



*Health Care in*

**NOWHERELAND**

*improving services for  
undocumented migrants in the EU*

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## **Policies on Health Care for Undocumented Migrants in EU27**

Country Report

Denmark

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## Preface

Undocumented migrants have gained increasing attention in the EU as a vulnerable group which is exposed to high health risks and which poses a challenge to public health. In general, undocumented migrants face considerable barriers in accessing services. The health of undocumented migrants is at great risk due to difficult living and working conditions, often characterised by uncertainty, exploitation and dependency. National regulations often severely restrict access to healthcare for undocumented migrants. At the same time, the right to healthcare has been recognised as a human right by various international instruments ratified by various European Countries (PICUM 2007; Pace 2007). This presents a paradox for healthcare providers; if they provide care, they may act against legal and financial regulations; if they don't provide care, they violate human rights and exclude the most vulnerable persons. This paradox cannot be resolved at a practical level, but must be managed such that neither human rights nor national regulations are violated.

The EU Project, "Health Care in NowHereland", works on the issue of improving healthcare services for undocumented migrants. Experts within research and the field identify and assess contextualised models of good practice within healthcare for undocumented migrants. This builds upon compilations of

- policies in the EU 27 at national level
- practices of healthcare for undocumented migrants at regional and local level
- experiences from NGOs and other advocacy groups from their work with undocumented migrants

As per its title, the project introduces the image of an invisible territory of NowHereland which is part of the European presence, "here and now". How healthcare is organised in NowHereland, which policy frameworks influence healthcare provision and who the people are that live and act in this NowHereland are the central questions raised.

### **Healthcare in NowHereland: Improving services for undocumented migrants in the EU**

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#### *Partners:*

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Centre for Research and Studies in Sociology (PT)

Malmö Institute for Studies of Migration, Diversity and Welfare (SE)

University of Brighton (UK)

## Introduction

This report is written within the framework of the research project, *NowHereland - Health Care in NowHereland – Improving Services for Undocumented Migrants in the EU*, and one of its work packages. The focus of this work package – *policy compilation* – was to collect data on policy approaches regarding access to health care for undocumented migrants in the EU member states, to deliver 27 Country Reports and to offer a clustering of the states. A descriptive approach has been applied. In order to contextualise health care access, certain other themes are covered, such as the main characteristics of the various health systems, aspects of policies regarding undocumented migrants and the general context of migration.<sup>1</sup>

The term used in this project is thus, “*undocumented migrants*”, which may be defined as third-country nationals without a required permit authorising them to regularly stay in the EU member states. The type of entry (e.g. legal or illegal border crossing) is thus not considered to be relevant. There are many routes to becoming undocumented; the category includes those who have been unsuccessful in the asylum procedures or violated the terms of their visas. The group does not include EU citizens from new member states, nor migrants who are within the asylum seeking process, unless they have exhausted the asylum process and are thus considered to be rejected asylum seekers.

All the reports draw upon various sources, including research reports, official reports and reports from non-governmental organisations. Statistical information was obtained from official websites and from secondary sources identified in the reports. As regards legislation, primary sources were consulted, together with the previously mentioned reports. One salient source of this project was information obtained via a questionnaire sent to recognised experts in the member states.<sup>2</sup>

## The General Migration Context

Denmark joined the European Union in 1973 and is situated on the border of the Schengen Area.

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<sup>1</sup> Information regarding the project and all 27 Country Reports can be found at <http://www.nowhereland.info/>. Here, an *Introduction* can also be found which outlines the theoretical framework and methodological considerations as well as a clustering of the states.

<sup>2</sup> For the report at hand, the person to acknowledge is: Nanna Ahlmark, Research Assistant, Danish National Institute of Public Health.

