Reviewer's report

Title: Access to healthcare and alternative health-seeking strategies among undocumented migrants in Denmark

Version: 2 Date: 6 March 2011

Reviewer: Monica Ruiz-Casares

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• Major compulsory Revisions

1. This paper documents the barriers encountered by precarious status migrants in accessing health care as well as the perceptions of ER nurses in providing care to this population in Copenhagen, Denmark. A human rights framework is utilized. Although not revealing any surprising results, this paper contributes to accumulating evidence internationally linking difficulties in accessing health care to negative health outcomes among undocumented migrants and refugees/refugee claimants.

2. The authors do not cover all the sections required for research articles submitted to BMC Public Health <http://www.biomedcentral.com/bmpublichealth/ifora/#h1text>. Most significantly, an abstract should be provided.

3. The qualitative approach utilized by the authors is appropriate for the questions they are trying to answer. However, methods are not always well described. For instance,

a. Was the lengthy pre-interview fieldwork done only with the 10 selected participants or with a larger group of undocumented/migrants? What does it mean that participants were “followed”? And that “the fieldnotes were used to design the interview guide”? Does the latter mean that the questions were based on the behaviour of participants at home and at work? (Although prolonged interactions are needed to build trust in research settings it is not clear why the authors present this ethnographic work as necessary to develop the list in Box 2). Why did the authors chose to proceed this way?

b. Why and how were these hospitals and head nurses selected? What criteria did the head nurse use to select the other nurse participant? How can this bias the results of the study? This is particularly relevant given the unanimous finding that “non-discriminatory care and patient confidentiality is a matter of professional integrity”. In our current study on the perceptions of healthcare professionals in Montreal and Toronto, we have found that this represents only one of the positions held by clinicians, with others not being so benign. Ultimately, why did the authors not recruit nurses through a different method as it seems like some of them did not have direct exposure to the population of interest?

c. Although several people were involved in the coding (reliability check), it is not
clear how the list of codes was generated (pre-existing based on topics and adjusted during data analysis? Free listing?). Also, their emphasis on comparing “different perspectives and viewpoints” leaves out equally important analysis of converging opinions and experiences, which the authors did too.

d. The term ‘in-depth’ for an interview that takes 20 minutes seems a bit exaggerated.

4. Despite the limitations imposed by a small sample, the authors fail to contrast the healthcare seeking behaviours of undocumented migrants and asylum seekers. For example, in regards to alternative strategies (pp. 7-8).

5. The discussion and conclusions are not always adequately supported by the data and the limitations of the work are incomplete. As suggested earlier, the authors may be overstating their conclusions as the selection of ER nurses through snowballing may have biased their sample of respondents significantly and some of the nurses did not have direct experience with the population of interest. The authors also overstate their findings by discussing other access problems in the system which do not stem from the data presented earlier.

6. The authors mention legislation and guidelines to respond to migrants’ fear to seek healthcare. However, they do not elaborate on the role of health institutions such as hospitals and primary health-care centers in developing, publicizing, and enforcing access policies. The lack of institutional guidelines seems to be common occurrence (we are definitely documenting it in our current study in Canada), although some institutions de iure or de facto adopt very restrictive guidelines so this would probably not ease the ethical dilemma that clinicians face on this issue. Within the framework provided by legislation, institutional regulations and enforcement should be emphasized.

7. The nurses’ report that “undocumented migrants seldom appeared in the ER” challenges the authors’ original assumption (leading to the selection of participants) and is similar to what we are finding in hospitals in Montreal. This common misconception is worth commenting on in the discussion and policy, program, and research recommendations should be drawn from it. For example, if undocumented migrants are not accessing health care through the ER, future researchers should recruit their participants from other hospital units or health care organizations.

8. I commend the authors for establishing ethical controls throughout the study. However, I must admit that I found it shocking that no approval from ethical committees is needed for qualitative studies in Denmark and wonder what the authors think about this. This may be part of their recommendations for the future. Additionally, was the post-interview debriefing conducted by a therapist? Where there other systems in place to refer participants to health care providers/other supports identified during the interview? Make sure that the combination of the information contained in Table 1 combined with their quotes throughout the paper cannot lead to the identification of participants within their communities (and beyond). The authors may want to re-think Table 1 and also consider using aliases instead of identifying participants by a number.
9. The following quote needs clarification and further development. One participant’s description of reporting to the police being conditional on whether “they [healthcare professionals] think it [reporting? Immigrant’s health condition?] is not so serious” is relevant yet the authors fail to comment on this in their interpretation of findings. As the authors indicate elsewhere, it is generally precarious status migrants who decide whether to seek help based on the severity of their illness. Do the authors have more information from this participant or others that may cast further light on this statement?

• Minor Essential Revisions

10. I agree with the authors that “healthcare professionals' ethical obligation to uphold the principle of confidentiality should extend to undocumented migrants and their citizenship status, thereby upholding their duty to do no harm.” In fact, beyond doing no harm by not reporting, health care professionals are ethically bound by an obligation to “consider first the well-being of the patient,” to “provide for appropriate care,” and to “refuse to support practices that violate basic human rights” (2004 Canadian Medical Association Code of Ethics). The authors may want to refer to the codes of ethics of the Danish medical, nursing, and other health care professional associations for additional arguments to strengthen their position.

