

Policies and practices in the health-related reception of quota refugees in Denmark

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ABSTRACT

INTRODUCTION: Quota refugees coming to Denmark are mandated refugee status offshore and approximately 500 quota refugees are resettled annually. Upon arrival to Denmark, quota refugees are received directly in the municipalities and municipal caseworkers therefore have the practical responsibility for their health-related reception. The aim of this study was to investigate the health-related reception of quota refugees in Denmark by focusing on the presence of municipal policies and practices, and to test for possible associations with these policies and practices.

MATERIAL AND METHODS: The study was based on a survey of all Danish municipalities that had received quota refugees after 1 January 2007. A questionnaire was designed on the background of preliminary research. A total 49 of the 58 includable respondents returned the questionnaire, which yielded a response rate of 84%.

RESULTS: We found that 49% of the municipalities had no policies for health-related reception of quota refugees and 69% had no specific policies regarding general practitioners' general health assessment of quota refugees upon their arrival. Disparities between the municipalities were also found regarding their health-related practices. The presence of health-related policies and certain health-related practices were found to be associated with the number of quota refugees received and the size of municipality.

CONCLUSION: Due to the lack of policies and the large responsibility of case workers who are not health professionals, there is a risk that the health needs of this particularly vulnerable group may not be met satisfactorily.

FUNDING: not relevant.

TRIAL REGISTRATION: not relevant.

In most European countries, refugees are granted asylum on the basis of a claim from the refugees upon their arrival to the borders of the country. These refugees are the so-called spontaneous asylum seekers. Alternatively, refugees may be quota refugees (QRs). This latter group arrives to asylum countries from refugee camps or areas of conflict on the basis of an agreement between the country of asylum and the United Nations High Commissioner for Refugees (UNHCR). Denmark has been receiving approximately 500 QRs for resettlement annually since 1989. Upon arrival to Denmark, QRs are sent directly to the receiving municipalities. In contrast, spon-



Two thirds of the Danish municipalities have no policies for general health assessments of newly arrived quota refugees.

ORIGINAL ARTICLE

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Dan Med J
2012;59(1):A4352

taneous asylum seekers live in Danish Red Cross asylum centres where they are assessed by health professionals and can receive care during the asylum process.

According to Danish law, all QRs – with the exception of those entering the country as urgent cases – must consent to participate in the Migrant Health Assessment (MHA) before being granted asylum. MHA is a mandatory general health assessment, which is performed outside the borders of Denmark by the International Organisation of Migration [1]. Importantly, the MHA does not include an introduction to the Danish health care system or immunization. Upon the QRs arrival to Denmark, the municipal caseworker is expected to assess whether immediate medical treatment is needed and to assign the quota refugee to a general practitioner (GP). Introduction to the Danish society, including the Danish health care system, is also the task of the receiving municipality [2, 3]. Besides these general expectations, there are no overall directions as to how municipalities and GPs should receive QRs with respect to their health needs. The practices of each individual caseworker and the policies of each municipality may therefore be pivotal in the determination of how newly arrived QRs' health needs are met. It is likely that meeting these needs requires good organisation, a cer-

tain municipality size and highly skilled and experienced employees. For moral and pragmatic reasons, meeting the QRs' health needs is an important task because refugee populations in general have/experience more health problems than native populations [4-13]. Premigratory, migratory and postmigratory factors have been found to affect both mental and physical health and the ability to take part in the receiving society, learn a new language and find employment [10, 14-16].

The objective of the present study was to map existing policies and practices of the Danish municipalities, with regard to health-related reception of newly arrived QRs. As part of this, we tested selected factors that might be associated with the presence of health-related policies and practices.

MATERIAL AND METHODS

The study was based on a survey of all Danish municipalities that had received QRs after 1 January 2007. A larger reform of the municipalities came into effect on that date and comparison with data from before 2007 was considered methodologically unviable. The survey was carried out through a semi-structured quantitative electronic questionnaire in which respondents had the opportunity to add qualitative answers. Respondents were municipal caseworkers (one from each municipality) with practical responsibility in the reception of QRs. Prior to the elaboration of the questionnaire, preliminary research was performed. This included literature searches and contacts to relevant authorities and non-governmental organisations responsible for or interested in the QR programme in Denmark. This led to the elaboration of questions about health-related policies and practices in the reception of QRs and to questions soliciting background information. The provisional questionnaire was written into an electronic internet-based questionnaire powered by defgo.net [17]. Pilot testing was then performed on three municipal caseworkers who had only few suggestions for changes in the wording of questions which led to minor changes. The caseworkers who participated in the pilot testing were included in the final survey.