Traditionally, Denmark has not regarded itself as a country of immigration. This is due to its relatively homogeneous population and the fact that until recently, immigration levels were moderate. Historically, Denmark experienced continuous immigration of groups and individuals over several centuries (ex. Dutch farmers in the early 16th century, Jews from several European countries in the 17th century and Germans in the 17th and mid-19th century). Before World War I, large numbers of unskilled workers arrived from Poland, Germany, and Sweden (Hedetoft 2006). Immigration during the 20th century primarily consisted of multiple waves of refugees. The two World Wars brought many Eastern Europeans, Jews, and Germans to Denmark. Between the late 1960s and 1973, Danish companies imported so-called guest workers, especially from Turkey, Pakistan, Yugoslavia, and Morocco. In the 1970s, Denmark accepted approximately 1 000 refugees annually from Chile and Vietnam. The Cold War, the breakdown of empires and federations, and conflicts in the Middle East led to the arrival of several new groups through the 1990s, particularly Russians, Hungarians, Bosnians, Iranians, Iraqis, and Lebanese (Hedetoft 2006). Until the mid-1990s, refugees were generally welcomed in Denmark. As more refugees began to arrive from third world countries however, a shift of policy and perception started to set in. Repatriation became an integral part of temporary residence programs from the early 1990s. Since 2001, refugees have clearly been discouraged from applying for asylum, and their numbers have declined dramatically. More than half the growth of the Danish population in the last 35 years, or more than 250 000 people, may be accounted for by immigrants and their descendants (Hedetoft 2006).

Currently, immigration to Denmark consists mostly of asylum seekers and persons who arrive as family dependents and in accordance with legislation regulating family reunification. In addition, Denmark annually receives a number of citizens from Western countries, notably Scandinavian countries, the EU, and North America, who usually come to work or study for a limited period of time. Also, workers from especially Poland and the Baltic nations have arrived to perform menial labour (e.g. construction, agriculture and cleaning) (Hedetoft 2006). Since 2002, a number of policy measures have restricted the ability to obtain asylum and residence permits in Denmark. As a result, financial support to asylum seekers has decreased markedly and the number of persons obtaining residence permits in relation to family reunification was halved between 2000 and 2007. The general climate for ethnic minorities, especially with Muslim backgrounds, has deteriorated over the last decade and cases of discrimination appear to be more frequent in Denmark compared to other EU countries (Holmberg et al. 2009). In 2008, Denmark received 2 375 asylum applications (Eurostat 66/2009). Among the applicants, 560 came from Iraq, 415 from Afghanistan and 195 from Iran (ibid.). The same year, 1 725 decisions were issued (in the first and second instance) and the rate of recognition was 58.3 % (in the first instance) (Eurostat 175/2009).

## **Total Population and Migrant Population**

By 1 January 2010, the population in Denmark was 5 547 088 (Eurostat)<sup>3</sup>. In 2008, the foreign-born population was 298 000 (Eurostat 94/2009). The main countries of origin were Turkey (28 800), Iraq (18 300) and Germany (18 000) (ibid.). Asylum seekers were primarily from Iraq, Serbia, Montenegro, Afghanistan and Iran. Most immigrants lived in Copenhagen County and its sub-districts (Holmberg et al. 2009). In 2007 the net migration in Denmark was 23 090 persons.

## **Estimated Number of Undocumented Migrants**

According to available estimates, the number of undocumented migrants in Denmark is low. (Baldwin-Edwards and Kraler 2009:41). This might be due to the fact that there are few ways to enter the country and that it can prove difficult for individuals who are not granted the right to stay (Wöger 2009 with reference to Vedsted-Hansen, 2000<sup>4</sup>: 402). The Danish Police state that there are no official statistics regarding the number of illegal immigrants in Denmark (Wöger 2009 with reference to Danish Ministry of Refugee, Immigration and Integration Affairs). Nevertheless, it is presumable that there are a number of persons stay illegally or irregularly in Denmark. Research is limited, due to the fact that the government until recently did not acknowledge the phenomenon (Wöger 2009:38). However, statistical estimates assume that between 1 000 and 5 000 illegal immigrants reside in Denmark and it is assumed that the major share of these persons are employed, mostly in the agricultural and construction sectors (Wöger 2009:38-39).

## **Categories of Undocumented Migrants**

In Denmark, there are no official statistics regarding the categories of undocumented migrants. However, the asylum process has a role in "producing" undocumented migrants (Baldwin-Edwards and Kraler 2009:41). In May 2009 there were 578 rejected asylum seekers awaiting deportation (Questionnaire Denmark). It may be estimated that the largest group of unauthorised immigrants residing in Denmark consists of rejected asylum seekers (Wöger 2009:38 with reference to Vedsted-Hansen, 2000:402f.). Furthermore, two other major groups may be identified, namely overstaying visitors and aliens working without legal authority (ibid.).

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<sup>3</sup> Eurostat.

<http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&language=en&pcode=tps00001&tableSelection=1&footnotes=yes&labeling=labels&plugin=1> (2010-03-09)

<sup>4</sup> Vedsted-Hansen, J. (2000): Regularisation of illegal immigrants in Denmark. In: De Bruycker, P. (2000): Regularisations of illegal immigrants in the European Union. Brussels: Bruylant.