11. Throughout the paper, there are numerous “one-sentence paragraphs” which should be avoided. For example, on p.1 (would be better if added to the following paragraph); p.7 (“Undocumented migrants reported different factors …” should be elaborated on (to wrap up that section and introduce the following section) or deleted; “Problems in accessing healthcare services…” should be linked to the following paragraph); and many others.

12. I agree with the authors that the role of NGOs and informal networks of healthcare professionals, while responding to a serious need, is problematic. However, beyond the authors’ argument of the limited resources available to these groups, I would encourage the authors to consider human rights, social justice, and political advocacy frameworks, and particularly the risk that this well-intentioned civil intervention may be legitimizing the lack of action on the part of the welfare state to provide for all.

13. Box 1: Two definitions are legally inaccurate: “Failed asylum seekers” are technically refugee claimants whose claim is denied, whether they stay underground or leave the country as requested is another issue. “Undocumented migrants by birth” does not take into account the ius soli regulating the acquisition of citizenship in a number of countries; although European states operate mostly by ius sanguinis and only a handful of countries have a modified ius soli (basically requiring parental proof of residence), this definition may surprise an American readership (as most countries in North and South America operate by ius sanguinis). In both cases, the authors should at a minimum clarify in the title of the box that these are the definitions used for the purpose of the study. In this line too, I would press the authors to better explain the contribution
that their study makes to the international literature on access to healthcare for precarious status migrants beyond the European context.

14. The quote that follows requires clarification: “No, that [what was being discussed?] was not a problem,” (p.4).

15. “The Danish Aliens Act states that foreigners residing illegally in Denmark may approach the Danish Immigration Service for necessary health services’ ” (p.2). A single quotation mark at the end does not suffice to identify a quote. An opening quotation mark is needed.

• Discretionary Revisions

16. For a readership not familiar with the Danish healthcare system, it is not clear how easy or difficult it actually can be to obtain access. On the one hand, the migrants interviewed seemed to operate more on fear than on negative encounters with the system. On the other, nurses “underlined the importance of explaining to those patients that they could be treated anonymously.” I imagine that reality is somewhere in between… please explain.

17. The introduction provides a good snapshot of the situation of undocumented migrants in Europe and Denmark. The reader is a bit surprised, though, to find out at the end that the authors are going to look at the perceptions of clinicians too. Adding a sentence or two to justify the selection of key informants would be useful.

18. Fear of deportation occupies a central place in seeking healthcare. It would be helpful for an international readership to have some statistics or results from other studies on the frequency of reporting and deportations in Denmark. Also, one nurse mentions a legal obligation to report. Is this so? (in the books and/or in practice)

19. The authors end with a recommendation to develop policies and guidelines on the health care [rather than medical] rights of undocumented migrants for healthcare professionals yet they do extend to educating migrants themselves as well as administrative staff in health care institutions (both of which are acknowledged earlier).

20. Clarification is needed in the following cases:

a. “These conditions lead to ideological, humanitarian and ethical challenges for social welfare systems and may question the status of international conventions on equal access to healthcare” (p. 1). These sentences seem so abbreviated that the meaning and readability are obscured: what ideological, etc challenges do the authors refer to? What does the second sentence mean? (the use of the potential ‘may’ and the term ‘status’ (often used to refer to whether a convention has been signed or ratified) render the second sentence too vague).

b. “… legislations that impede their range of activities and deter citizen involvement.” (p.2) Please clarify in the context of current criminal legislation in Denmark.
c. The term “the illness behaviour” and the sentence “to illuminate access to healthcare and the illness behaviour of undocumented migrants, we included overstayers and failed asylum seekers as well as health care professionals.” (p.2) read strange.
d. “In the following,….” (p.4) would be clearer as ‘in the following quote,…’.
e. “Changes in legislation and policies are important factors in framing undocumented migrants’ health” (p. 12). Are the authors referring more precisely to ‘access to healthcare’? And in the sentence “just as these factors influence healthcare professionals,” do they refer to ‘healthcare professionals’ practice’?
f. The authors call for studies that “use a longitudinal design with multiple interviews, preferably combined with interviews and observations among different groups of undocumented migrants and healthcare professionals situated in different sections of the healthcare system” (p. 12). Again, these sentences seem too abbreviated. A couple of sentences are needed to clarify, for instance, why different groups of migrants and healthcare professionals, what sections of the healthcare system, and design/method choices (e.g. not qualitative studies).
g. The use of the terms such as ‘health rights’ and ‘medical rights,’ or ‘health’ and ‘health care (access)’ as synonyms is confusing/inaccurate, particularly in the context of a human rights discourse. The authors should be clear in stating their concurrent use early on at least.

21. The authors could elaborate on any positive effects of alternative health-seeking strategies mentioned by respondents.

22. The authors could exhibit more assertiveness in some of their statements. For example, “In this study we aimed to examine…” (p.2) do you mean ‘In this study we examined…’?

23. Although this would be fixed at the typesetting phase, the font size throughout the paper is extremely small and difficult to read and spaces between paragraphs are not consistent/always existent; additionally, it seems like the font used for participants’ quotes is smaller than the rest.

**Level of interest:** An article whose findings are important to those with closely related research interests

**Quality of written English:** Needs some language corrections before being published

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests