Summary Report on the MIPEX Health Strand & Country Reports

International Organization for Migration (IOM) Regional Office Brussels Migration Health Division (MHD)

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http://members.costadapt.eu/images/8/89/MIPEX.pdf

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Health strand and Country Reports

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Map showing total scores on the MIPEX health strand (divided according to rank order into 5 groups of roughly equal size)
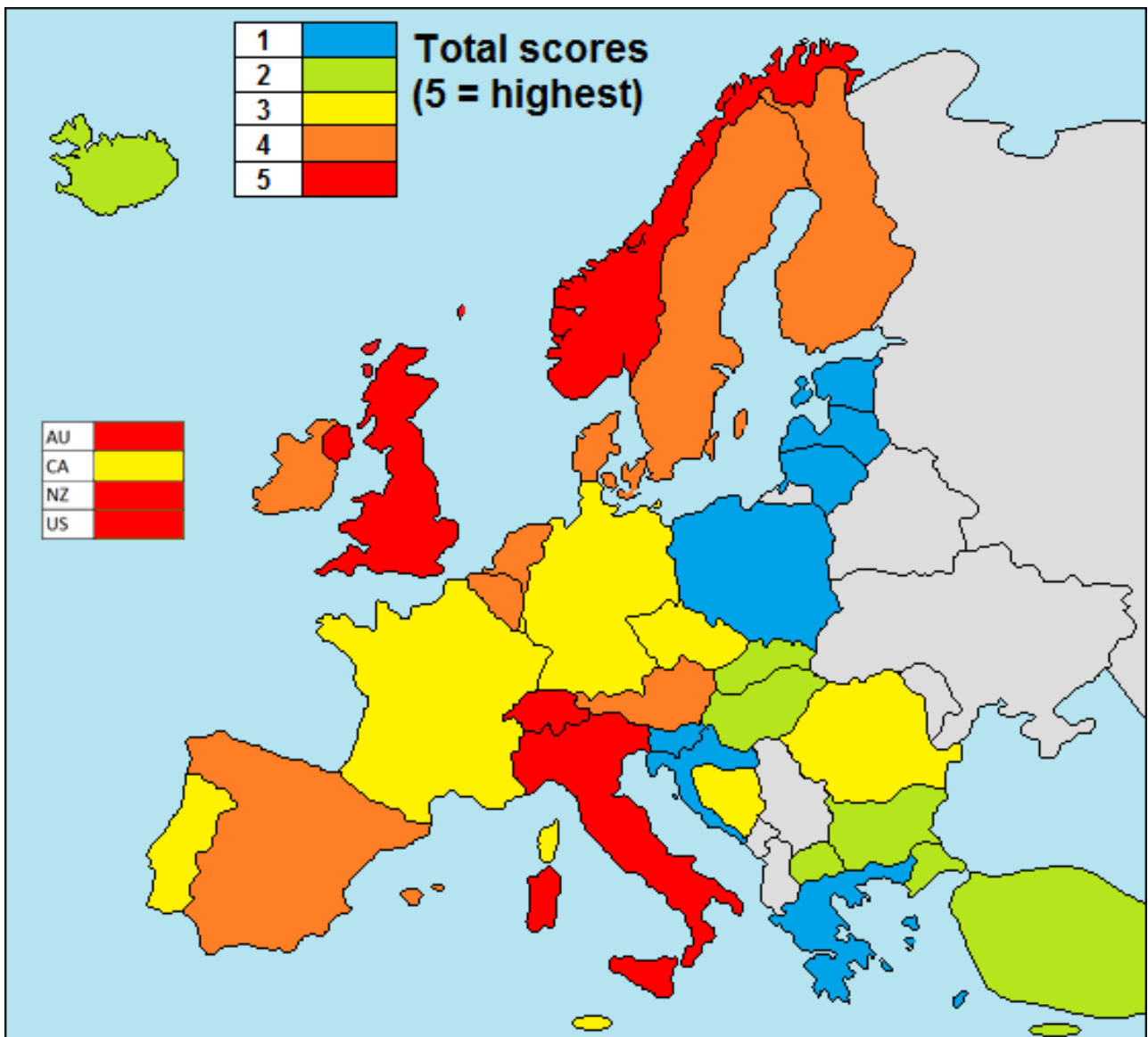
Note. Following MIPEX methodology, data in Italy, Spain, Switzerland and Austria were collected from regions with a higher concentration of migrants. The same was true to some extent in other countries (see p. 16).

EXECUTIVE SUMMARY

The MIPEX Health strand is a questionnaire designed to supplement the existing seven strands of the Migrant Integration Policy Index, which in its latest edition (2015) monitors policies affecting migrant integration in 38 different countries. The Health strand questionnaire is based on the *Recommendations on Mobility, migration and access to health care* adopted by the Council of Europe in 2011, which were based in turn on a consultation process which lasted two years and involved researchers, IGOs, NGOs and a wide range of specialists in health care for migrants. The questionnaire measures the equitability of policies relating to four issues: (A) Migrants' entitlements to health services; (B) Accessibility of health services for migrants; (C) Responsiveness to migrants' needs; and (D) Measures to achieve change. The work described in this report formed part of the EQUI-HEALTH project carried out by the IOM from 2013-2016, in collaboration with the Migrant Policy Group (MPG) and COST Action IS1103 ('Adapting European health services to diversity').

Part I of this report shows that many studies have already been carried out on migrant health policies, but because they tend to select different countries, concepts, categories and methods of measurement it is difficult to integrate and synthesise all these findings. The MIPEX Health strand set out to surmount this obstacle by collecting information on 38 carefully defined and standardised indicators in all MIPEX countries, as well as Bosnia-Herzegovina and Macedonia. The individual questions were combined into scales relating to the four issues listed above, as well as summary scales for 'Access' (Sections A and B), 'Quality' (C and D) and the total score. Where separate policies apply to migrant workers, asylum seekers and undocumented migrants, data are disaggregated for each group. Migration within the EU/EFTA region is not studied because special measures exist to harmonise access to health care within this region.

