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ORIGINAL ARTICLE

Policies of access to healthcare services for accompanied asylum-seeking children in the Nordic countries

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Abstract

Aims: Asylum-seeking children constitute a vulnerable group with high prevalence and risk for mental health problems. The aim of this study was to compare policies of access to healthcare services, including physical examination and screening for mental health problems on arrival, for accompanied asylum-seeking children in the Nordic countries. *Methods*: This study was based on the national reports "Reception of refugee children in the Nordic countries" written by independent national experts for the Nordic Network for Research on Refugee Children, supplemented by information from relevant authorities. *Results*: In Sweden, Norway and Iceland, asylum-seeking children had access to healthcare services equal to children in the general population. On a policy level, Denmark imposed restrictions on non-acute hospitalisations and prolonged specialist treatments. Regarding health examinations, Sweden deviated from the Nordic pattern by not performing these systematically. In Denmark, Iceland, and some counties in Sweden, but not in Norway, screening for mental health problems was offered to asylum-seeking children. ***Conclusion*: Access to healthcare services for asylum-seeking children differs in the Nordic countries; the consequences of these systematic differences for the individual asylum-seeking child are unknown. For asylum-seeking children, access to healthcare has to be considered in a wider context that includes the core conditions of being an asylum-seeker. A comparative study at policy level needs to be supplemented with empirical follow-up studies of the well-being of the study population to document potential consequences of policies in practice.**

Key Words: *Access, asylum-seeking children, comparison, healthcare, mental health, Nordic, policy, refugee children, Scandinavia, screening*

Introduction

In 2009, European countries received 286,700 applications for asylum. Norway ranked fourth in terms of receiving asylum-seekers per 1000 inhabitants, Sweden was fifth, Denmark fourteenth, and Iceland was twenty-fifth [1]. Norway received an average of 2590 asylum-seeking children per year [2], Sweden 7320 children [3], and Iceland 20 children [4]. The number of children submitting asylum applications in Denmark was not available from the Danish Immigration Service.

Three phases of traumatic experiences

Three phases of traumatic experiences are described as predictors of mental health problems for asylum-seeking children [5]: (1) Pre-migration: exposure to violence while in the country of origin [6,7]; (2) During the flight: experiences of neglect, trafficking, and sexual assault [5,8]; (3) Post-migration: environmental factors such as prolonged length of stay in asylum centres, multiple relocations between centres, and cultural isolation [5–7,9,10]. Stress and difficulties in the family sphere, particularly psychiatric disorders in

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parents, are shown to have a great influence on the asylum-seeking children's mental health [6,11]. Children already traumatised before migration are more vulnerable to subsequent traumatic experiences or stress factors, as pre-migration experiences may be exacerbated by post-migration stresses [7].

Prevalence of health issues

The literature provides inconsistent prevalence rates for diseases and psychiatric disorders among asylum-seeking children. Depending on sample, assessments tools, and time of study, studies have documented mental health problems in children in asylum-seeking families with a prevalence rate ranging from 20 to 75% [5,6,9,10], whereas physical disease prevalence has been found to correspond roughly to disease prevalence among children in the general population [12].

Access to healthcare

Accordingly, there is a great need for accessing healthcare services for asylum-seeking children in terms of diagnosis, treatment, and preventive care. Among adult asylum-seekers, access to healthcare in the EU countries differs in content and restrictions [13]. Despite the Convention on the Rights of the Child emphasising the rights of access to healthcare for the child and obligations of the state [14], which most Western countries have ratified, access to healthcare services for asylum-seeking children has not previously been examined.

Access to healthcare is a complex and multidimensional concept [15,16]. Lu Ann Aday et al. defined access as "those dimensions which describe the potential and actual entry of a given population group to the healthcare delivery system" [16]. According to this, the probability of an individual's entry into the healthcare system is influenced by the availability and organisation of healthcare resources as well as the individual's attitudes, resources, and needs that bring them to the healthcare-seeking process [15,16]. In this paper, we define access to healthcare as asylum-seeking children's eligibility to healthcare services that are available and accessible. Our focus is on the policies of access (the potential access) and when relevant we describe whether the potential access has been realised (access to healthcare in practice).

