indicates yet another potential threat against the statutory right to health for the vulnerable group of undocumented migrants, since nurses commonly are the first front professionals deciding about further access to care. The National Board of

Health and Welfare has in a report about the concept '*care that cannot be deferred*' declared that it is "not ethically and medically possible or appropriate to list diagnoses, conditions or measures covered by the concept" (32). They have, however, clarified what kind of health care that is to be included in this specific concept. We proposed to our participants eight different definitions of *'care that cannot be deferred'*, whereof The National Board of Health and Welfare claimed that six should be included in the concept. Our results show that only 74%, 58%, 49%, 40%, 29% and 24% of the participants respectively agreed on these six definitions. This signify that participants in our study are not fully aware of what kind of health care that should be included in the concept *'care that cannot be deferred'*. These results indicate a potential threat to patient security, patient rights and means that The Act in practice is violated.

In a recent follow-up report about The Act (on request by the parliament), it was reported that the informants, i.e. representatives of all counties in Sweden, stated that the new regulatory framework had been "relatively easy" to implement (31). Our results suggest that there is a gap between the perception of civil servants, who meant that the implementation of The Act was "relatively easy", and the experience of health care professionals on the ground, who were set to implement The Act in practice. Four out of five of the participants in our study expressed a need for further education regarding The Act. We believe that there might be a connection between our results, indicating that health care professionals in VGR lack good knowledge of The Act and request further education, and previous reports who claim that the County Councils' information about The Act is "difficult to access, inconsistent, and in many cases misleading" (31, 32). The results in our study also show that participants who had been informed about The Act were significantly more likely to know The Act well,

agree on that The Act had led to changes in how they perform their work and to be confident regarding guidelines at their workplace on undocumented migrants, compared to those who had not been informed about The Act.

4.3 Has The Act led to any changes

Only a little more than a quarter of the respondents reported that The Act had led to changes in how they perform their work. Psychologists in our study were distinguished by their significant lower odds for considering that The Act had led to changes in how they perform their work compared with all other professions, and participants working in primary care and psychiatric care showed significant higher odds compared with participants working in the emergency care and "other health care". One possible explanation to this could be that psychologist to a lower extent have to decide whether to give the undocumented migrant care or not, since these professionals do not work as front desk personnel, and more rarely meet this patient group without a referral from another profession. There are reasons to believe that participants who work at the emergency units handle undocumented migrants in the same way as they did before The Act was introduced in 2013. VGR, the region from which data were collected in this study, had in 2008 formulated region-wide guidelines for medical care of undocumented migrants where they stated that the region had to ensure that undocumented migrants received emergency or other immediate care if needed, regardless of ability to pay at the given moment (13). For health care professionals working in the emergency care, who treat patient with obviously urgent medical conditions, one can suppose that The Act only confirms what earlier guidelines already supported. For health care professionals working in the primary or the psychiatric care, who treat patients with sometimes less evident urgent medical conditions, one can suppose that The Act had led to changes in how they

perform their work, since the concept of *'care that cannot be deferred'* enshrined in The Act, includes wider indications for treatment than only immediate or urgent treatment. However, we see in our results that participants who stated that they knew The Act well, or had been informed about The Act showed significant higher likelihood ratios for considering that The Act had led to changes in how they perform their work. These findings suggest that one reason for that participants do not believe that The Act had led to changes in how they perform their work is that they do not have sufficient knowledge about the same, and therefore handle undocumented migrants in the same way as they did before The Act was introduced.

4.4 Advantages and/or disadvantages with The Act

More than a third of the participants stated that there had been uncertainties at their workplace regarding undocumented migrants' health care, but the odds for stating this was as much as 5 times higher for those having dealt with undocumented migrants, compared with those who had not. The results also showed that particularly health care professionals working in emergency or primary care experience problems concerning undocumented migrants' health care. One possible explanation to this is that health care professionals working in these two type of units meet undocumented migrants more often compared to other type of units, since we in our analyses did not take into account if participants had dealt with undocumented migrants once or more often. Another possible explanation is that the handling of undocumented migrants is more complex at these two type of units compared to other type of units. Descriptive analyses suggest that participants both in the emergency and primary care consider particularly "administration", responsibility of costs", "the right to health care" and "follow-up care" as problem areas.