In keeping with the fact that policies in the health sector are influenced by multiple actors, a multilevel concept of policy is used. Development and piloting of the questionnaire were undertaken by the ADAPT network and the data were collected by independent experts working in each country. The methodological issues involved in transforming qualitative data into qualitative scales in this way are also discussed in Part I. Computer simulations showed that varying the assumptions used to make these transformations had little effect on the results obtained.

Part II describes the conceptual framework underlying the questionnaire and the way in which aspects of policy were operationalised and scored in the 38 indicators. This is followed in Part III by a detailed description of the pattern of results found in 34 European countries on each item in the questionnaire.

- Section A covered legal entitlements to health care coverage for migrants, also taking into account the administrative barriers which often make it difficult for migrants to actually obtain this coverage. A score of 100 on this section would represent complete parity with nationals. Migrant workers score 71 on this scale, asylum seekers 60 and undocumented migrants only 35. For migrant workers, requirements related to employment or length of stay often obliged them to take out private insurance or pay their own medical bills. Asylum seekers were seldom entitled to the complete basket of health care services, while coverage for undocumented migrants ranged from practically non-existent to almost the same as for nationals (subject to a means test).

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- Scores on Section B (Accessibility) also showed that countries differed greatly in the efforts that were made to inform migrants about their rights to health care and how to exercise them, as well as other measures to help them find their way into care. Often, health workers appeared to be as badly informed about entitlements as migrants themselves. For undocumented migrants, the threat – real or perceived – of being reported to the authorities was a significant barrier to access in a number of countries.
- Section C (Responsiveness) shows the widest variations between countries: 8 countries take no measures whatsoever to meet the special needs of migrants, while 6 have scores above 70.
- Section D showed that the data collection, research, planning, consultation and coordination which are needed to develop good policies existed in few countries.

Part III reports the results of statistical analyses of these data. First, the reliability, validity and structure of the scales is examined. Scores on all the individual questions are quite highly intercorrelated (Cronbach's alpha = .86), but factor analysis shows that the four sections to some extent measure different dimensions of policy – as indeed they are supposed to. Overall scores on Sections C and D (together measuring 'Quality') are strongly correlated (r = .67, p < .01), but Sections A and B ('Access') are only weakly related to them. In keeping with this, we see that countries like France and Iceland give very good access to migrants but make almost no adaptations, while the UK appears to have the opposite priorities. Despite these anomalies, the average score on all sections of the Health strand gives a reasonable indication of the overall 'migrant-friendliness' of a country's health system. Remarkably, Section A on Entitlements shows no correlation with Section D on Achieving change. Clearly, the 'change' which the latter refers to has much more to do what goes on *inside* health services than with migrants' ability to access them.

Finally, the relations between Health strand scores and background variables are examined. Here it is often difficult to disentangle the effects of different variables, because the latter tend to be strongly intercorrelated. Health strand scores are related to GDP, health expenditure, the percentage of migrants in a country, scores on the other strands of MIPEX, and the date of accession of countries to the EU (i.e. before or after 2000). Strikingly, the strongest predictor among these highly intercorrelated variables turned out to be the last one: the policy environment for migrant integration, especially regarding health, is much more negative in the 13 countries that joined the EU after 2000 than in the EU15. Further research is needed to shed light on this difference, which can be seen clearly in the scores on each section.

Two other interesting findings are that the type of health financing used in each country (tax-based or insurance-based) makes a difference to 'Quality' but not to 'Access'. It is widely assumed that tax-based systems are more inclusive, but this does not appear to be the case for migrants. On the other hand, such systems do seem better at introducing measures to adapt services to the needs of migrants. Again, further research is called for. Finally, the results show that the 'traditional countries of immigration' (Australia, Canada, New Zealand and the USA), which are often assumed to have better developed policies on migrant health than European countries, tend to have higher scores but also show the effects of recent political shifts. While the Affordable Care Act in the USA has improved access for migrants, governments in Canada and Australia have – as in some parts of Europe – rolled back earlier measures to make their health systems 'migrant-friendly'. These results are only the first of many which are expected to result from the availability of the comprehensive, standardised data in the MIPEX Health strand.

I. INTRODUCTION TO THE PROJECT

The MIPEX Health strand is an instrument for measuring the equitability of a country's policies relating to the health of migrants. Many studies of migrant health policy have been carried out in the last two decades, but research in this area is hampered by the fact that they have made different selections of countries, policy issues and categories of migrant. It has also not been possible to combine the results of studies using different categories, concepts and methods. As a result it has been difficult to make systematic comparisons and carry out quantitative analyses.

The instrument combines the methodology of MIPEX (the Migrant Integration Policy Index) with the normative framework adopted by the Council of Europe in its *Recommendations on Mobility, migration and access to health care* (CoE, 2011). Developing the questionnaire, as well as collecting and analysing the data from 34 countries and producing Country Reports based on this information, was the third component of the IOM's EQUI-HEALTH action (http://equi-health.eea.iom.int/).

The 2015 round of MIPEX covers the following 8 'strands' of integration policy:

Labour market mobility	Political Participation
Family reunion	Permanent Residence
Education	Access to Nationality
Health	Anti-discrimination

Each strand is measured by a questionnaire containing four 'dimensions', with 4-6 questions providing the indicators for each dimension. Each indicator classifies the country's policies on a given topic on a three-point scale. The three scores correspond to

  0   the worst case (no policies exist to further migrant integration)
 50   a specified intermediate level of policy development, and
100   the best case (policies give migrants the same rights as national citizens).

The method of scoring will be described in Section E below. The quantitative results have been uploaded to the MIPEX website (www.mipex.eu).

In addition, Country Reports are being produced for EQUI-HEALTH, which will be available online on the project's website. These are separate from the MIPEX project but make use of the same questionnaire data. They are written in narrative form and provide more detail as well as background information. The MIPEX scores are based on the situation at the beginning of 2015, but more recent information has also been included in some Country Reports.

A. The project partnership

The MIPEX Health Strand was created in the framework of a collaboration between three organisations:

- **International Organisation for Migration (Regional Office Brussels, Migrant Health Department)**

The project is part of the action EQUI-HEALTH, which started in February 2013. EQUI-HEALTH is co-financed under the 2012 work plan of the second programme of Community action in the field of health (2008-2013), by direct grant awarded to IOM from the European Commission's Directorate General for Health and Food Safety (DG SANTE) through the Consumers, Health, Agriculture and Food Executive Agency (Chafea).