All the Nordic countries have primarily tax-based healthcare systems with equal access to healthcare for all citizens as a guiding principle. Although the Nordic countries supposedly share the same foundation in the values of human rights, each country has its own strategies and policies towards immigration in general, and towards health issues related to immigration in particular. A comparison of the policies of access within the different Nordic healthcare systems can help identify strengths and weaknesses in each system as well as provide a background for understanding the processes of access to healthcare services in practice.

The overall aim of this study was to compare policies of access to health care services for accompanied asylum-seeking children in Sweden, Norway, Iceland and Denmark.

The specific study questions were:

A. What are the national policies regarding access to health care for accompanied asylum-seeking children in the Nordic countries and how do they differ?
B. What are the national policies regarding physical examinations and screening for mental health problems on arrival for accompanied asylum-seeking children in the Nordic countries and how do they differ?

Materials and methods

Data collection

The study aims were addressed through a comparative analysis of data provided by the Nordic Network for Research on Refugee Children in the national reports 'Reception of refugee children in the Nordic countries', written by health and social science researchers from each member country [17]. The Nordic Network for Research on Refugee Children works to promote research on health and well-being of refugee children in the Nordic countries. Denmark, Norway, Iceland, Sweden and Finland are represented in the network [17]. Finland was excluded from this study since a national report regarding reception of refugee children has not yet been written. In the national reports, different aspects of the reception of asylum-seeking and refugee children through 2002–2007/2008 were documented for the

Table I. Organisation of healthcare for asylum-seeking children in the Nordic countries.

	Sweden	Norway	Iceland	Denmark
Integrated into care for residents	Yes	Yes	Yes	No
Contracted with NGO	No	No	No	Yes

Table II. Unrestricted access to healthcare for asylum-seeking children.

	Sweden	Norway	Iceland	Denmark
General practitioners	Yes	Yes	Yes	Yes
Preventive healthcare examinations for children and vaccinations	Yes	Yes	Yes	Yes
Specialised treatment	Yes	Yes	Yes	No
Psychiatrist	Yes	Yes	Yes	No
Psychologist	Yes	Yes	Yes	No
Hospitalisation, acute	Yes	Yes	Yes	Yes
Hospitalisation, non-acute	Yes	Yes	Yes	No
Dental treatment	Yes	Yes	Yes	Yes

Table III. Health examination of asylum-seeking children.

	Sweden	Norway	Iceland	Denmark
Physical	V/not syst.	V	V/C	V
TB	V/not syst.	C	V/C	V/not syst.
HIV	V/not syst.	V	not syst.	V/not syst.
Mental	V/not syst.	not syst.	V/C	V

C: compulsive and systematically performed; V: voluntary and systematically offered; V/C: systematically performed, but not known whether voluntary/compulsive; V/not syst.: voluntary, but not performed or not offered systematically; Not syst.: not performed or not offered systematically.

respective countries. Children were defined as individuals below the age of 18.

A number of key issues regarding accompanied asylum-seeking children were listed for comparison, and data were extracted from the reports accordingly. To cross-check the information provided in the reports, supplementary information was gathered during the fall of 2010 through the web-pages of the Ministries of Immigration, Health, and Social Affairs of the different countries. In some cases where the reports and the homepages did not provide detailed information or unambiguous data, additional sources were contacted in 2010. The coordinating nurse of child healthcare at the Danish Red Cross supplied us with information regarding the content of health examinations in Denmark. The consultant regarding children at the Danish Red Cross and head of communications for the Danish Immigration Service contributed to clarifying the organisation of health care in Denmark. The authors of the Swedish report helped identify supplementary sources for information regarding the organisation of healthcare in Sweden.