Health care professionals' obligations toward their patients are described both in health care regulations as well as in national and international agreements. Health care professionals' duty is above all to offer appropriate medical care to every person in need, and that those with the greatest need for care should be given preference, without discrimination (20, 21, 32, 34, 35). Half of the respondents in this study reported that discrepancies between different laws governing health care in Sweden could lead to “that care is not provided with respect for the equal worth of all”, “that the patient's need of continuity and safety in the health care is not met” and “that the patient with the greatest need of care is not given priority”. It is possible that it is difficult for health care professionals to work and act, when national health care legislation is not congruous or in fully accordance with important principles of medical ethics. Furthermore, previous studies claim that even if undocumented migrants are granted full access to health care there are practical obstacles that could prevent them from benefitting from it, such as unawareness among both health care providers and health care users, lack of quality and continuity, and economic obstacles (24). In our study, less than half of the participants agreed to be confident regarding guidelines at their work place concerning undocumented migrants, and the results showed no significant differences between professions or type of unit. However, participants who had been informed about The Act, or stated that they knew The Act well, showed significant higher likelihood ratio for considering that The Act had led to changes (OR 2.50, 6.03 respectively). We believe that clear, well-grounded guidelines at the work place, would not only give health care professionals greater support in their work, and in the medical ethical conflict that current legislation may cause, but also greater security in their handling of undocumented migrants, which also most likely would mean increased patient safety for patients in this particularly

vulnerable group. According to our results, one way to achieve greater confidence regarding guidelines for undocumented migrants at the work place is to inform health care professionals about The Act so that their knowledge of the same increase. Furthermore, less than 10% of the participants in this study believed that those affected by The Act, i.e. undocumented migrants, were aware of the same and their right to health care. This is in line with another report, where 11 European countries were included, who claim that one of the reasons undocumented migrants not having access to the health care that they are legally entitled to is that they are not aware of their rights (45). We therefore believe that it would be beneficial if the information about The Act not only reached health care professionals involved, but also those affected by it and the local guidelines applied.

4.5 Methodological discussion

No previous studies in Sweden has surveyed such a diverse group of health care professionals' and their perception of The Act as we set out to do. One of the purposes with this study was to investigate if there were any differences regarding the perception of The Act between those who had dealt with undocumented migrants, and those who had not. It was therefore essential to include health care professionals both from work areas where undocumented migrants more often seek medical care, and from work areas where undocumented migrants never or rarely seek medical care. This study was conducted in VGR, one of the regions in Sweden assumed to host a large part of the undocumented migrants. The broad scope of the sample, in terms of profession and type of unit, allows for a more complete overview of the areas where the implementation of The Act has been successful and those where it has not, and thus, where targeted measures such as information campaigns and further education may be necessary in the future.

This study has limitations which is to be considered. Due to pragmatic challenges concerning access to contact details for health care professionals in Sweden, our participants were chosen with a non-probability sampling method, i.e., we chose to send the questionnaire to health care professionals (line managers, physicians, nurse and front desk staff) working in adult clinics in VGR, instead of choosing a specific number of participants representing all the regions in Sweden with a stratified probability-sampling method. The downside of the non-probability sampling method is that the sample may or may not represent the entire population accurately, and the result of the research cannot be used in generalizations pertaining to the entire population. However, this type of sampling can be used when demonstrating that a particular trait exists in the population (46). Another limitation is that the response rate in this study was low (8,8%). When comparing the participants' sociodemographic data with those from the sample, we can however see that the participants are reasonably representative for the sample group. 60% of the participants stated that they had dealt with undocumented migrants in their work, and one can, partly in the light of this, suppose that those who have chosen to participate in the study are concerned about its research questions. This may of course have an impact of our results. It is possible that the participants for example were more likely to report that they need further education about The Act, and that uncertainties have occurred at their work place, compared with what the entire sample group would have reported. However, another assumption is that the participants for example were more likely to report that they know the law well, and to have better knowledge of what is to be included (according to The National Board of Health and Welfare) in the concept '*care that cannot be deferred*', compared with what the entire sample group would have reported. In future studies it would be important to analyze why such a