- **Migrant Policy Group (MPG)**

The MPG is responsible for MIPEX, a longitudinal project which evaluates and compares what governments are doing to promote the integration of migrants in EU Member States and several non-EU countries[1]. The first version of MIPEX was published in 2004: subsequent rounds have been carried out in 2007, 2011 and 2015. During this period the number of countries studied and the range of indicators used has steadily increased. Together with its partner CIDOB (the Barcelona Centre for International Affairs), MPG carried out the 2015 round of MIPEX with co-financing from the EIF (European Fund for the Integration of Third-Country Nationals) in the project *Integration policies: Who benefits? The development and use of indicators in integration debates*. This project ran from December 2013 to June 2015.

- **COST Action IS1103 'ADAPT'**

ADAPT *(Adapting European Health Systems to Diversity)*[2] is an interdisciplinary scientific network involving 130 experts in 30 countries, financed by the European Commission through the COST Association[3] and running from December 2011 to July 2016. It extends and builds on the work of COST Action HOME *(Health and Social Care for Migrants and Ethnic Minorities in Europe).*[4] While HOME (2007-2011) focussed on inequities in health and health care for migrants, identifying both the problems and the proposed solutions, ADAPT is concerned with implementing this knowledge through policy measures. The cornerstone of the work plan is the mapping of policies on migrant health through the joint work with IOM and MPG, which started in May 2013. Using the results, recommendations for improving policies are being formulated and the 'levers for change' identified.

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[1] See http://www.mipex.eu/history
[2] http://www.cost.eu/COST_Actions/isch/IS1103
[3] http://www.cost.eu/
[4] http://www.cost.eu/COST_Actions/isch/IS0603

B. Aims and background

Studies of policies relating to migrant health have been carried out since the 1990's (for example Bollini 1992; Bollini & Siem 1995; Huismann et al. 1997; Carballo et al. 1998; Vulpiani et al. 2000; Watters 2002; Ingleby et al. 2005; Mladovsky 2007, 2009; Huber et al. 2008; Rechel et al. 2011). In addition, a number of reports on policies for separate categories such as irregular migrants[5] or asylum seekers have been published. Landmark studies of this kind were the article by Romero-Ortuño (2004) and the 2007 PICUM report on IMs, as well as the study by Norredam et al. (2005) on asylum seekers. These have subsequently been compemented by many others.

Bollini's 1992 study showed that out of seven advanced industrial countries, only three (Canada, the UK and Sweden) had taken steps to promote equity of access and quality for migrants in their health services. The rest maintained a 'passive' attitude, expecting migrants to adapt themselves to the demands of the services. Almost a quarter of a century later we can say on the basis of the MIPEX results that attention to health equity for migrants has become more widespread, but many countries remain passive in their approach. There are even countries (such as the UK, the Netherlands, Spain and Portugal) where policies to promote equity have been withdrawn, under the influence of austerity policies or political opposition to migration and multiculturalism.

A major drawback of previous studies is that they make different selections of countries, policy issues and categories of migrant. In addition, the separate indicators are not combined into dimensions or scales, making it hard to get an overview of tendencies in different countries. The MIPEX Health strand sets out to overcome these limitations by collecting comparable data on migrant health policies in 40 countries, using a standard list of 38 indicators. Not only can countries be compared with each other, but the results on Health can also be compared with those from other MIPEX strands. Moreover, since the MIPEX measurements are repeated every 4 years, it will later be possible to study changes over time.

C. Countries and migrant groups studied

Countries
There are slight differences in the sample of countries used in the main MIPEX study and EQUI-HEALTH. For the latter project, data were collected and Country Reports written for the EU28, the 3 EFTA countries Norway, Switzerland and Iceland, and Bosnia-Herzegovina, FYR Macedonia and Turkey. In addition to these 34 countries, questionnaire data alone were collected for the MIPEX website on 4 'traditional countries of immigration' (Australia, Canada, New Zealand and the USA). The scores of these 4 countries are mentioned in this report from time to time for purposes of comparison, but the statistical analyses have been carried out using only the 33 European countries and Turkey.

Because the main MIPEX study did not include Macedonia and Bosnia-Herzegovina, data on other strands of MIPEX are not available for those countries. Two additional OECD countries in the main MIPEX study (Japan and South Korea) are not mentioned in this report because the policy context in these countries differed too widely from the main sample.

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[5] In MIPEX the term 'undocumented migrant' is used. The term currently preferred by most organisations is 'irregular migrant', standing for 'migrant in an irregular situation' (abbreviation: IM). For the sake of consistency with other MIPEX publications the older term will be used in this report (abbreviation: UDM).

Countries studied

MIPEX	EQUI-HEALTH
EU28, Norway, Iceland, Switzerland	EU28, Norway, Iceland, Switzerland (with Country Reports),
Australia, Canada, New Zealand, USA	Australia, Canada, New Zealand, USA
	Bosnia-Herzegovina, FYR Macedonia
Japan, South Korea	

Migrant groups

The Health strand defines the target groups for policies in the same way as the rest of the MIPEX study. In EU/EFTA countries the focus is on migrants who are 'third-country nationals' (TCNs), i.e. not citizens of another EU/EFTA country. This is because in the latter countries, health policies grant virtually the same entitlements to migrants from other EU/EFTA countries as to national citizens, as a result of the EU's 'Cross-border Directive' of 2011 and bilateral agreements with EFTA countries.[6] By contrast, the entitlements of TCNs vary greatly from country to country. (In non-EU/EFTA countries the concept of 'third-country national' is of course inapplicable.)

Some countries have reciprocal agreements with other countries, exempting migrants from those countries from restrictions on health coverage normally applying to migrants. These agreements are usually based on historical, political or economic ties and vary greatly from country to country. They have not been systematically listed in this project, but their existence should always be borne in mind. The neighbouring countries outside the EU/EFTA studied here (MK, BH and TR) have each signed such agreements with about half of all EU/EFTA countries.

The basic definition of 'migrant' adopted in this report is that used by the UN, World Bank, OECD and EU, i.e. "a person who changes his or her country of usual residence" (UN, 1998). The minimum length of time a person must have resided in a country in order to be regarded as a resident rather than a visitor (i.e. the lower boundary) varies according to national legislation: generally, it is three months. According to United Nations terminology (UN, op.cit.), migrants staying for less than a year are classified as 'short-term' and those staying (or having permission to stay) for a longer period are 'long-term'. Since the implementation in 2008 of new EU regulations on the reporting of statistics,[7] short-term migrants have been excluded from Eurostat data on migration. As a result, an important type of intra-EU mobility – seasonal or brief migration – is not visible in EU statistics. Nevertheless, short-term migrants still count as 'migrants' in national policies.

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[6] Directive 2011/24/EU on patients' rights in cross-border healthcare.
http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:EN:PDF
[7] http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2007:199:0023:0029:EN:PDF

Regarding the upper boundary (the period after which migrants cease to be regarded as such) no limits are adopted in Eurostat and UN data on 'migrant stock': migrant status is determined on the basis of 'country of birth' or 'country of origin'. Even after a migrant has acquired citizenship of the receiving country, they are still classified as a migrant. However, entitlements to health care coverage are usually based not on country of birth or origin but on nationality. Migrants who become naturalised will acquire the same entitlements as other nationals.

Unlike policies determining entitlements to health care, policies designed to adapt health services to the special needs of migrants may continue to be relevant to migrants after naturalisation; these needs are more likely to depend on country of birth than nationality. Naturalisation in itself will make little difference to problems such as linguistic or cultural barriers, social disadvantage and discrimination, so naturalised migrants may have as much need for health services which are adapted to their needs as those who remain foreign citizens. Some researchers on health also argue that newcomers and recent migrants should form a separate target group, but such a distinction is not often made in policies or research, except in relation to information or consultations for newly arrived migrants.

Policies that affect migrants are not always targeted at migrants as such. Firstly, the target group may be defined as 'migrants and ethnic minorities', or even just 'ethnic minorities'. This mainly applies to measures to adapt health services to accommodate varying needs, rather than entitlement to use the services. Policies adapting services to differences between ethnic groups may at the same time improve the matching of services to the needs of migrants, so they are also considered in this survey. (This is particularly important in the UK, where most such policies are targeted at 'minority ethnic groups' rather than migrants.) However, a drawback of policies formulated in such terms is that they often overlook important issues that are specific to migrants, such as their different legal situation and their initial unfamiliarity with the receiving country's health system.

The term 'ethnic minorities' is often used to refer both to migrants and their descendants (particularly the so-called 'second generation'). This double focus can be very useful, since many problems affecting the first generation (e.g. linguistic or cultural barriers, social disadvantage and discrimination) may also affect later ones. How useful this focus is, depends on the context: when policies exist to improve access and quality of health care for *indigenous* minorities such as the Roma, it is possible that they will encourage sensitivity to other forms of diversity. However, if the provisions for Roma are specially labelled as such (e.g. 'Roma health mediators'), migrants may not benefit from them.

Secondly, some policies affecting service provision do not refer either to 'migrants' or 'ethnic minorities' but to 'diversity' in general, including differences in socioeconomic position, education, language, gender, religion, age etc. Indeed, there is a tendency in many countries to promote health system responsiveness to a whole range of differences, often under the label of 'patient-centred care' or 'intersectionality'.[8] Such measures can benefit migrants and ethnic minorities, but only if they encourage attention to the specific problems of these groups. A

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[8] The 2013 revision of the 2001 CLAS Standards (*National Standards for Culturally and Linguistically Appropriate Services in Health Care)* urged attention to "socio-economic status, race, ethnicity, disability status, sexual orientation, gender identity and other factors", while nevertheless continuing to emphasise 'culture' as the main driver of disparities. See https://www.thinkculturalhealth.hhs.gov

general exhortation to take account of differences between individuals, families and their social situation is usually not specific enough to tackle inequities affecting migrants.

Policies relating to three groups of migrants are studied. Here too, this report uses MIPEX terminology:

a. Legal migrants

This category refers to legally residing migrants. To reduce the complexity of the data, this study focuses on the rules that apply to *migrant workers.* These may differ from those for family members, students, pensioners and beneficiaries of the various types of international protection (refugee status, subsidiary protection, a humanitarian permit or 'tolerated residence'). No account is taken of the different rules that may apply to migrants in the latter categories. Asylum seekers, who are also legally present in a country, are studied as a separate category (see below).

Some legal migrants may have been 'regularised' after a period of illegal residence. However, this is not a permanent status: in some countries (e.g. Spain), they can be 'deregularised' again if they lose their jobs.

Legislation concerning 'legal migrants' is mainly based on foreign nationality and therefore does not apply to foreign-born persons who have acquired national citizenship through naturalisation. Acquiring citizenship confers on such migrants the same rights as nationals.

b. Asylum seekers

An asylum seeker is a person who has applied for international protection and has not yet received a final decision on their claim. Persons still involved in appeal procedures but denied permission to await the outcome in the receiving country count as 'undocumented migrants'.
In some countries, entitlements and health services for asylum seekers differ according to where they live. Provisions for those living in state-run reception centres may be different than for asylum seekers living in the community. In such cases, scores are based on the provisions that apply to *most* asylum seekers. The same applies when health service entitlements differ according to the length of time an asylum seeker has been in the country, as in Germany.

c. Undocumented migrants (UDMs)

This refers to migrants who lack authorisation to reside in the country where they are living. Unauthorised residence can result either from unauthorised entry, or (more frequently) from infringement of the conditions on which residence was authorised (e.g. overstaying a visitor's visa or violating conditions regarding work). The term has the same meaning as 'migrant in an irregular situation' (often abbreviated to 'irregular migrant'). It is used here because it is standard terminology in MIPEX. As with asylum seekers, there may be differences in the provisions for UDMs living independently and in the care of the state (which usually means in detention). In this report, conditions in detention will be described separately: the MIPEX scores apply to UDMs not in detention.

D. Policy issues studied

Sometimes equity can be achieved by simply having the same policies for both groups, but 'equality' does not always mean 'equity'. The following illustration sums up the difference:[9]

An instrument such as the MIPEX, which investigates the degree to which policies promote equity between migrants and native citizens, must obviously be based on some assumptions about the policies that are important and desirable to this end.

Equity in *legal entitlements to care* can be achieved simply by making no distinction between migrants and native citizens. In other cases, however, achieving equity requires creating differences, as the right-hand picture shows above: then, 'one size fits all' is not an equitable policy[10].

What are the most important policy changes required to make service delivery equitable? This issue has been intensively debated during the last 3-4 decades. The question cannot be decided purely on the basis of which policies give better clinical outcomes: priorities for change cannot be established purely on an empirical basis. If a policy is based on normative principles, it does not need to be backed up by evidence of better clinical outcomes. For example, the principle that no group should suffer unfair disadvantage in terms of reduced access to health services, inferior service quality, or other forms of discrimination, does not need any empirical justification, even though improved outcomes would provide an additional argument. The principle of non-discrimination does not have to be defended on pragmatic grounds. At a more detailed level, however, there is room for disagreement about the particular measures likely to have the most impact on reducing inequities (for example, the way language barriers should be tackled). Unfortunately, research on the relationship between

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[9] Source: http://on.fb.me/1nsh5mG
[10] These were the topics of the COST Action HOME referred to above, described in the Action's published books (Ingleby et al. 2011a, 2011b).

policies and outcomes is expensive and fraught with difficulties, and there are relatively few findings in the area of migrant health.

Another issue concerns the level at which policies should be changed. Since the 1980s the emphasis has shifted in the direction of a more multi-level approaches. Initially, the remedy for inequities was thought to lie in the acquisition of 'cultural competence' by individual health workers. However, by the end of the 1990's in the USA a 'whole organisation approach' came to prevail: individual competence was still regarded as necessary, but it had to be promoted and backed up by organisational policies. Progress would be made by implementing 'good practices' in service provider organisations. Later still came the realisation that not all problems can be solved at the level of provider organisations. Entitlements to health services are usually not determined by these organisations but at the national, state or regional level, while 'flanking measures' such as data collection, research or consultation between stakeholders and policymakers are also essential and have to be organised at higher levels. A 'public health' approach is necessary, which by definition involves more than the sum of individual organisational initiatives. This shift was signalled in a phrase used at the Portuguese EU Presidency conference on migrant health in 2007: "Good practices are not enough".[11]

This means that not only service providers, but the health system itself must respond to diversity: moreover, some issues even fall outside the remit of health ministries. Following the principle of 'health in all policies', some of the increased health risks to which migrants are exposed can only be tackled from other sectors, such as industrial safety or immigration policy.

Several relevant sets of recommendations or standards have been published in recent years. A study carried out by members of ADAPT (Seeleman et al. 2015) compared six widely known approaches to 'responsiveness to diversity' in Europe, the USA and Australia. The authors concluded that "despite differences in labelling, there is a broad consensus about what health care organizations need to do in order to be responsive to patient diversity". Most of the recommendations studied were aimed at service provider organisations:

- *The CLAS Standards - National Standards for Culturally and Linguistically Appropriate Services in Health Care* (U.S. Government's Office of Minority Health, 2001)
- *Cultural Responsiveness Framework. Guidelines for Victorian health services* (Victorian Government, Department of Health, Australia, 2009)
- *JCR Roadmap for Hospitals* (US Joint Commission, 2010)
- *Standards for Equity in Health Care for Migrants and other Vulnerable Groups* (WHO-HPH Task Force on Migrant-Friendly and Culturally Competent Healthcare, 2013).

Two approaches, however, consider the whole health system:

- *Recommendation of the Council of Ministers to member states on Mobility, migration and access to health care* (Council of Europe, 2011)
- *Equality Delivery System for the NHS* (UK Department of Health, 2012).

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[11] Padilla et al. (2009), p. 107

Approaches at health system (rather than organisational) level are more relevant to MIPEX because they also consider national legislation on entitlements to care, as well as the 'flanking measures' mentioned above.

A Delphi study based on the opinions of 134 experts in 16 countries was carried out within the EC-supported project EUGATE (Deville et al. 2011),[12] concerning "principles of good practice in health care for immigrants in Europe". Experts were chosen from academia, the non-governmental sector, policy-making and health care practice, on the basis of their experience and expertise concerning health care for migrants. The findings were broadly consistent with the approaches listed above, but in this study a considerable amount of disagreement was also noted, both within and between countries. This is hardly surprising considering that views were sought at an individual level.

Basis of the MIPEX Health Strand in the Council of Europe Recommendations

By a fortunate coincidence, the Council of Europe's *Recommendations on Mobility, migration and access to health care* (2011) were published shortly before the present project began. The background to this document was a series of initiatives at European level, including:

- CoE recommendations on *Health services in a multicultural society* (2006)[13]
- The Bratislava Declaration on *Health, Human Rights and Migration* (2007)[14]
- Outcomes of the Portuguese Presidency conference on *Health and migration in the European Union – Better health for all in an inclusive society* (2007)[15]
- Resolution WHA61.17 of the World Health Assembly (2008) on *Health of migrants*[16]
- Spanish Presidency document *Moving forward equity in health* (2010)[17]
- European Commission Communication *Solidarity in health: Reducing health inequalities in the European Union* (2009)[18]

The recommendations were drawn up by a Committee of Experts made up of 12 independent specialists. In the course of a two-year consultation process, many different sources were consulted by this committee, including scientific authorities as well as representatives of the International Organisation for Migration (IOM), World Health Organisation (WHO), Office of the High Commissioner for Human Rights (OHCHR), the Platform for International Cooperation on Undocumented Migrants (PICUM) Doctors of the World (MdM), etc.

The document that was drawn up on the basis of these consultations contains 14 recommendations, which are explained in 23 guidelines, divided into 6 categories:

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[12] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3182934/
[13] http://bit.ly/1KxPBk9
[14] http://www.coe.int/t/dg3/health%5CSource%5Cdeclaration_en.pdf
[15] http://www.episouth.org/doc/r_documents/Challenges_for_Health_in_the_age_of_Migration.pdf
[16] http://apps.who.int/gb/ebwha/pdf_files/WHA61-REC1/A61_Rec1-part2-en.pdf
[17] http://bit.ly/1o0ZqQJ
[18] http://ec.europa.eu/health/social_determinants/policy/commission_communication/index_en.htm

1. Improving knowledge about migrants and their situation
2. Migrants' state of health
3. Entitlement to health service provision
4. Accessibility of the health system
5. Quality of health services
6. General measures to promote change

These topics are incorporated in the MIPEX Health Strand, but since a MIPEX strand only has four dimensions, categories 1 and 2 have been incorporated in category 6. This results in the following dimensions:

1. Entitlement to health services
2. Policies to facilitate access
3. Responsive health services
4. Measures to achieve change

Each dimension contains six questions, which may have more than one indicator.

Concept of 'policy' underlying the Health strand

Multilevel concept of policy

Within the Health strand policies are regarded as *regulated practices*, i.e. practices that follow rules. To qualify as 'policy' these rules must be explicitly stated.[19] Especially in the health sector it is important to adopt a *multilevel* concept of policy, in recognition of the fact that policies in the health system are made at many levels and by many actors. In fact, the concept of 'levels' may be misleading: actors cannot always be arranged in a hierarchy.

Since 2000, WHO has adhered to the following definition of health systems (WHO, 2000): "all the activities whose primary purpose is to promote, restore or maintain health". Although the WHO regards governments as ultimately responsible for a country's health system, tasks and policy-making may be shared out among a wide range of organisations. As well as national governments these may include regional and municipal authorities, service provider organisations, professional organisations, educational institutions, health insurers, accreditation agencies, CSOs, private enterprise and advocacy groups (such as migrant or human-rights organisations). Over and above the whole system, international organisations such as the UN, WHO, IOM, EC or CoE exert influence using instruments ranging from 'hard' (treaties and other laws) to 'soft' (recommendations, technical advice).

An important concept in relation to health systems is 'subsidiarity'. EC treaties make clear that "the organization and delivery of health care services is the responsibility of the Member States and not of the EU" (McKee et al. 2010:232). 'Soft' measures such as the 'open method of coordination' (European Council, 2000) are required to enable the EU to exert any meaningful degree of influence over policies concerning health care. Most other international

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[19] Ideally rules should be written down, but instructions given verbally (e.g. by management to staff) can also be regarded as 'explicit' rules.

bodies listed also have to confine themselves to issuing recommendations and giving technical advice. In spite of this, the influence of such bodies can be considerable.

With so many levels and actors involved, it is very unlikely that policies within a health system will make up a completely harmonious whole. To achieve this would require a degree of 'top-down' control that suggests an almost totalitarian style of governance. Health systems vary greatly in the amount of control that national governments attempt to exert. Control tends to be tighter in tax-based National Health Systems than in 'Bismarckian' social health insurance based systems, though the connection between financing mechanisms and governance is not as rigid as is often assumed (Kutzin, 2011). Moreover, responsibilities may be devolved or decentralised when a country has a federal structure or strong regional autonomy. For all these reasons, policies at different levels often come into conflict with each other.

This is one reason why simply listing the policies that have been laid down by government may not give an accurate impression of what happens 'on the shop floor'. The degree to which government policies are actually implemented is not captured. However, 'implementation gaps' seldom arise at random. When a government policy is implemented poorly or not at all, this is often because it conflicts with other policies, rather than because of weak legislation, arbitrary negligence, or disobedience. For example, policies requiring the highest standards of care may conflict with other policies requiring cost reduction.

The advantage of applying a many-layered notion of 'policy' is that it brings our descriptions closer to the realities that confront migrants. While governments may have national plans (or even laws) that state how migrants should be dealt with, regions and individual service providers may have their own policies that oppose these laws (either in a 'migrant-friendly' or 'migrant-unfriendly' direction). The MIPEX Health strand tries to capture the policies that are laid down by whatever actor or actors exert effective control. In medical education this may be the universities, in service provision the provider organisations, in clinical practice a professional body, and so on.

Where regional authorities have an important say in policy making, the standard MIPEX procedure is followed: two regions in the country that have a high percentage of migrants are studied and the description of the country is based on aggregated results from these two areas. This method carries the risk of a bias towards higher scores for such countries, though legal entitlements are usually the same in all regions. However, such a bias is at least partially counteracted by the method used for collecting data on health service delivery.

Legal entitlements and the administrative procedures required to make use of them are more likely to be uniform across a country than policies to make service delivery responsive to the needs of migrants. Such policies are often left to 'the field', i.e. to professional bodies, educators, insurance companies, accreditation agencies and service providers themselves. This can result in wide variations in the 'migrant-friendliness' of the services offered. The degree of adaptation across the whole country therefore has to be based on a estimate of the *proportion* of service providers that adopt 'migrant-friendly' policies. It is logical that more attention will be paid to the needs of migrants in areas where they form a larger proportion of the population, so in this project more attention has been paid to those areas.

But how 'friendly' must these policies be? It is easy to define 'no adaptation', but how should we define the 'maximum' and 'intermediate' levels of an indicator? To this question a pragmatic answer has been adopted. For the MIPEX Health strand to be useful it must enable us to distinguish different stages of progress in a country. The highest stage does not correspond to complete adaptation – simply that the need for adaptation is accepted and efforts to realise it are well under way. To achieve an intermediate score, it is only necessary that the adaptations made are capable of significantly influencing care for migrants. In this respect, the efforts made in 'migrant-rich' areas or service providers are given the most weight. In this way, the bias produced by the procedure followed in countries with strong regional differences is to some extent counteracted. On the next page a map is reproduced from Eurostat showing the density of foreign citizens in different regions within Europe.

Which aspects of policy could not be included?

It is important to note that some relevant issues are not captured by the MIPEX Health strand questionnaire. For example, question 10 concerned policies to reduce practical barriers to access for migrants, such as inconvenient hours of service or problems of transport. This question had to be removed because of low item-total correlations. One problem was that a lack of policies might simply mean that there were few such barriers to be removed. Another problem was the difficulty of distinguishing practical barriers that may be experienced by *all* users from those that particularly affect migrants.

Another barrier that was impossible to measure was direct, individual discrimination against migrants – for example, hostile or disrespectful behaviour, or unjustifiable denial of treatment to which the migrant was entitled. The questionnaire measures policies, and such behaviour is unlikely to be mandated by an explicit policy (even though it might be a part of 'organisational culture'). However, reports of such discrimination were recorded as comments in the questionnaire and in the Country Reports.

The third issue which could not be measured was the extent of out-of-pocket payments (co-payments). This problem is discussed in Section II A.

The role of NGOs

The questionnaire concerns the 'mainstream' health system in a country. If deficiencies are compensated for by NGOs or other CSOs this is not taken into account in the scoring, except when the activities in question can be regarded as integrated in the mainstream. This will be the case if a health authority decides to outsource certain activities to NGOs which are specially well equipped to carry them out. However. for these activities to count as 'policy', the government has to cover all or most of the cost.

The role of the IOM is different from that of NGOs because it is an IGO (intergovernmental organisation). Although autonomous, it is financed by government contributions. Activities carried out in a given country by the IOM are therefore regarded as part of health system policies, provided they are carried out in collaboration with the relevant authorities.

Foreign citizens, by NUTS level 3 region, 2011 (¹)

(% of the population)

Guadeloupe (FR)   Martinique (FR)
0   25   0   20

Guyane (FR)   Réunion (FR)
0   100   0   20

Açores (PT)   Madeira (PT)
0   50   0   20

Canarias (ES)   Malta
0   100   0   10

Liechtenstein
0   5
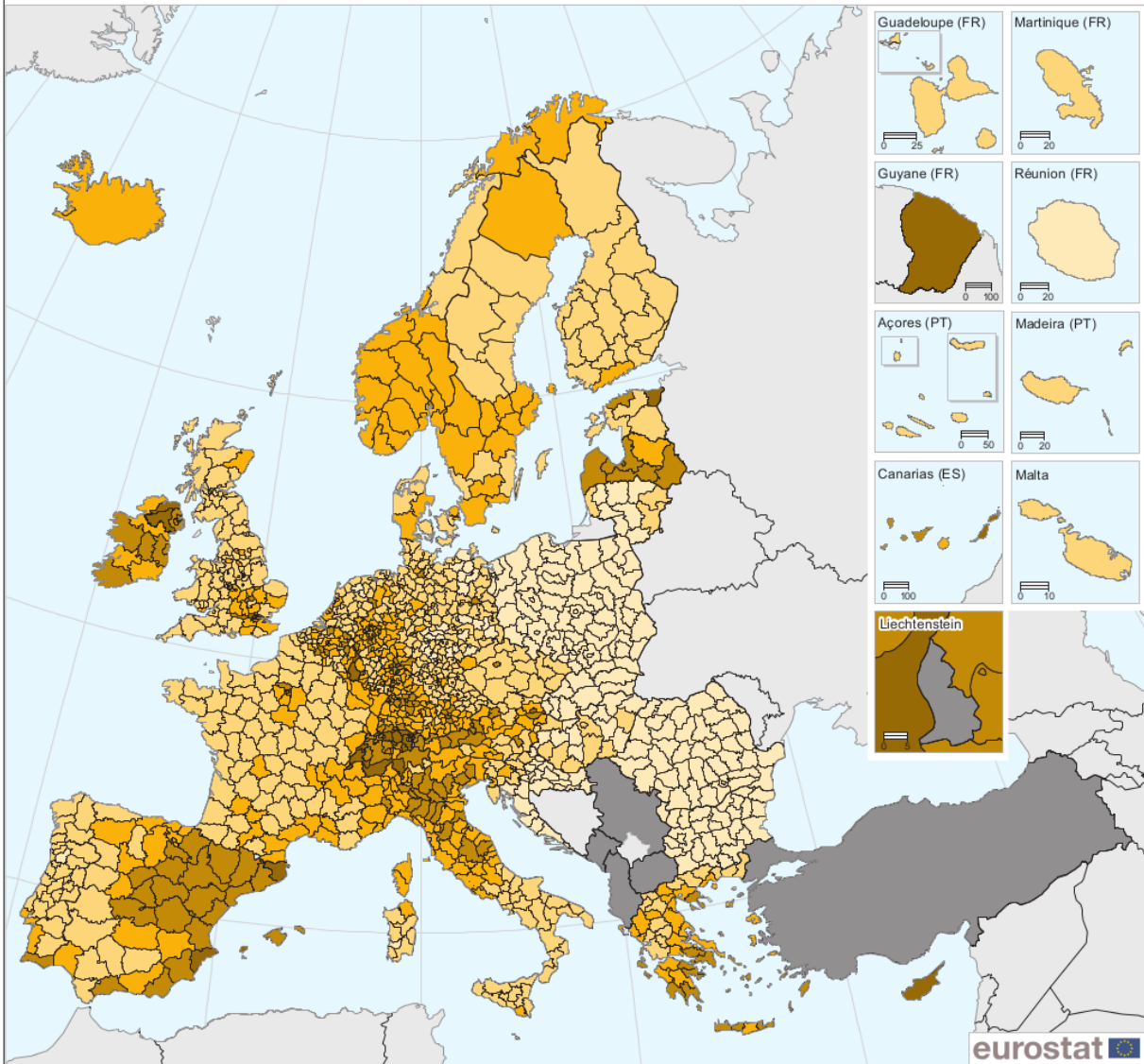
eurostat

(% of the population)

EU-28 = 6.3

- ☐ < 1
- ☐ 1 – < 5
- ☐ 5 – < 10
- ☐ 10 – < 20
- ☐ >= 20
- ☐ Data not available

Administrative boundaries: © EuroGeographics © UN-FAO © Turkstat

Cartography: Eurostat – GISCO, 04/2015

0   200   400   600   800 km
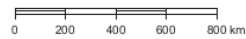
(¹) Oswiecimski (PL216), Tarnowski (PL217), Bytomski (PL228), Tyski (PL22C), Krosnienski (PL323), Sandomiersko-jedrzejowski (PL332), Suwalski (PL345), Pilski (PL411), Koninski (PL414), Leszczynski (PL417), Stargardzki (PL423), Grudziadzki (PL614), Wloclawski (PL615), Elblaski (PL621), Elcki (PL623), Starogardzki(PL635): low reliability.