Results

Policies of access to healthcare

In Sweden, Norway and Iceland, healthcare for asylum-seeking children was integrated into the general healthcare for residents provided by the state and municipalities (Table I) [2–4]. In Denmark, asylum-seekers did not have direct access to the healthcare services. Instead, healthcare during the asylum period was outsourced in a contract between the Ministry of Refugees, Immigrants and Integration and the operators of the asylum centres: Danish Red Cross and one Municipality [18,19].

In Sweden, Norway and Iceland, asylum-seeking children were entitled to the same healthcare services, including preventive healthcare examinations for children and vaccinations, as resident children (Table II) [2–4]. However, as the number of asylum-seeking children was relatively low in Iceland, each child was evaluated and treated as an individual case, and considered by his or her personal state of health [4]. In Denmark, healthcare, including preventive healthcare examinations for children and vaccinations, was provided in the asylum centres by the operators (20). The children had free access to general practitioners and five consultations with a private practicing specialist doctor and three consultations with a psychiatrist or psychologist. The contract between the Ministry of Refugees, Immigrants and Integration and the operators, however, carried a number of restrictions for additional healthcare services, implying only 'necessary, pain reducing and acute treatments' could be initiated. Prolonged contact with a specialist doctor, hospitalisation, mental assessment and treatment as well as medicines, for instance, for cancer, HIV and strong pain reduction, required approval and guarantee of payment from the Danish Immigration Service [11,18,19].

Access to healthcare in Denmark in practice

According to the Danish Immigration Service and Danish Red Cross, asylum-seeking children in Denmark in practice had equal access to healthcare as resident children. Healthcare services would be granted and the costs would be met, if such treatment would be likely to be offered to resident children. The Immigration Service rejected roughly 15% of all applications regarding social and healthcare services from 2004–06, but according to Danish Red Cross and the Danish Immigration Service almost no applications regarding healthcare services for children were rejected, although exact numbers were unavailable from either organisation [18,21–23].

Policies on health examinations upon arrival

In all four countries, programmes for health examinations for asylum-seeking children were identified, and the costs for these examinations were covered by the government [2–4,18]. In Norway, Iceland, and Denmark, health examinations were organised and performed systematically [2,4,18], in Sweden, health examinations were not performed systematically throughout the country and did not follow a standard procedure [3,24,25].

In Norway, the examination was performed in the primary healthcare system or in the Section for Migration Health in Oslo upon arrival in the country [2]. In Sweden, the organisation varied between counties. In some counties, health examinations were performed by private doctors, in some counties at special care centres, and in some counties they were integrated into primary healthcare [3]. In Iceland, asylum-seeking children had initial health examinations in the primary healthcare system upon arrival, performed by GPs and other specialists as needed [4]. In Denmark, the examinations were performed by health visitors, doctors, and psychologists in the reception centres upon arrival [18,26].

In all four Nordic countries, physical examinations were performed or offered to asylum-seeking children (Table III) [2–4,18]. Physical examinations were voluntary in Norway, Sweden, and Denmark [2,3,18]. In Iceland, health examinations were said to be accepted and considered positive by the asylum-seekers, and the issue of voluntary versus compulsive had not been raised [4]. Screening for tuberculosis was compulsive in Norway, but voluntary in Sweden and Denmark [2,3]. In Sweden, screening for tuberculosis was to be offered to all asylum-seekers [3], whereas in Denmark, screening was only offered when the medical history raised concerns [20]. HIV tests were voluntary in all countries [2–4,18,20].

Screening for mental health problems was offered in Sweden, Iceland, and Denmark, but not in Norway [2–4,18]. In the Icelandic health examinations, interviews with mental evaluation of asylum-seeking children were included, performed by child healthcare professionals [4]. In Denmark, screening for mental health problems consisted of interviews, observations, and questionnaires [26]. In Norway, no information about mental health was gathered in the initial health examination, but the Directorate of Health recommended that municipal health services contact newly arrived asylum-seekers to evaluate their physical and mental health and need for medical services [2].

Health examinations in practice

In Sweden, the content of health examination varied greatly between counties. Health examinations tended to focus less on mental health problems, and only in a few counties were mental health problems addressed in accordance with a well-defined strategy [3,24,25]. In Denmark, statistics concerning physical health examinations were unavailable, but 94% of asylum-seeking children underwent screening for mental health problems on arrival in 2009 [26]. In Iceland, no statistics were available, but all asylum-seeking children were reported to be given health examination [4]. In Norway, no statistics were available from either the Norwegian directorate of immigration nor the Norwegian directorate of health [2]. In Sweden, health examinations were to be offered to all new asylum-seekers in the county of registration, and the Migration Board was to inform applicants of the possibility of medical examinations. The proportion of asylum-seekers actually examined depended on the health organisation and varied between different counties. In 2009, 38% of all new asylum-seekers were examined. The methods and content of these examinations varied. There were no specific data on children. Communication problems between immigration authorities and healthcare providers seemed to be the main reason that medical examinations and health consultations were not implemented [3,27].

Discussion

In Sweden, Norway, and Iceland, policies were found that grant asylum-seeking children equal access to health services compared with children in the general population. Denmark imposed restrictions on non-acute hospitalisation and prolonged specialist treatment, for which approval and guarantee of payment by the Danish Immigration Service were needed. In practice, however, it seemed that almost all requests were

approved. In all the Nordic countries, except Sweden, physical health examinations were performed systematically. In Sweden, 38% of asylum-seekers underwent health examinations in 2009. In Norway, Iceland, and Sweden, health examinations included screening for tuberculosis – compulsive in Norway and Iceland, and voluntary in Sweden. In Denmark, screening for tuberculosis was only offered when the medical history raised concerns. In Denmark, Iceland and in some counties in Sweden, screening for mental health problems was offered to asylum-seeking children. In Norway, screening for mental health problems was not offered as part of the health examination.

Consequences of policies on asylum-seeking children

The Convention on the Rights of the Child offers an important theoretical and legal framework for protection of children [5]. It emphasises the fundamental rights of all children. Of particular concern to healthcare is article 24.1. "*States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such healthcare services*" [14]. The consequences of the Danish organisation of healthcare services for the individual asylum-seeking child are unknown. There is no evidence that asylum-seeking children living in Danish asylum centres do not receive the necessary treatment, but it remains undocumented what the children are offered and whether they receive relevant and equal treatment compared to resident children [11]. Two separate follow-up studies have focused on the long-term mental health of refugee children with residency in Denmark and Sweden. Despite different samples, these studies showed similar prevalence of mental health problems over time and did not demonstrate significant differences between the two countries and the way access to healthcare services was organised [6,9]. To document the effect of policies in practice, and to discover more about the relative benefits and disadvantages of the different organisations of healthcare services for asylum-seeking children, a comparative study at policy level needs to be supplemented with empirical follow-up studies of perceived access and access to healthcare services in practice among asylum-seeking children as well as their health status.

The purpose and content of health examinations

Health examinations are of primary benefit for screened individuals, but also of benefit for the host country by preventing expensive treatments and problems on integration at a later date [13]. There is a need for further research documenting the number of children who undergo health examinations in practice, the content in practice of these examinations, and the results of these examinations. Nevertheless, with the high number of mental health problems among asylum-seeking children in mind [5,6,9,10] a need for systematic health examinations, including screening for mental health problems, is evident [8,28]. A status report on results of the screening programme in Denmark recommended that screening for mental health problems should be integrated within the overall health examination consisting of several supplementary methods [26]. The identification of pre and post-migration stress helps improve the recognition of asylum-seeking children in need of mental health services [7]. To make systematic health examinations worthwhile, the relevant treatment and resources needs to be available – both regarding physical and mental health. If the resources for individual treatment are not available, a systematic health examination programme may not be legitimised, even if the programme could identify children with physical or mental health problems or children at risk of developing problems [5,8,10].