Data collection

Fourteen of the 98 municipalities were initially excluded because, according to Statistics Denmark, they had received neither QRs nor spontaneous asylum seekers after January 2007. Subsequently, the Danish Immigration Service, the Danish Refugee Council and Local Government Denmark were contacted regarding information about which municipalities had specifically received QRs since January 2007. However, none of them could provide the specific data. Consequently, an email requesting that it be forwarded to responsible casework-

ers was sent to the general email addresses of the remaining 84 municipalities and subsequently phone calls were made to non-responders. This procedure made clear that 58 Danish municipalities had received QRs since 2007. In total, 49 municipal caseworkers, each representing one municipality, responded out of the 58 includable municipalities, providing a response rate of 84%.

Analysis

A frequency analysis was performed on all responses. Deploying Fisher's exact test, we tested if the presence of health-related policies for the reception of QRs and the practice of arranging for a GP visit for all QRs upon arrival was associated with the number of QRs received in the municipality or its population size. Since respondents were given the possibility to answer "Do not know", those answers had to be excluded from the exact test, which reduced the number of responses from 49 to 45 and 47, respectively. Qualitative answers added specific examples to the quantitative answers, apparently in particular to those experienced as problematic.

Trial registration: not relevant.

RESULTS

Municipalities had received QRs of 29 different nationalities; the most frequent were Afghan, Bhutanese, Congolese, Iraqi, Iranian and Myanmar. The numbers of QRs received varied from two to 170 from January 2007 to May 2010; a total of 1,849 individuals.

Among respondents, 58% were trained social workers; and 77% reported that they had received education in typical reactions to torture, psychological and physical traumas, post-traumatic stress disorder, or consequences of resettlement.

Policies of any kind regarding health in the reception process, as for example immunization of children or dental care, were present in 39% of the municipalities (**Table 1**). Specific policies regarding general health assessment upon arrival and immunization were present in respectively 27% and 29% of the municipalities. In practice, 71% arranged for a GP visit for all QRs upon arrival and some respondents added that general health assessment was always arranged for newly arrived children. Several respondents added that general health assessment at a GP was no longer offered systematically after the implementation of the MHA in 2005 and that it was up to the caseworker to assess the refugee's need for a general health assessment upon arrival. Furthermore, 33% of the respondents reported that they had no knowledge of the MHA. The number of respondents who answered "Do not know" to the above-mentioned questions ranged from 0% to 18%.

Collaboration between GPs and municipalities regarding the reception of QRs was found mostly to occur ad hoc and without formal agreements (71%). Six percent had scheduled meetings and 2% had a written agreement. Two respondents from rural areas of Denmark added that lack of GPs is a problem and that due to this, some refugees were not assigned to a GP.

By means of a Fisher's exact test (**Table 2**) it was established that municipalities that had received more than 25 QRs since 2007 were significantly more likely to have policies regarding health in the reception process and policies for general health assessment at a GP upon arrival of a refugee. Larger municipalities (population > 45,000) were significantly more likely to have policies for QRs' immunization upon arrival than were smaller municipalities.

DISCUSSION

Thirty nine percent of the municipalities were found to have policies regarding health in the reception process and only 27% had specific policies for general health assessment at a GP upon arrival of the QRs. Nevertheless, 71% of the municipalities did make ad hoc arrangements for all QRs to see a GP upon arrival. Municipalities that had received more than 25 QRs since 2007 were more likely to have policies for general health assessment at a GP upon arrival of the QRs.

Consequently, at least an estimated 71% of QRs who arrived to a Danish municipality during the study period would have seen a GP shortly after their arrival. However, for the remaining smaller number of QRs, there is a substantial risk that they have not been assessed for general health problems, needs for immunization or have been introduced to the Danish health care system by a Danish health professional. In addition, collaboration about QRs' health between municipalities and GPs was in most cases found to be unstructured and driven by ad hoc communication.

There are several different approaches to investigating the health-related reception of QRs in Denmark. The chosen, mainly quantitative, survey yielded important data on the presence of policies and practices. However, this approach does not fully reveal how certain policies or practices affect the quality or outcome of the reception and integration process.

Due to the broad inclusion criteria, some respondents had limited experience with the reception of QRs because only a few QRs had been received in the municipality or because the respondent was new in his/her position. It is likely that this heterogeneity among respondents affected the answers and thus might represent a bias in that respondents with little experience may be more likely to answer "Do not know". On the other hand, difficulties in answering the questionnaire

due to limited experience might represent an interesting finding since it reveals the vulnerability of practices that are not supported by overall policies.

The high response rate (84%) could be explained by a total response time of more than two months, several email and telephone call reminders in the data collection process, and the fact that topics regarding refugees and integration are frequently debated. Consequently, it may be expected that caseworkers with personal experiences had strong opinions about the topic and therefore found it meaningful to participate.

