Healthy lives in bad surroundings and unhealthy conditions

- Ethnic minorities in Nordic countries are forced into a nomadic life in no-mans land between health and illness, security and insecurity, inclusion and exclusion, self-awareness and paralysis

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What was done?

The hospital based cross disciplinary migrant health at Odense University hospital was established in 2008 as the first of its kind in Europe. The present abstract/presentation reports on the experiences from the first five years[1, 2]. Patients were referred to the clinic from family doctors, hospital departments, psychiatrists and emergency wards. Patients referred to the clinic have long lasting unresolved health complaints, complex compliance issues, failure to accept potentially lifesaving clinical investigations or treatment or low patient empowerment. Most patients have one or more of the following issues: life histories of neglect, childhood deprivation, family responsibility at a young age, abuse, domestic violence and over 60 % have previously unknown war related trauma or history of exposure to torture.

With the aim of looking at equity in outcome of health care for ethnic minorities, the present abstract/presentation presents a comprehensive mixed analysis of how and where professional factors and settings like health and integration policies, the organization of social welfare sector, social workers, hospital organization, family doctors and legal frameworks create and strengthen inequity in access to and outcome of: preventive care, clinical investigations, treatment, outpatient follow-up, rehabilitation and palliative care.

Participants and methods

700 patients seen at the clinic from 2008-2013 were evaluated in a cross disciplinary environment and followed until clinical investigations were finalized and the patient had sufficient empowerment and disease insight.

Problems and solutions

Ethnic minority patients seem to end up as a group of patients in a clinical no-mans land: they are too complex and time consuming for the general practitioner and they are often too complex with more than one chronic disease and time consuming for a highly specialized hospital department.

Ethnic minority patients experience barriers within hospitals that reduce their access to and outcome of standard hospital care ranging from too complex written communication to use of low quality interpreters and lack of clinical ethnic competencies among health care workers. The types of barriers include professional misinterpretation of symptoms, overlooking symptoms, lack of specialised ethnically competent clinical teams and complex compliance issues. Lack of respect for language barriers, health literacy and functional illiteracy are key drivers of inequity. A certain group of health conditions associated with social stigma requires special hospital attention.

It is recommended that, in order to alleviate unequal outcomes in hospital treatment and to support general practitioners, each of the five regions in Denmark establish a Migrant Health Clinic with the aim of reducing inequality in health care through documentation, patient information, training of professionals and clinical assistance in cases that require specialist clinical ethnic competencies. Hospital based migrant health clinics should develop joint management programs with centers that treat trauma and torture survivors and community health centers.

What was particularly good?

The clinic was surprisingly well received by general practitioners and hospital departments and social workers were more cooperative across sectors than anticipated. There was a remarkable professional interest to "do better" when it comes to ethnic minority patients but health care professionals and social workers seemed to lack both the ethnic competencies, a favourable administrative environment and the time to enable them to perform they way thay actually wanted.

How do we know if it was succesfull?

A health technology assesment has been carrried out and will be published in March 2014. A 5 year report documenting barriers to equity in health and hospital treatment was published in 2013 [1]. A migrant health clinic was started at Hvidovre Hospital in Copenhagen as a consequence of the experiences at Odense University Hospital. The clinic has been made responsible for training of all staff in the region and is part of the curriculum of all social and health educations. The clinic was awarded an equity price in 2010. The experience from the migrant health clinic was a direct cause for the formulation of a new law on better health assessment of newly arrived refugees and the model for the clinic has been copied in Romania and Japan. The clinic has been highlighted by the Danish Institute for Human Rights and an example of models for creating equal access to health care [3] The clinic has been appointed a national knowledge center on Health of ethnic minorities by the Ministry for Integration (http://www.integrationsviden.dk/videnscentre/knowledge_center_folder_view?b_start:int=0)

Where can we learn more?

The five year report published in 2013 summarizes experiences and interventions points and includes an English summary [1]. Links to all published reports, seminars and media reports about the clinic can be found at: www.ouh.dk/indvandrerklinik.

1. Sodemann, M., *Tak fordi du lavede en bedre version af mig*. 2013, Indvandrermedicinsk Klinik.
2. Sodemann, M., A. Svabo, and A. Jacobsen, *De hårde kampe starter, når krigen er slut.* Ugeskrift for Laeger, 2010. **172**(2): p. 141-4.
3. Slot, L.V., *Udfordringer og veje at gå - mødet mellem sundhedsprofessionelle og patient uanset etnisk oprindelse*, ed. M. Zarrehparvar. 2013, København: Institut for Menneskerettigheder.