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Access to oral health care for undocumented migrants: Perspectives of actors involved in a voluntary dental network in the Netherlands

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Abstract

Objective: Undocumented migrants in Europe face multiple barriers in access to oral health care. This study aimed to explore the accessibility of a voluntary dental network providing dental treatments to undocumented migrants in the Netherlands, from the perspectives of patients, dentists and staff members of nongovernmental organizations involved.

Methods: This qualitative study used semi-structured interviews (n = 21) with undocumented migrants (n = 12), dentists (n = 7) and staff members of nongovernmental organizations (n = 2) during the implementation of a voluntary dental network. Interviews were analysed using a framework analysis method.

Results: As a temporary answer to problems in access to oral health for undocumented migrants, the voluntary dental network targeted initial barriers to dental care. Main challenges within the network were conflicting expectations and perceived treatment outcomes by patients, dentist and NGO staff members, limited financial resources, logistic and communication barriers and an increasing administrative burden. Furthermore, feelings of compassion for and trust of the patient affected the ethics of the professional relationship and influenced treatment decisions of dentists.

Conclusion: Through the implementation of a voluntary dental network, treatments could be provided to undocumented migrants as a temporary solution. However, the voluntary nature of dental care in the network resulted in a fragmented provision of oral health care among undocumented migrants. To reduce inequalities in oral health on the long term, systemic barriers in access to oral health care need to be addressed.

1 | INTRODUCTION

Oral diseases are among the most prevalent diseases worldwide, and they disproportionally affect populations of a lower socioeconomic position (SEP).[1] The oral health of migrants in particular has been a widely neglected issue, while their health compromising living circumstances prior, during and postmigration, combined with different oral health beliefs and practices may expose them to more oral diseases compared to the host populations.[2] During the past decade, controlled migration of refugees into Europe has

strongly increased.[3] The number of undocumented migrants residing in Europe remains unknown. In 2013, an estimated number of 35.000 migrants resided undocumented in the Netherlands.[4] Undocumented migrants are among the most vulnerable populations in Europe, including the Netherlands. The majority of this population lives under precarious living conditions such as the exclusion from the legal labour market, instable housing situations, limited social networks and fear of deportation, which hamper access to health care.[5-8]

Several studies suggest that facilitating informal health structures, for example by providing healthcare free of charge and thereby strongly depending on volunteers, could improve the accessibility of health care for undocumented migrants.[9] One way to organize this is to establish voluntary networks that are 'typically managed by organizations that recruit [health professionals] who commit to accepting a certain number of uninsured patients into their practices and agree to treat these patients at no charge or at greatly reduced fees'.[10]

However, a comprehensive overview and systematic evaluation of existing voluntary networks seems to be lacking. Few studies describe how voluntary networks have been organized[10-12] and how they contribute to the health system in terms of cost-effectiveness and the number of medical visits.[13] In the United States of America, local authorities attribute a high return on investment in terms of health improvement to the inclusion of voluntary networks in their health policy targeting uninsured residents.[14,15] In Europe, documentation of voluntary networks remains limited to reports by nongovernmental organizations (NGOs).[7,16,19] Regarding the implementation of these networks, major challenges have been reported at the organizational level (such as financial shortages), service-related level (such as difficulties meeting contemporary healthcare standards) and contextual level (such as a relatively large or even growing population that is excluded from regular health facilities).[11,13]

In the Netherlands, healthcare providers who treat undocumented migrants can be partly reimbursed for treatments that are included in the national health insurance scheme.[17] However, oral treatments for adults have been excluded from this scheme since 2006.[18] As opposed to general health care, accessing oral health care for adults (including emergency treatments) requires out-of-pocket expenses in most cases, which poses a major barrier for oral health care consumers, in particular for undocumented migrants.

Given the financial barriers to oral health care for adult undocumented migrants and the complexity of creating an informal health structure for vulnerable populations with minimal budget spending, at least two issues remain underexplored. First, little is known about how voluntary networks are used to improve access to oral health care and the challenges that have been encountered. Second, it is unknown to what extent oral health care for undocumented migrants is influenced by the fact that it is provided on voluntary basis.