Substantial variations were found among municipalities with regard to the presence of policies and practices in the health-related reception procedure of QRs. It is worth noticing that variation in policies and practices among municipalities is intended owing to the principles of self-government of Danish municipalities, and is obviously not bad by nature. But, specifically for the health-



TABLE 1

Policies and practices in health-related reception of quota refugees in Danish municipalities. The values are % (n) (N = 49).

| | Yes, % (n) | No, % (n) | Don't know, % (n) |
|--|---------------|--------------|-------------------------|
| Policies of any kind regarding health in the reception process | 39 (19) | 49 (34) | 12 (6) |
| Policies for general health assessment at general practitioner on arrival | 27 (13) | 69 (2) | 4 (2) |
| Policies for immunization | 29 (14) | 53 (26) | 18 (9) |
| Arrange for general practitioner visit for all quota refugees upon arrival | 71 (35) | 29 (14) | 0 |



TABLE 2

Associations between characteristics of the municipalities and the presence of policies and practices for health-related reception of quota refugees.

| | Population in municipality > 45,000 ^a | | | Number of received quota refugees > 25 ^a | | |
|--|--|-------|-------------|---|-------|-------------|
| | yes, n | no, n | p, χ^2 | yes, n | no, n | p, χ^2 |
| Policies of any kind regarding health in the reception process | | | | | | |
| Yes | 11 | 9 | 1.000 | 18 | 2 | < 0.001 |
| No | 13 | 12 | | 7 | 18 | |
| Policies for general health assesment at GP on arrival | | | | | | |
| Yes | 6 | 7 | 0.752 | 12 | 1 | < 0.001 |
| No | 18 | 16 | | 12 | 12 | |
| Policies for immunization | | | | | | |
| Yes | 12 | 2 | 0.007 | 10 | 4 | 0.186 |
| No | 10 | 16 | | 12 | 14 | |

GP = general practitioner.

a) The independent variables population size of municipalities and number of received quota refugees in municipalities were dichotomized by the median and, subsequently, "Do not know" answers were excluded.

related reception of QRs, managed by caseworkers who are not health professionals, decentralised administration implies a considerable risk in that the health needs of QRs may not be met in some municipalities.

Likely explanatory factors for the variation in policies and practices were found to be the number of received QRs and the population size of the municipality. Another explanation for the variation in policies, as well as in practices, is probably the absence of overall national policies as revealed in the preliminary research process. Accordingly, decisions about how to meet the QRs' health needs are made by the individual municipality. Since a substantial part of the municipalities were found not to have any policies, practices regarding the health-related reception of QRs were therefore highly dependent on initiatives taken by the individual caseworker and GP.

In 2002 the National Board of Health published a report containing expert opinions on the health services offered to newly arrived refugees, specifically concerning infectious diseases [18]. In the light of the differences between municipal practices also found in this report, it was recommended to introduce national policies for general health assessments of newly arrived QRs. Whether this recommendation has not been followed due to ignorance of the report on the part of other authorities or due to other circumstances was not revealed in our study.

There are several reasons why the MHA cannot fully compensate for a general health assessment performed upon arrival in Denmark. The MHA does not include immunization, nor does it comprise an introduction to the Danish health care system [4], and QRs entering as urgent cases have not always participated in the MHA [1]. Moreover, a third of respondents reported to be ignorant of the MHA. It is therefore of concern that some QRs might not be assessed by a physician upon their arrival in Denmark. Due to the complex health problems seen in refugee populations [4-16], it is our opinion that general health assessments should be offered to all newly arrived QRs for the following reasons, as also stated by the National Board of Health [18]: 1) improved and more coherent diagnosis, prevention, treatment and follow-up, and 2) improved introduction to the Danish health care system. Furthermore, a satisfactory health-related reception of QRs seems to require better collaboration between municipal caseworkers, GPs, specialists and the QRs themselves.

CONCLUSION

Our study documents large variations in the policies and practices for the reception of QRs in the municipalities. Much responsibility for the QRs' health lies in the hands

of municipal caseworkers who are rarely educated health professionals and who have no national policies to guide them. Therefore, there is a considerable risk that the health needs of QRs are not being met satisfactorily. Thus, the results appear to call for more policies and for the implementation of more systematic practices in the health-related reception process of QRs.

Furthermore, studies on GPs' reception of QRs, including the contents and outcomes of general health assessments and immunization, would add important knowledge to the subject. Also, it would be relevant to explore the reception procedure as experienced from the QRs' point of view, or hard end-points like morbidity, mortality, or level of employment of the received QRs. Such studies are very few and more are needed to evaluate present and future effects of the health services provided to QRs.

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ACCEPTED: 6 October 2011

CONFLICTS OF INTEREST: none

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