large part of the survey recipients chose not to respond, and to investigate whether this loss may be considered affect the representativeness of the survey results.

Another limitation is that no pilot study was conducted before we completed our final version of our questionnaire. This means that there is uncertainty about how well the questions used in the study measures what they were intended to.

5 Conclusions

Our findings show that less than half of health care professionals in the Region Västra Götaland did know The Act well, and were confident regarding guidelines at their work place concerning undocumented migrants. Nurses, who in many health care units also work as front desk staff, lacked information and good knowledge of The Act to a larger extent compared to other professions (line managers, physicians, midwifes). This indicates a potential threat against patient security since front desk staff are the entry point to access treatment for undocumented migrants, as well as for other patient groups. It was also found that the demand for further education is high, regardless of profession, area of work (type of unit) or if the participants had dealt with undocumented migrants or not in their work. The results imply that the information and training about The Act has been insufficient. In order to ensure that the lawful right to care for this vulnerable group of undocumented migrants is provided, and to support health care professionals in their work, we suggest more efficient information from the region to the health care professionals as well as clear local guidelines. The method used in this study is quantitative, in future studies it would be of relevance to investigate more thoroughly about health care professional perception of The Act by qualitative methods. It would for example be of interest to investigate what kind of solutions health care professionals themselves propose to

improve their conditions at work regarding undocumented migrants, or how to assure that this patient group receive the health care that they are legally entitled to.

Populärvetenskaplig sammanfattning

Asylsökande och papperslösa över 18 år i Sverige har idag inte rätt till hälso-och sjukvård (i samma utsträckning och) på samma villkor som svenska medborgare. Papperslösa är en särskilt utsatt grupp, inte minst ur ett hälsoperspektiv (vars rättigheter skyddas av de Mänskliga rättigheterna, inklusive Rätten till hälsa). Sverige, som tidigare hade kritiserats internationellt såväl som nationellt för att inte följa internationella överenskommelser gällande asylsökandes och papperslösas rättigheter, införde i juni 2013 en ny hälso-och sjukvårdslag; *Lag (2013:407) om hälso- och sjukvård till vissa utlänningar som vistas i Sverige utan nödvändiga tillstånd* (Lag (2013:407).

Lag (2013:407) ger papperslösa, som före 2013 endast hade rätt till osubventionerad akut vård, samma rätt till hälso- och sjukvård som asylsökande. Detta innefattar: 1) hälso- och sjukvård och tandvård som inte kan anstå, 2) mödravård, 3) preventivmedelsrådgivning, 4) vård i samband med abort, samt 5) en hälsoundersökning. Tidigare rapporter och studier har visat att den viktigaste åtgärden för att försäkra sig om att denna sårbara grupp av papperslösa får den hälso- och sjukvård som de är berättigade till, är att sjukvårdspersonal har god kännedom om den lag som reglerar detta.

Målet för denna studie var att undersöka hur vårdpersonal uppfattar Lag (2013:407) och dess tillämpning. Förhoppningen var att studiens resultat skulle kunna användas som underlag för att genomföra riktade insatser där eventuella brister gällande lagen och dess implementering påvisats, med målet att förbättra såväl vårdpersonals arbetsmiljö, som patientsäkerhet och tillgång till hälso- och sjukvård för papperslösa.

För att undersöka hur vårdpersonal uppfattar Lag (2013:407) och dess tillämpning använde vi oss av en webbaserad enkätundersökning. Våra resultat visar att mindre än hälften utav de som deltog i vår studie (vårdpersonal i Västra Götalandsregionen) känner till Lag (2013:407) väl, och känner sig trygga med de riktlinjer som råder på sina arbetsplatser gällande papperslösa. En knapp tredjedel av våra deltagare hade blivit informerade om Lag (2013:407) av sina arbetsgivare, och behovet av vidareutbildning gällande denna lag var mycket stort, oavsett yrkeskategori, arbetsplats, eller om man hade handlagt papperslös eller ej i sitt arbete. Resultaten visade även att sjuksköterskor hade blivit informerade om Lag (2013:407) i lägre utsträckning, och hade sämre kännedom om den, jämfört med andra yrkeskategorier. Detta är allvarligt eftersom sjuksköterskor på många vårdenheter är ansvariga för inskrivningen av patienter, och således är förstalinjens beslutfattare om vilka som ges tillgång till vård. Våra resultat visar också att de deltagare som hade blivit informerade om Lag (2013:407) i högre utsträckning ansåg att de kände till lagen väl, att lagen hade lätt till förändring i hur de utför sitt arbete, och kände sig trygga med rådande riktlinjer gällande papperslösa.

Sammanfattningsvis, Sverige har ratificerat de flesta konventioner om Mänskliga rättigheter (bland annat Konventionen om ekonomiska, sociala och kulturella rättigheter, där Rätten till högsta uppnåeliga fysiska och mentala hälsa ingår). Detta innebär att Sverige har en skyldighet att följa dessa överenskommelser. Vårdpersonal har, i och med sitt yrkesval, accepterat att följa de medicinska etiska riktlinjer som råder, och att fatta ansvarsfulla beslut i enighet med dessa. Resultaten i denna studie tyder på att informationen och utbildningen om Lag (2013:407) ej har varit tillräcklig. Detta innebär att den medicinska säkerheten äventyras och att såväl papperslösa hälsa som vårdpersonalens arbetsförhållanden riskerar att påverkas negativt. För att försäkra

att papperslösa får den vård de lagligen är berättigade till, samt för att stödja vårdpersonal i sitt arbete, föreslår vi mer omfattande information och utbildning från regionen till vårdpersonal gällande Lag (2013:407). Vidare föreslår vi att tydliga lokala riktlinjer utformas, efter olika verksamheters behov gällande papperslösa hälso- och sjukvård.

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Appendices

Appendix 1

Förfrågan om deltagande i enkätundersökning om hälso- och sjukvårdspersonals erfarenheter av vård för vuxna

Hej,

Vi vill tillfråga dig om du vill delta i en webbaserad enkätundersökning rörande dina erfarenheter av vård för vuxna papperslösa utifrån din erfarenhet som hälso- och sjukvårdspersonal i Västra Götalandsregionen. Syftet med undersökningen är att undersöka hur lagen om vård för papperslösa som infördes 2013 fungerar i praktiken, samt att identifiera eventuella behov av utbildning och stöd hos vårdpersonal.

Studien är ett samarbete mellan Sahlgrenska akademin, Göteborgs universitet, och Angereds Närsjukhus och har tillkommit efter samtal med Statskontoret, som har blivit tillfrågade av Regeringen att undersöka hur denna lag har fallit ut bland berörda. Studien är förankrad hos koncernledningen i Västra Götalandsregionen via Ann Söderström och har etikgranskats i enlighet med Angereds Närsjukhus forskningsetiska riktlinjer. Studien genomförs som ett examensarbete av läkarstudent Louise Hansen.

Vi är medvetna om att du som får denna förfrågan har begränsat med tid, men hoppas ändå på din medverkan. Ditt deltagande är viktigt för utvärderingen av denna lag, och kan bidra till förbättringar av vårdpersonalens arbetsvillkor, papperslösas vård och patientsäkerheten.