This qualitative study explores the views and perspectives of undocumented migrants, dentists and NGO staff on the provision of voluntary dental care and the accessibility of a voluntary dental network in Amsterdam, the Netherlands.

2 | METHODS

2.1 | Design and setting

This study uses a qualitative descriptive research approach.[19] The study setting is a voluntary dental network in Amsterdam, the Netherlands, which aimed to improve access to oral health care for undocumented migrants by providing for at least one treatment per month free of charge at private dental clinics. Eligibility criteria to take part in a voluntary treatment were an undocumented status and the existence of oral pain and/or chewing problems. Fourteen dental clinics in Amsterdam participated in the network. Undocumented migrants were identified and screened by two NGOs.

2.2 | Recruitment

The researchers purposively selected undocumented migrant participants from an anonymized register of patients who received voluntary treatment, of whom over two-thirds were male, based on gender and divergent oral health complaints (oral pain, oral bleeding, chewing problems and cosmetic problems). By purposively recruiting participants with diverse oral health complaints, we intended to capture a large variety of needs and viewpoints on oral treatment. From the 49 undocumented migrants that were initially selected and asked whether they were willing to participate in the research by an intermediary person, 10 males and 2 females took part in an interview. Participants were in the age groups of 18-30 years (n = 2), 31-40 years (n = 4), 41-50 years (n = 2) and 51-60 years (n = 4) and originated from Burundi (n = 1), China (n = 1), Egypt (n = 2), Eritrea (n = 1), Morocco (n = 2), Pakistan (n = 2), Sudan (n = 1), South Sudan (n = 1) and Turkey (n = 1). From the remaining 37 potential participants, 10 could not be reached and 27 refused participation due to a variety of reasons (no time, no interest, other priorities, reasons that could not be clarified due to language or communication problems). Participants were offered compensation for travel fares.

Criteria for dentists were the involvement and representation within the voluntary dental network for at least six months. Fourteen dentists were invited for an interview, of which seven dentists participated. Language proficiency of the clinic staff of all practices was Dutch and English, while clinic staff members of four dental practices were able to communicate in Arabic, Spanish and/or French. Reasons for nonparticipation were lack of time (n = 5) and nonresponse (n = 2).

Criteria for NGO staff were the involvement in the organization and/or coordination of the network. These criteria were met by two staff members who participated in an interview. Both were managed a volunteer team for the screening of patients, arranging dental appointments and administrative tasks. One staff member was also

involved in the recruitment of voluntary dentists and communicating guidelines regarding the voluntary dental network.

2.3 | Data collection

The research team developed a guideline for each sample group to support that participants, specifically undocumented migrants, were diligently informed about the goal, procedure and confidentiality of the interview. See Appendix for topic lists for interviews with participants from the three participant groups, based on the framework of access to healthcare as conceptualised by Levesque[20].

Interviews with undocumented migrants were conducted by IH in English or Dutch at the office of Doctors of the World or another familiar public place, depending on their preferences, and lasted between 30 and 60 minutes. Interviews with dentists and NGO staff members were conducted by MM in Dutch at the affiliated dental clinic or organization's office and lasted between 45 and 75 minutes. All interviews were audio-recorded and transcribed verbatim. In one case, due to technical failure, the researcher noted the contents in detail immediately after the interview.

All participants gave their verbal and written informed consent. The study protocol was reviewed by the Medical Ethical Committee (MEC) of the Academic Medical Centre (AMC) of the University of Amsterdam (reference W17_185#17.214). The committee stated that the study does not require further assessment and approval from the MEC of the AMC or from any other officially accredited Medical Ethical Research Committee in the Netherlands. In line with the General Data Protection Regulation[21] and the AMC code for the good conduct of medical research,[22] provisions were made to assure the participants' confidentiality in collection, storage and analysis of the data, while reporting and presentation of data precluded participants' traceability. After 12 interviews with undocumented migrants, no new themes emerged during the interviews. Hence, it appeared that data saturation was reached which is a criterion for sufficient sample size in qualitative studies. Given the limited number of dentists (n = 7) and NGO staff members (n = 2) who met the inclusion criteria, these sample groups were small. Although very few new themes emerged in the latest interviews, saturation may not have been fully reached.