## **Policies Regarding Undocumented Migrants**

### **Regularization Practice, its Logic and Target Groups**

There have been two regularisation programs in Denmark since 1997 (i.e. 1992-2002 and 1999-2000), both related to the wars in the former Yugoslavia and Kosovo. People were granted temporary permits (1.5 years) on humanitarian grounds (persons in distress). These migrants consisted mostly of Bosnians (4 889) and Kosovans (3 000) (Wöger 2009:40).

### **Internal Control: Accommodation, Labour, Social Security and Education**

In Denmark, undocumented migrants can not sign a contract of accommodation nor access employment or the related social security. There is no regular entitlement to education for a child as there is no obligation for schools to enroll children who are irregularly resident, whilst a proof of residence status is required prior to admitting children into the school system (European Commission 2004:33).

## **Main Characteristics of the Health System**

### **Financing, Services and Providers**

Denmark is characterised by a strong welfare state tradition, with universal coverage of health services. The system is financed via taxation (proportional taxation at the national level and municipal taxes). Other sources of finance include user charges for certain health goods and services and voluntary health insurances which are used to partially cover user charges (Strandberg-Larsen et al. 2007:51). The Danish health system is governed by a combination of national state institutions, regions and municipalities (all with democratically elected assemblies) and with a tradition of decentralisation of management and planning to the regional authorities and municipalities. The state is responsible for the overall legal framework for healthcare and coordinating and supervising the regional and municipal delivery of services. Five regions are responsible for delivering both primary and secondary health services (Strandberg-Larsen et al. 2007:xv).

Access to the health system, including diagnostic and treatment services, is free for all citizens, except for certain services such as dental care, physiotherapy and medicine requiring patient co-payments (Strandberg-Larsen et al. 2007). Services covered are: universal health care (accidents included) and to a certain extent, dental care.

In Denmark, the main providers of care are state driven bodies. Most hospitals are owned and operated by the regional authorities, and hospital doctors are salaried employees of such. However, practicing doctors are private, rather than state practitioners, but receive almost all of their income from services paid for by the regional authorities (Strandberg-

Larsen et al. 2007:xv). There are also non-profit organisations active in the healthcare sector (Questionnaire Denmark).

### **Basis of Entitlement**

In Denmark, the basis of entitlement to healthcare is legal residency (Strandberg-Larsen et al. 2007:30). However, to be entitled to free access to healthcare an individual must have been registered as a resident for more than six weeks. All those who have the right to tax-financed health care receive a health certificate card. The right to healthcare services is regulated by legislation, with no option of opting out of the publicly funded system. Persons over the age of 16 who have the right to tax-financed services may choose between Group 1 and Group 2 coverage.<sup>5</sup> With regard to many services, a person's rights depend on which group they have chosen. Children under the age of 16 are covered by the same form of coverage as their parents. A considerable proportion of the Danish population is covered by additional voluntary health insurance (VHI) (ibid.).

### **Special Requirements for Migrants**

Special rules and requirements for accessing health services apply for tourists, foreigners, legal immigrants, asylum seekers and illegal immigrants. Tourists and foreigners temporarily staying in Denmark must pay for health care services on a fee-for-service basis. They may receive reimbursement if they have a European Health Insurance Card or if they can provide evidence of private health insurance at the point of delivery. Legal immigrants are covered by the tax-financed system and they have the same rights as residents with Danish citizenship. Asylum seekers (as non-residents) do not have these entitlements; they may receive basic primary services and emergency hospital services, but are required to apply for specialised treatment in the case of life threatening and painful chronic diseases, which are financed by the Danish Immigration Service (Strandberg-Larsen et al. 2007:29).

### **Difference Sensitivity**

In Denmark, some adaptive structures to undocumented migrants are to be found, such as mediation and translation services, translated materials and health services adapted to migrant specificities (for example, meals in hospitals). However, from 2011 legislation is to be enacted which provides that immigrants resident in Denmark for more than seven years are no longer entitled to free translation services within the healthcare system (Questionnaire Denmark).

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<sup>5</sup> The main difference is whether the patient has free choice of care provider or not <https://www.sundhed.dk/Artikel.aspx?id=20186.1> (2010-02-20).