Asylum-seeking children inside or outside general healthcare

An advantage of healthcare being provided within the asylum centres – as in Denmark – is the high numbers of asylum-seekers reached by the systematic health examination programme and the potential for detailed reports of physical and mental health problems found, which could help document the need for the health examination. Furthermore, the medical staff in the centres are specialised and qualified in the specific health issues of asylum-seeking children compared to general practitioners who might seldom encounter asylum-seeking children [28]. However, when healthcare for asylum-seeking children is provided specifically for asylum-seekers, there is a risk that the medical staff involved gradually will lose the sense of healthy child development and functioning. When healthcare is provided outside the centres, informal psychological and sociocultural barriers in accessing and using services may become more important and can contribute to unequal access to healthcare services. These barriers include the availability of translation, distance to healthcare services, lack of time for complex examination and consultation, and lack of information and knowledge of available and appropriate services [13,29]. This is evident in Sweden and contributes to

the low number of asylum-seekers examined on arrival.

Providing healthcare services within the asylum centres can contribute to isolating and marginalising instead of normalising and integrating these children into society. As asylum-seeking children in Denmark are placed outside the community, in terms of housing as well as healthcare, their status as non-members of society is emphasised. It has been argued that a discourse of asylum-seekers posing a threat to society at large has overridden the claims of childhood for asylum-seeking children as a universal position. The children are positioned primarily as asylum-seekers, rather than children, potentially creating situations "when a child is not a child", and in which asylum-seeking children's political and juridical rights, opportunities, obligations, and limitations differ from those of other children, and the Convention of the Rights of the Child has ceased to apply [30].

Methodological strengths and weaknesses

The comparisons and evaluations of access to healthcare services for asylum-seeking children in the Nordic countries are challenging, as both the healthcare systems and asylum policies are complex and constantly changing in relation to immigration policy and refugee flows. The strengths of this study are partly its comparative character, which examines policies and practices across national borders, and partly the foundation of the reports written by independent experts, and based on a large amount of data from a number of sources, which are again cross-checked with other sources. Limitations are that the country reports gave unequal weight to different subjects, and that the information was collected in different ways. The reports could be coloured by the perspectives of the authors and the context within which the research was commissioned. To overcome these shortcomings and to confirm the reliability, some of the information was cross-checked, primarily with the relevant Ministries and with the Danish Red Cross, but no important discrepancies were found. As precise data or statistics concerning the numbers of granted or rejected applications for healthcare services for asylum-seeking children in Denmark were not available, assessment of policy restrictions in practice had to rely on informants.

Immigration policies and restrictions in access to healthcare

Healthcare policies and welfare policies are interwoven with and impacted by immigration policies. In recent years, asylum policies in the EU countries have aimed at deterring potential asylum-seekers from entering the country, and at increasing the return rate of failed asylum-seekers by using "policies of deterrence" and restrictions. Removing access to civil entitlements, such as healthcare, welfare, and employment rights, can thus also become means or methods of supporting or enforcing immigration policies [29]. The categorical – although possibly not implemented – restrictions in access to hospital care and specialised treatment for asylum-seeking children conflict with both the Convention of the Rights of the Child and with the Nordic goal of equal access to healthcare, which aims particularly to ensure sufficient care for vulnerable groups and thereby minimise differences in health among its residents [13]. If or when national self-interest and national immigration policies are at odds with human rights, the principle of promoting the best interest of the child may be disregarded [5].

Focus on prevention through the environment

Health examinations and treatment are not sufficient in creating and maintaining a good health. Asylum-seeking children's health is related to the very core of the child and his or her caretakers being asylum-seekers. The living conditions and the asylum procedures are in themselves stressful and potentially harmful. Basic environmental conditions concerning housing, education, and economic needs have to be fulfilled to reduce risk factors, prevent physical or mental health problems, and create and maintain good mental health and well-being of asylum-seeking children. The status of being a child and the best interest of the child must be primary considerations in all actions affecting the child [7,9,10,29].

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Conflicts of interest

The authors declare that there is no conflict of interest.

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