2.4 | Data analysis

For each of the sample groups, two researchers (IH and MM) analysed the transcripts using the framework analysis model of Ritchie and Spencer[23] and applied the framework analysis technique as

TABLE 1 Quotations of undocumented migrants (U), dentists (D) and NGO staff members (N)

Reasons to join the voluntary dental network	U5: 'The whole day you're in pain. I can't even eat. […] Nothing happens and now I'm broken. Sometimes I even cry, because my teeth… everything is gone'. D6: 'I like the idea of doing something useful for people who can't afford to pay for oral care, especially when it concerns basic treatment'. N2: 'We had so many clients with dental problems. I don't even know where to start. […] Together we found a way to make dental care more accessible for them'.
Expectations	U3: 'I want [a dentist] to relieve my pain. And to give me some teeth, so that I can eat'. D6: 'I see it as a sport to have a good relationship with my patients, as well as a personal connection. In fact, that's what I like most about my job'. N1: 'It seemed quite simple: demand and supply, we can match it and the problem will be fixed'.
Dealing with challenges	U12: '…and then he said: "no, there is no money". They only want to pull [out my teeth]. And nobody wants to do something'. D3: 'When you reserve your time to help someone, you also expect that person to be grateful, instead of showing an unhappy face'. D4: 'So you start a treatment and then you find out: this nerve is affected, that is going to be só very… this is going to be a real problem for the patient. So, a root canal treatment is necessary and who is going to pay for that? That is not going to happen, so the tooth needs to be extracted as well'. D1: 'There was a woman with a baby, they were left all to themselves… She told me the whole story and yes, that was the reason I did a lot for her. It costed me about two hundred euro, but well…' N1: 'I have spent many hours on the telephone. […] I would call the dentist, and then the patient, and their stories seemed almost incompatible. For example, the patient would say: "the dentist was rude to me. He didn't even explain what he was doing." While the dentist was annoyed because the patient didn't appreciate the free treatment'.
Perceptions of outcomes of care regarding access and quality of care	U9: 'To promise, promise, promise… but in the end, there was no result. Look [points at toothless gums] - out. My eating problem is still there… like that. And my gums are still in pain'. D2: 'When you do something extra for one patient, it is actually unfair for the other. In case of an emergency, the treatment is clear, but in case of complex problems, the decision is up to you. As a result, one dentist will give a cosmetic treatment, while another will limit his treatment to pain relieve. And then it makes a real difference to which dentist the patient is referred'. N1: 'I felt that we weren't able to really support our clients and the dentists. They kept struggling and we couldn't provide a sustainable solution for the problems we encountered'.

described by Smith & Firth.[24] This entails three phases. In the *data management phase*, the researchers inductively generated in vivo codes from the interview transcriptions. They also discussed each interview that was conducted with undocumented migrant participants to determine the level of saturation. The researchers constantly compared data within and across the three participant groups to identify emerging topics and deviant cases and to integrate these in subsequent interviews. In the *descriptive accounts phase*, the same researchers grouped initial themes into categories. The researchers discussed any coding differences until consensus was reached. By discussing initial themes and categories, links between the different frameworks began to emerge. For example, from the interviews with undocumented migrants, the researchers established a category labelled 'being undocumented', covering initial themes such as 'isolation', 'fear' and 'lack of support'. A category established from interviews with dentists that was labelled 'undocumented patients' included initial themes such as 'unfamiliar with population' and 'just like ordinary people', showing a discrepancy in viewpoints. In the *explanatory accounts phase*, the researchers developed and visualized final overarching themes by drawing mind maps, until a whole picture emerged. From all patterns emerging from interviews within each separate sample group, the overarching categories were organized into four main themes across sample groups, deductively derived from the framework of Levesque.[20]

Preliminary findings were thoroughly evaluated and discussed with EB and presented to a broad expert group during a workshop on migrant oral health inequalities.[2]

3 | RESULTS

The presented findings reflect the opinions of undocumented migrants, dentist and NGO staff members, supported by quotations (Table 1). The main themes are summarized in Appendix.