## Health Care for Undocumented Migrants

### Relevant Laws and Regulations

According to The Health Act para. 80 (Sundhedsloven), every person present in a region (even if not resident) shall be provided emergency care if in need.<sup>6</sup>

The Aliens Consolidation Act, together with Danish health policy statements, deals (sporadically) with access to healthcare for undocumented immigrants (Rytter Hansen et al. 2007:50). According to the Aliens Consolidation Act, the Danish Immigration Service is responsible for covering necessary healthcare for foreigners who are not entitled to stay in Denmark (Rytter Hansen et al. 2007). However, this does not apply if the foreigner's place of residence is unknown. Undocumented migrants may enquire at one of the asylum centres or at the Danish Immigration Service when in need of treatment.

All in all, there are three different suggestions with respect to how undocumented immigrants should obtain access to healthcare: 1) According to the Aliens Consolidation Act, undocumented immigrants may enquire at the Danish Immigration Service when in need of treatment. 2) According to the National Board of Health, doctors have a duty to treat patients who have provided false identification, however not in cases of elective (i.e. non-emergency) treatment. 3) In the Copenhagen area, hospitals are not entitled to reject treatment (according to the Copenhagen Hospital Co-operation Board of Directors).

The Law on Preventive Examinations for Children and Youth (Law no. 546 of the National Health Law) provide specific entitlements to children.

### Access to Different Types of Health Care

Undocumented migrants are entitled to acute treatment, but are not otherwise covered by the tax-financed system (Strandberg-Larsen et al. 2007:30). Consequently, they are not entitled to primary or specialist care. However, there is no provision in the Danish Law of Hospital Services ("Sygehusloven") regarding how foreigners should identify themselves when paying for treatment (Questionnaire Denmark with reference to Michelsen, Jensen & Nielsen 2000:211; Jensen 1997; PICUM 2003:35). Thus, if an undocumented migrant has the means to provide payment, it is possible for them to obtain general healthcare. It is, however, unlikely that an undocumented immigrant will have the means to pay for healthcare (PICUM 2003:35).

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<sup>6</sup> The Health Act (Sundhedsloven), [http://www.im.dk/artikler\\_im\\_dk/Files/Fil1/3857.pdf](http://www.im.dk/artikler_im_dk/Files/Fil1/3857.pdf) (2010-02-18)  
Para. 80 in Danish "Regionsrådet yder akut behandling til personer, som ikke har bopæl her i landet, men som midlertidigt opholder sig i regionen [...]".

### **Costs of Care**

As regards the costs of healthcare, the emergency care which all foreign citizens staying temporarily in Denmark are entitled to, is free of charge (Rytter Hansen et al. 2007:67) and corresponds to the general fee level. The cost for emergency care is paid by the state, or more precisely, the Ministry of Refugees, Immigration and Integration Affairs (Questionnaire Denmark). All other treatment must be paid for (full cost) if the person does not have a Danish health insurance certificate or if there is no special agreement between the person's home country and Denmark. In practice, undocumented migrants in need of services other than emergency healthcare often borrow another person's health insurance certificate. In such cases, the state, through the regional authorities, pays the cost indirectly.

### **Specific Entitlements**

Children have the right to preventive examinations in terms of the Law on Preventive Examinations for Children and Youth (Law no. 546 of the National Health Law), which includes health care, children's vaccinations, preventive examinations at general practitioners, school health services and municipal dental care.

HIV is dealt with in terms of specific entitlements, which include the right to be tested for HIV.<sup>7</sup> It is also, depending on the county of residence, possible to be tested and treated for sexually transmitted diseases anonymously and for free at special clinics or at hospitals (Rådgivningsklinikker). Some counties do not offer such services and instead refer patients to their regular physicians, which is not an option for undocumented migrants (Rytter Hansen et al. 2007).

### **Regional and Local Variations**

Generally, the Danish system appears to be an integrated, yet decentralised public health system (Strandberg-Larsen et al. 2007:139). In terms of entitlements to care, it is fair to say that there are some variations, due to disagreements and ambiguities in the legislation and its implementation (Rytter Hansen et al. 2007:50). All in all, there are three different suggestions with respect to how undocumented immigrants should obtain access to healthcare: 1) According to the Aliens Consolidation Act, undocumented immigrants may enquire at the Danish Immigration Service when in need of treatment. 2) According to the National Board of Health, doctors have a duty to treat patients who have provided false identification, however not in cases of elective (i.e. non-emergency) treatment. 3) In the Copenhagen area, hospitals are not entitled to refuse treatment (according to the Copenhagen Hospital Co-operation Board of Directors). Furthermore, the right to be tested

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<sup>7</sup> The right to test anonymously is based on the key principle of Denmark's AIDS policy that prevention should be carried out without compulsory measures and, if necessary, based on anonymity (Strandberg-Larsen (2007). Denmark introduced an anonymous HIV case-reporting system in 1990 (see [http://www.euro.who.int/aids/ctryinfo/overview/20060118\\_12](http://www.euro.who.int/aids/ctryinfo/overview/20060118_12).) (2010-02-20).

and treated for sexually transmitted diseases anonymously and for free at special clinics or at hospitals depends on the county of residence. Some counties do not offer such services and instead refer patients to their regular physicians, which is not an option for undocumented immigrants (Questionnaire Denmark with reference to Rytter Hansen et al. 2007).

### **Obstacles to Implementation**

The obstacles to the implementation of healthcare services for undocumented migrants are created by the disagreements and ambiguities in the legislation and its implementation (Rytter Hansen et al. 2007:50) (see above). A further obstacle involves undocumented migrants often being afraid of being reported to the authorities if they attend the health services for acute care (Strandberg-Larsen et al. 2007:125).

### **Obligation to Report**

As previously stated, undocumented migrants may enquire at one of the asylum centres or the Danish Immigration Service when in need of (emergency) treatment. However, The Danish Immigration Service is then obliged to keep the police notified of such persons' places of residence (Rytter Hansen et al. 2007: 50). However, there are different interpretations of this duty, as well as a discussion in this respect relating to the use of false identity cards. By February 2003, the Copenhagen Hospital Co-operation Board of Directors informed the city's hospitals that the fact that a patient is suspected to have unsettled matters with the police or the immigration authorities does not entitle the hospital to refuse treatment or to report the patient for an illegal stay (Ibid.). It has also been clarified, by The National Board of Health, that health staff do not have a duty to report the use of another person's health insurance certificate to the authorities, as it is not considered an offence serious enough to be reported. In practice, this means that health personnel should treat patients using another person's health insurance certificate. But, whilst there is no duty to report such cases to the police, there appears to be no restriction on the right of staff to report such cases. This creates uncertainty as to whether there are any legal consequences for using another person's health insurance certificate (Questionnaire Denmark, with references to Haller 2004).

### **Providers and Actors**

#### *Providers of Health Care*

Given the entitlement to emergency care, providers of care to undocumented migrants in Denmark are the hospitals' emergency units (Questionnaire Denmark). There are doctors present at asylum centres who may also refer patients to hospitals or specialists (Questionnaire Denmark).

However, a significant proportion of healthcare is provided outside the established public healthcare system, within informal networks of healthcare providers. Also, sex workers living illegally in Denmark receive assistance from nongovernmental organisations, which

treat them for sexually transmitted infections and other conditions (Strandberg-Larsen et al. 2007:125).

The providers of care may be found in both the main and smaller cities. There are a total of 12 asylum centres located in different parts of the country. The Danish Immigration Service is located in Copenhagen. Undocumented migrants may seek care at those facilities. The providers cannot be said to be coordinated.

#### *Advocacy Groups and Campaigns*

In Denmark, there have not to date been any informational campaigns regarding the right to health for undocumented migrants. Certain NGOs support undocumented immigrants on a voluntary basis, but very few advocate their cause with respect to healthcare (Questionnaire Denmark).

#### *Political Agenda*

Undocumented immigrants are not considered a social problem and are therefore not an important issue in political and public discourse (Wöger 2009:39). This may primarily be explained by the low numbers of undocumented migrants. There is thus not much public debate regarding undocumented migrants. Most of the debate relates to the rejected (mainly Iraqi) asylum seekers. The debate in this regard is mainly rights oriented and control oriented. Another topic in discussions involves returning persons. An efficient return policy is considered to be an important tool for preventing illegal migration. In this respect, the Danish government has signed readmission agreements with countries from which Denmark receives illegal migrants, to return persons who do not have the right of residency. Denmark has initiated specific measures for rejected asylum seekers who do not cooperate with the police in facilitating their own return. Engaging actively in migrants' regions of origin is part of the Danish strategy to fight irregular migration (Wöger 2009:39).

#### *International Contacts*

The actors in the field of healthcare for undocumented migrants do not currently have international contacts.

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