Enkätundersökningen tar ca 10 minuter att genomföra. Ditt deltagande är helt anonymt och frivilligt och du kan när som helst avbryta din medverkan.

För att delta i studien, klicka på följande länk:

Vänligen,

Louise Hansen
läkarstudent, Sahlgrenska akademin, Göteborgs universitet

Henry Ascher
professor / överläkare, Enheten för Socialmedicin och Epidemiologi (EPSO), Sahlgrenska akademin, Göteborgs universitet / Angereds Närsjukhus

Vania Ranjbar
forskare / verksamhetsutvecklare, Enheten för Socialmedicin och Epidemiologi (EPSO), Sahlgrenska akademin, Göteborgs universitet / Angereds Närsjukhus

Appendix 2

Enkätundersökning om hälso- och sjukvårdspersonals erfarenheter av vård för vuxna papperslösa

Bakgrund till studien

Du har tillfrågats att delta i denna studie, som vänder sig till hälso- och sjukvårdspersonal inom Västra Götalandsregionen och som undersöker deras erfarenheter av lagen om vård till ”papperslösa”.

2013 trädde en ny lag om vård för ”papperslösa” i kraft: *Lag (2013:407) om hälso- och sjukvård till vissa utlänningar som vistas i Sverige utan nödvändiga tillstånd*. För att undersöka hur väl lagen fallit ut har Regeringen gett i uppdrag till Statskontoret att undersöka hur lagen fungerar i praktiken. Som en komplettering och efter diskussion med Statskontoret vill Sahlgrenska akademin vid Göteborgs universitet, i samarbete med Angereds Närsjukhus och med stöd från Koncernledningen i Västra Götalandsregionen, genomföra en uppföljningsstudie. Ditt deltagande är därför av stort värde. Studien genomförs som ett examensarbete av läkarstudent Louise Hansen med undertecknade som handledare.

Syftet med studien är att undersöka hur lagen fungerar i praktiken, samt att identifiera eventuella behov av utbildning och stöd som finns bland vårdpersonal. Detta för att kunna öka patientsäkerheten för ”papperslösa” såväl som att bättre kunna stödja vårdpersonal i deras dagliga arbete.

Deltagande

Om du väljer att delta i studien kommer du att få besvara en webbenkät, vilket beräknas ta cirka 10 minuter. Frågorna rör bland annat kunskaper om lagen, om du upplever att lagen inneburit några förändringar i ditt arbete, vilka fördelar, begränsningar och utmaningar du upplever med lagen, samt vilken bedömning du skulle göra i ett fiktivt fall.

Ditt deltagande är helt frivilligt och anonymt och du kan, utan närmare förklaring och påverkan på ditt arbete, välja att avbryta din medverkan när som helst fram till dess att du skickar in dina svar. Studien har granskats och godkänts i enlighet med Angereds Närsjukhus forskningsetiska riktlinjer (Dnr: ANS 82-2014).

Det utgår ingen ersättning vid deltagande i studien. Din medverkan är dock av vikt för att öka patientsäkerheten för ”papperslösa” patienter samt för att kunna stödja vårdpersonal i deras dagliga arbete.

Övriga frågor

Studien beräknas vara färdig våren 2016. Om du önskar ytterligare information kring studien eller ett exemplar av den färdiga uppsatsen går det bra att kontakta ansvariga:

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031-786 6841

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0700- 82 49 85

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Sahlgrenska akademin
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gusloui44@student.gu.se

Appendix 3

Samtycke till deltagande i forskningsstudie

- Jag har informerats skriftligen om studien.
- Jag känner till syftet med studien och vet varför jag har blivit tillfrågad att medverka.
- Jag är medveten om att min medverkan är helt frivillig och att jag när som helst och utan närmare förklaring kan avbryta den fram tills dess att jag sänder in mina svar.
- Jag samtycker härmed till att delta i denna studie.

Appendix 4

GÖTEBORGS UNIVERSITET

1. • Jag har informerats skriftligen om studien. • Jag känner till syftet med studien och vet varför jag har blivit tillfrågad att medverka. • Jag är medveten om att min medverkan är helt frivillig och att jag när som helst och utan närmare förklaring kan avbryta den fram tills dess att jag sänder in mina svar.

☐ Jag samtycker härmed till att delta i denna studie.

GÖTEBORGS UNIVERSITET

Frågor gällande Lag (2013:407)

Vi har i denna enkätundersökning valt att kalla *utlänningar som vistas i Sverige utan nödvändiga tillstånd* för papperslösa. En utlänning utan legal status kan vara en individ som tidigare sökt asyl i landet, men som fått avslag, eller en individ som vistas i landet utan att ha ansökt om asyl.

Enligt *Lag (2013:407) om hälso- och sjukvård till vissa utlänningar som vistas i Sverige utan nödvändiga tillstånd* skall bland annat landstingen erbjuda papperslösa individer som har fyllt 18 år samma vård som asylsökande, vilket innebär 1) vård som ej kan anstå, 2) mödrahälsovård, 3) vård vid abort och 4) preventivmedelsrådgivning.

2. Hur väl känner du till Lag (2013:407)?

☐ Mycket väl

☐ Väl

☐ Ganska väl

☐ Inte särskilt väl

☐ Inte alls väl

3. Har du blivit informerad om lagen sedan den infördes 2013?

☐ Ja

☐ Nej

4. Vem/vilka gav denna information?

(Fler än ett svarsalternativ är möjligt.)

☐ VGR (regionövergripande)

☐ Lokal chef

☐ Frivilligorganisation

☐ Media

☐ Annan

____

5. Vad innehöll denna information?

☐ Informationen innehöll:

____

____

☐ Minns ej

6. Anser du att det finns ett behov av vidareutbildning gällande denna lag?

☐ Nej

☐ Ja

7. Jag behöver större kännedom om:

(Fler än ett svarsalternativ är möjligt.)

☐ Hur jag som vårdgivare ska tolka begreppet vård som inte kan anstå

☐ Hur man går till väga om en papperslös individ ej har möjlighet att betala sin vårdavgift

☐ Hur man signerar recept så att papperslösa får subventionerade läkemedel enligt lag

- ☐ Hur mycket en papperslös individ ska betala i patientavgift
- ☐ Huruvida jag som vårdgivare har rätt att ge mer omfattande vård till papperslösa än vad lagen föreskriver
- ☐ Huruvida jag som vårdgivare kan remittera vidare en papperslös individ eller ej
- ☐ Lagen i stort
- ☐ Skillnader mellan svenska medborgare, asylsökande och papperslösa vad gäller rättigheter till vård och hälsa
- ☐ Vart jag ska vända mig om jag har frågor gällande papperslösa individers vård
- ☐ Vem som bär ansvar för att papperslösa har tillgång till den vård som lagen föreskriver
- ☐ Vem som är betalningsansvarig för den papperslösa individens vårdavgifter
- ☐ Vilka riktlinjer som gäller på min arbetsplats för vård av papperslösa
- ☐ Vilka sekretessregler som gäller för vård av papperslösa
- ☐ Annat:

____

____

8. Anser du att lagen inneburit några förändringar i hur du utför ditt arbete?

- ☐ Ingen förändring
- ☐ Liten förändring

- [ ] Ganska stor förändring
- [ ] Stor förändring
- [ ] Vet ej

9. Hur har lagen förändrat ditt arbete?

- [ ] Lagen försvårar mitt arbete
- [ ] Lagen underlättar mitt arbete
- [ ] Annat:

____

____

10. Hur väl överensstämmer detta påstående med din arbetssituation: ”Jag känner mig trygg angående vilka riktlinjer som gäller på min arbetsplats när papperslösa individer söker vård”?

- [ ] Mycket väl
- [ ] Väl
- [ ] Ganska väl

☐ Inte särskilt väl

☐ Inte alls väl

☐ Min arbetsplats har så vitt jag vet inga interna riktlinjer gällande vård av papperslösa

11. Har det på din arbetsplats inträffat att det uppstått oklarheter gällande papperslösas vård?

☐ Ja

☐ Nej

12. Oklarheterna har gällt:

(Fler än ett svarsalternativ är möjligt.
Eventuell kommentar till ditt svar kan skrivas i rutan för Annat.)

☐ Administration

☐ Betalningsansvar

☐ Huruvida patienten har rätt till vård eller ej

☐ Patientsäkerhet

☐ Remisshantering

☐ Uppföljande vård

☐ Återbesök

☐ Annat:

____

____

13. Vem anser du ansvarar för att besluta om en papperslös individ ska erbjudas undersökning eller ej?

(Fler än ett svarsalternativ är möjligt.
Eventuell kommentar till ditt svar kan skrivas i rutan för Annan.)

☐ Behandlande läkare

☐ Behandlande sjuksköterska

☐ Samtliga behandlande vårdpersonal

☐ Receptionist

☐ Enhetschef

☐ Verksamhetschef

☐ VGR

☐ Vet ej

☐ Annan:

14. Vem anser du ansvarar för att besluta hur en papperslös individ ska behandlas? (T.ex. typ och omfattning av behandling.)

(Fler än ett svarsalternativ är möjligt.
Eventuell kommentar till ditt svar kan skrivas i rutan för Annan.)

☐ Behandlande läkare

☐ Behandlande sjuksköterska

☐ Samtliga behandlande vårdpersonal

☐ Receptionist

☐ Enhetschef

☐ Verksamhetschef

☐ VGR

☐ Vet ej

☐ Annan:

---

15. Hur väl anser du att följande påstående stämmer: ”De som berörs av lagen, d.v.s. de papperslösa individerna, är medvetna om lagen och sina rättigheter till vård”?

- ☐ Mycket väl
- ☐ Ganska väl
- ☐ Väl
- ☐ Inte särskilt väl
- ☐ Inte alls väl
- ☐ Vet ej

16. I Lag (2013:407) § 7 står det att ett landsting ska erbjuda papperslösa som har fyllt 18 år vård som inte kan anstå. Vad anser du att ”vård som inte kan anstå” innebär?

(Fler än ett svarsalternativ är möjligt.)

- ☐ All typ av vård
- ☐ Akutvård
- ☐ Vård som syftar till att undvika mer omfattande vård och behandling av ett specifikt sjukdomstillstånd

- [ ] Vård och behandling av sjukdomar och skador där även en måttlig fördröjning kan innebära allvarliga följder för patienten
- [ ] Vård som kan motverka ett mer allvarligt sjukdomstillstånd
- [ ] Vård som är följdinsatser av vård som getts
- [ ] Vård för att minska användningen av mer resurskrävande akuta behandlingsåtgärder
- [ ] Går ej att definiera
- [ ] Vet ej
- [ ] Annat:

____

____

17. Anser du att det finns vård som kan anstå?

- [ ] Ja, till exempel:

____

____

- [ ] Ja, men det måste bedömas från fall till fall
- [ ] Nej

18. Anser du att det finns motstridigheter mellan olika lagar som reglerar hälso- och sjukvården i Sverige (Hälso- och sjukvårdslagen, Patientsäkerhetslagen, Lag [2013:407] m.fl.) med hänseende till papperslösas vård?

☐ Ja

☐ Nej

☐ Vet ej

19. Motstridigheter i lagverk skulle kunna leda till att:

(Fler än ett svarsalternativ är möjligt.)

☐ Den som har det största behovet av hälso- och sjukvård inte ges företräde till vården

☐ Hälso- och sjukvården inte arbetar för att förebygga ohälsa

☐ Patientens behov av kontinuitet och säkerhet i vården inte tillgodoses

☐ Vård inte ges med respekt för alla människors lika värde

☐ Vårdgivaren inte kan planera, leda och kontrollera verksamheten på ett sätt som leder till att kravet på god vård upprätthålls

☐ Annat:

____

20. Hur hanterar du denna/dessa motstridighet/er?

21. Har du några förslag på hur lagen skulle kunna förbättras för att underlätta ditt arbete?

☐ Nej

☐ Ja:

VÄSTRA GÖTALANDSREGIONEN

GÖTEBORGS UNIVERSITET

Fiktivt fall

Läs igenom följande text och besvara därefter på efterföljande frågor:

En 39-årig papperslös kvinna från Afghanistan söker vård på din mottagning på grund av huvudvärk, ångest, sömnproblem och magont. Kvinnan har inga identitetshandlingar och inget uppehållstillstånd, hon har heller inga försäkringar eller möjligheter att betala.

22. Anser du att patienten har rätt till vård?

☐ Ja

☐ Nej

23. Skulle du ge patienten vård?

☐ Ja

☐ Nej

24. Om patienten inte har möjlighet att betala patientavgiften, hur går du till väga?

(Fler än ett svarsalternativ är möjligt.)

☐ Erbjuder den vård hen behöver och överlåter åt den administrativa personalen att i efterhand göra upp om ersättning

☐ Erbjuder fri vård

☐ Erbjuder ingen vård

☐ Kontaktar ansvarig/a på min arbetsplats och ber om råd

☐ Vet ej

☐ På min arbetsplats har vi rutiner vid dessa omständigheter vilket innebär att:

____

____

25. Från ditt perspektiv, vilka är de eventuella skillnaderna gällande behandling (inklusive uppföljande behandling) för denna patient jämfört med en patient med svenskt medborgarskap och liknande symptom?

26. Från patientens perspektiv, vad tror du är de specifika problem som denna patient skulle kunna stöta på, och som skiljer sig från dem en patient med svenskt medborgarskap och liknande symtom skulle kunna stöta på?

GÖTEBORGS UNIVERSITET

Frågor gällande din bakgrund

27. Har du någon gång i ditt arbete handlagt en papperslös individ?

- ☐ Ja
- ☐ Nej
- ☐ Vet ej

28. Hur ofta?

- ☐ Varje vecka
- ☐ Varje månad
- ☐ Någon gång per år
- ☐ Mer sällan

29. Har du någon gång i ditt arbete behövt besluta om en papperslös individ ska ha rätt till vård eller ej?

- ☐ Ja
- ☐ Nej

30. Hur ofta?

- [ ] Varje vecka
- [ ] Varje månad
- [ ] Någon gång per år
- [ ] Mer sällan

31. Kön?

- [ ] Kvinna
- [ ] Man
- [ ] Jag definierar mig som

____

32. Ålder?

____

33. Inom vilket område arbetar du?

- ☐ Akutsjukvård
- ☐ Primärvård
- ☐ Psykiatri
- ☐ Annat:

____

34. Vad har du för titel?

- ☐ Underläkare
- ☐ AT-läkare
- ☐ ST-läkare, ange vilken specialitet:

____

- ☐ Specialistläkare, ange vilken specialitet:

____

- ☐ Överläkare, ange vilken specialitet:

____

- [ ] Sjuksköterska
- [ ] Specialistsjuksköterska, ange vilken specialitet:

____

- [ ] Annan:

____

35. Vilket är ditt yrke?

- [ ] Läkare
- [ ] Sjuksköterska
- [ ] Receptionist
- [ ] Enhetschef
- [ ] Verksamhetschef
- [ ] Annat:

____

36. Hur länge har du arbetat inom vården?

37. Övriga synpunkter gällande enkätundersökningen?

Stort tack för din medverkan!