3.1 | Reasons to join the voluntary dental network

Undocumented migrants expressed their concerns about dental pain, chewing problems and issues regarding their physical appearance, which they believed were caused by their marginal living conditions before, during or after migration. They emphasized that accessing oral health facilities was problematic because of legal and financial constraints and limited support networks (U5).

Dentists explained that their desire to contribute to society was the main reason for providing treatments free of charge to vulnerable individuals (D6).

NGO staff members described oral health as one of the most problematic areas in healthcare accessibility for undocumented migrants in the Netherlands. Referral through a voluntary network of dentists was seen as a solution for treatment and pain relief of their clients (N2).

3.2 | Expectations

Undocumented migrants expected the voluntary dental care to have a positive impact on their daily lives. In terms of treatment, their expectations could be categorized along the lines of pain relief (eg in case of acute problems), restoration of dental functioning (eg in case of chewing problems) and cosmetic improvements (eg in case of missing front teeth) (U3). Undocumented migrants highly valued the preservation of their existing teeth during treatment.

Most dentists expected to treat predominantly urgent cases. The most commonly shared expectation was that undocumented migrants would be grateful for the time and effort the dentist invested in providing care on a voluntary basis (D6).

NGO staff members expected to tackle barriers that prevented undocumented migrants from receiving oral health care. Establishing a dental network was perceived as an alternative for a structurally inaccessible oral health system (N1).

3.3 | Dealing with challenges

Undocumented migrants frequently mentioned barriers to oral health care—even to voluntary care—because of financial constraints (U12). Other barriers mentioned were related to logistic issues (eg lack of money for transportation, difficulties with finding the clinic) and miscommunication with the dentist or the referring NGO (eg about the treatment or follow-up).

All dentists mentioned cases of late show or missed appointments by undocumented migrants. While most dentists reasoned that patients were hampered by an accumulation of financial, logistic and cultural obstacles, they perceived late shows and missed appointments as very disruptive. Dentists said that, in some cases, they experienced a lack of personal connection or gratitude from the patient (D3). Furthermore, dentists stated that financial limitations in treatment mostly occurred in cases of complex or serious oral health issues, as appropriate treatment included high material costs. This compelled them to set priorities about medical treatment (D4). In most cases, treatment was limited to meeting the most urgent oral health needs, thereby considering the medical necessity of the oral health problem, treatment duration and material costs. In some cases, however, dentists ignored financial issues by assuming the full treatment costs (D1). Narratives of dentists show that their treatment decisions were influenced by relational aspects (having a 'connection' with the patient, feeling compassion for the patient, having trust in the patient's intentions to obtain free treatment, and receiving gratitude from the patient) and their perceived satisfaction from the voluntary work. By making these decisions, which may have affected the ethics of the professional relationship with their patients, dentists tried to deal with dilemmas that arose from providing dental care free of charge.

NGO staff members described several challenges during the organization and coordination of the network. First, the waiting list

for dental appointments quickly increased. Second, practical support (eg appointment reminders, instructions about public transportation or directions, volunteers guiding patients to the clinic) appeared to be very time-consuming. Third, screening criteria for patient eligibility were applied inconsistently, due to difficulties with verifying the legal status of migrants (as formal documentation is typically absent) and a lack of oral health expertise of NGO staff. Fourth, the coordination between voluntary dentists and NGO volunteers required a larger investment than expected. Recruitment and training of new volunteers were time-consuming, and a typically high turnover had led to omissions and miscommunication concerning dental appointments. As a result of these challenges, NGO staff members noticed an increasing demand for mediation in response to unmet expectations of undocumented migrants and dentists (N1).

3.4 | Perceptions of outcomes regarding access and quality of care

While undocumented migrants expressed their appreciation for receiving free oral care, nine out of 12 participants also complained that their actual problems had not been addressed and that their oral health issues still persisted (U9). Undocumented migrants argued that the type of treatment they received depended on the goodwill of the dentist. Some complained that they felt misunderstood or not taken seriously by the dentist.

Most dentists said that they had been able to provide a relatively small, yet meaningful, contribution to the improvement of oral health accessibility for undocumented migrants. However, some dentists found it problematic that patients with similar dental problems were treated in different ways (D2).

NGO staff members stated that, while the voluntary dental network contributed to better oral healthcare accessibility for undocumented migrants with acute dental problems, nonacute or complex oral health problems often persisted. Regarding organizational aspects, the NGO could not meet the coordination requirements to keep the network operational. Eventually, they argued that the voluntary dental network lacked the financial capacity to solve the identified problems (N1).

4 | DISCUSSION

This qualitative study, exploring the views and perspectives of undocumented migrants, dentists and NGO staff on the provision of voluntary dental care and the accessibility of a voluntary dental network in Amsterdam, the Netherlands, shows that removing initial barriers (eg lack of finances, logistic problems) increased elements of accessibility of dental care for undocumented migrants. Furthermore, treatment decisions during the voluntary provision of dental care changed the ethics of the relationship between health professionals and patients, as boundaries of care were blurred, leaving individual health professionals to decide on the extent of investment in time and material costs for individual patients.

To check plausibility of the key findings, the researchers presented and discussed preliminary findings and conclusions during an expert meeting of (oral) health researchers, policymakers and professionals.[2] In addition to these strengths, this study also has limitations. The interviews took place during a reorganization phase of the voluntary dental network. Data from interviews with coordinating NGO staff may reflect perceived uncertainties regarding future activities of the network, which may have led to a stronger focus on the need for improvements of the programme than on achieved results. Furthermore, the precarious living conditions of undocumented migrants may have influenced their willingness or opportunities for participation in this research, and a relatively small number of females participated in an interview, which inevitably may have led to the omission of additional viewpoints. As the number of dentists and NGO staff members who met the sampling criteria were small, saturation of interview data may not have been fully reached. It should also be noted here that the framework of access to health care of Levesque (2013),[20] which was used to explore the perspectives of three different participant groups, does not address the context of accessibility and affordability for oral health in particular. The use of a different model[25] perhaps might have emphasized different aspects of accessibility to oral health care, but it is not expected that this would result in a major change of the key findings regarding barriers in access to oral health care for undocumented migrants.

To our knowledge, this study is the first to describe the experiences of people involved in a voluntary dental network in Europe. It is also the first study describing experiences regarding the implementation of a voluntary network from the perspectives of all actors involved, that is health professionals, coordinating staff and end-users, in order to provide a comprehensive understanding of the systemic barriers in access to oral health care for undocumented migrants.

This study shows that the provision of voluntary care temporarily increased the accessibility to oral health care for undocumented migrants. However, treatment outcomes remained unsatisfactory to undocumented migrants, dentists and NGO staff members involved. This finding is in line with the conceptual definitions of Harris (2013),[25] who distinguished *entry access* (in terms of opportunities for access and dental visits) from *effective access* (in terms of equitable access and oral healthcare outcomes).[25] The voluntary provision of care included cases in which contemporary standards of care were not met, which reflects lessons learned from similar programmes.[12-14] Scott et al suggested that an administrative structure largely reliant on volunteer staff lacked the capacity to carry out the complex process of patient eligibility screening, case management and overall coordination of the network activities.[12] This study adds that dentists provided extensive treatment in specific cases, while other patients' needs remained unaddressed, resulting in unequal access to and unwarranted variations in oral treatment of undocumented migrants.

Unwarranted variations in health care (which cannot be explained by the incidence of illness, the constraints of medical science or the

preferences of individuals) are a frequently observed and targeted problem in healthcare systems and can lead to an unequal distribution of health care.[26,27] Within the voluntary dental network, limited financial resources fostered unwarranted variations, resulting in an unequal distribution of health care, in the provision of dental care for undocumented migrants. Providing dental care on voluntary basis fundamentally changed the ethics of the relationship between health professionals and patients, as the lack of financial compensation for treatment compelled dentists to search for other ways to define which treatment is appropriate in specific situations. In some cases, treatment decisions of dentists were related to feelings of compassion for and trust of the undocumented patient, which could be evoked by the patient acting as expected, for example by showing gratitude for the voluntary treatment. Previous studies have shown that the dentist-patient relationship influences the nature of care provided, resulting in a higher quality of restorative treatment for more cooperative patients.[28,29] A mismatch of perspectives and expectations of patient and dentist on treatment and its results may have been amplified by the limited standardization between dentists working in the voluntary dental network, as well as by the lack of clear evidence-based guidelines regarding acute oral health care in the Netherlands.

The exclusion of dental treatment for adults from the national basic health insurance scheme was implemented in 2006.[18] In addition, it should be acknowledged that a low SEP and a poor oral health status are strongly associated.[30] As a result of the 2006 system change the financial and social burden of low SEP individuals of maintaining oral health increases. Directly targeting financial barriers to emergency dental treatments would address a major part of the affordability and accessibility issues of oral health care. On micro level, some of these issues are partly solved by the voluntary dental network. However, to compel an equitable distribution of dental treatments among undocumented migrants within this network, voluntary care should be standardized according to guidelines regarding the quality of dental care and patient perspectives should be included in the evaluation of individual treatment results.

Based on the findings of this study, we recommend to assign an oral health professional for the screening of eligible patients and to continuously manage expectations of patients and dentists during screening, referral and evaluation of the dental visit. Financial compensation for dentists, at least for material costs of the treatment, may help to prevent imbalanced relationships between patients and dentists. Specific attention is needed for the standardization and quality of care. This study adds to previous studies that, in a context of limited financial resources, the voluntary nature of dental care created new challenges such as compromised health care and unwarranted variations in provided dental care. This underlines the importance of a thorough exploration and evaluation of voluntary networks, which can shed light on unintended (side) effects in the implementation of voluntary care that may lead to unequal access to health care.

This study emphasizes that voluntary dental networks only offer temporary answers to structural barriers in access to oral health care. Meanwhile, these networks could foster steps towards structural improvements of oral health accessibility by exchanging lessons learned and involving oral health professionals in the current debate on equal access to oral health for vulnerable individuals. By organizing voluntary dental care, the informal sector is filling a gap that the formal sector is currently not sufficiently attending to. Formal care should urgently attend to this gap.

5 | CONCLUSION

While the voluntary dental network removed financial barriers and improved initial access to care for undocumented migrants, new challenges emerged, as a result of the dependency on volunteers for both the implementation of the network and the provision of dental care. In this context of limited resources, unmet expectations of undocumented migrants, dentists and NGO staff members resulted in an increasing administrative burden and cases of compromised dental care and unwarranted variation in the provision of dental care. The voluntary nature of care influenced the ethics of the relationship between dentists and patients when treatment decisions of dentists were influenced by feelings of compassion for and trust of the patient.

The voluntary dental treatments were provided as a temporary solution for barriers in oral health for undocumented migrants. To reduce inequalities in oral health on the long term, essential system barriers in access to oral health care for undocumented migrants need to be addressed.

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AUTHOR CONTRIBUTION

MM, EB, CA and MK have been involved in the conception and design of the study. MM, IH and EB have been involved in data collection and data analysis. GH, CA and EB have been involved in acquisition for the research. All authors were involved in data interpretation, drafting the manuscript and revising it critically and have given final approval of the version to be published. All authors agree to be accountable for all aspects of the work, ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

DATA AVAILABILITY STATEMENT

Data available on request due to privacy/ethical restrictions. The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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