Source: Census hub (https://ec.europa.eu/CensusHub2)

E. The questionnaire

The construction of the questionnaire was carried out in Work Package 1 of COST Action IS1103 'ADAPT', in close collaboration with IOM and MPG. Seven international meetings were devoted to this process, each with about 25 participants. The reason why such an intensive investment of time was necessary is that MIPEX is a longitudinal project, with measurements repeated every four years. Making improvements to the questionnaire after the current round would not be permissible, because it would undermine the comparability of the measurements. The questionnaire therefore had to be 'right first time', and every weakness that was discovered had to be remedied.

The first task was to decide on the methodology and draw up a list of indicators based on the CoE Recommendations. Some indicators were combined into a single question averaging them. Following this, several rounds of piloting and 'fine tuning' were carried out in selected countries. After each round, the questions were adjusted in the light of difficulties reported and results found.

Even after the final round of data collection, improvements were made to the method of scoring and structuring the information collected. For example, when a highly skewed distribution of scores was found (i.e. with nearly all countries scoring in one or two categories), category boundaries were redefined to yield a more even distribution. The scoring of Section A (Entitlements) was organised so that three separate scores could be extracted for legal migrants, asylum seekers and UDMs. Finally, the item-total correlation for each question was calculated, and one weak item (a question which was clearly being interpreted in different ways) was removed.

An important point is that scores are relative: they measure the gap between provisions for migrants and for national citizens, not the absolute levels of quality. In the 34 countries studied there are very wide differences in the overall quality of health services provided. These reflect the extreme differences in wealth among European countries. GDP per capita (adjusted for the cost of living) ranges from 28 in Bosnia-Herzegovina to 263 in Luxembourg (a ratio of 1 to 9), while annual spending on health per capita ranges from €644 in Macedonia to €4,392 in Switzerland (1 to 7). Provisions for migrants in some countries may be very inadequate, but if those for national citizens are equally inadequate, then 'equity' between the two groups will have been achieved.

Because we are not measuring the absolute level of health services for migrants, but only their relation to those available to nationals, we tend to ignore in this survey the overall quality of health service provisions in each country (although it is reported as a background variable). The UN's well-known 'AAAQ framework'[20] states that "all [health] services, goods and facilities must be **available, accessible, acceptable** and **of good quality**." The MIPEX Health strand, however, does not measure availability: it is assumed that all services that exist are equally available in principle for migrants and nationals, as long as they have access to them. This may not be the case when services for a particular migrant group are delivered using a different system (for example, in asylum-seeker centres or in detention). Such exceptions have been noted in the Country Reports, but are not registered by the MIPEX scores.

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[20] UNHCR, WHO (2008) *Factsheet on The Right to Health.* Geneva: UNHCR and WHO.

Administration of the questionnaire

In each country one or more researchers were appointed with responsibility for completing the questionnaire, as well as one or more peer reviewers who carefully reviewed the results obtained. All were chosen for their expertise on the topic of migrant health policy. In total, 103 researchers were involved; of the 82 working in Europe, 48 were members of COST Action IS1103 'ADAPT'. A list of their names is given in Appendix 1. In accordance with MIPEX rules, all researchers were independent: none were employed by governments or other policymaking authorities.

Researchers used a variety of methods to gather the required data. Some used a network of informants to provide information, especially concerning policies in service provider organisations. Other information was obtained from publications (scientific or 'grey' literature), published legislation and regulations, as well as other official information on internet. Key figures and informants were contacted and some interviews were held. All results were checked by a peer reviewer from the same country.

Submitted questionnaires were checked by the coordinator of the project to make sure the scores given were adequately justified and that standard criteria were used. Staff of MIPEX carried out a further check to ensure that rules of scoring were carefully followed.

Scoring of the questionnaire

The issue of weighting

MIPEX combines qualitative information to make quantitative scales. As we saw earlier, answers to the questionnaire items are scored on a three-point scale. Average scores are calculated for each of the four sections (A-D) separately; the overall Health strand score is the average of these four scores. Respondents are required to provide detailed information on each question in an extra column, to explain the score they have given,. This is the standard method used all strands of the MIPEX.

However, from the point of view of measurement theory, two potential weaknesses are inherent in this method of constructing scales. Firstly, for each indicator it could be argued that the mid-point should not be scored 50, but a higher or lower number. For example, on the indicator 'conditions for entitlement' scores are 'unconditional entitlement' = 100, 'conditional entitlement' = 50, and 'total exclusion' = 0. If it is very difficult for migrants to meet the condition being applied, we might want to score the middle category, 'conditional entitlement', as (say) 10 rather than 50.

Theoretically, the correct weight for this category is the percentage of migrants that satisfy the condition. However, this percentage can never be known in advance, because it depends on the composition of a particular migrant group in a particular country at a particular time. For example, there will be variations in time and between countries in the percentage of legal migrants who satisfy the condition of being employed. It is therefore not possible to know in advance what value should be assigned to the category 'conditional entitlement'. MIPEX calls it 50, on the assumption that in the long run, overestimations and underestimations will tend to cancel each other out.

Secondly, in the total score for Section A we average together the entitlement scores for legal (i.e. labour) migrants, asylum seekers and undocumented migrants, despite the fact that the first group is usually more numerous than the other two. This can be justified by arguing that legal migrants are better able to look after themselves, so that the other two groups are more vulnerable to bad policies. A similar problem arises over the weighting of the individual questions in each section; furthermore, the topics addressed by the four sections (Entitlement, Accessibility, Responsiveness and Measures to Achieve Change) may not all be equally important components of equity. In all these cases, there is again no way to accurately weight the scores in advance, because the relative importance of an indicator will depend on the migrant population in the country being studied. For example, if most of the migrants in a country speak the local language, reduction of language barriers will not be very important for improving service delivery for migrants.

As remarked earlier, such reservations apply to all MIPEX strands, not just Health. Despite this, the reliability and validity of MIPEX as a measuring instrument has been shown to be satisfactory (Ruedin, 2011; Ruedin et al., 2015). It is also possible to relate policies as measured by MIPEX to the outcomes they are intended to produce (Bilgili et al., 2015). The next section describes tests have been carried out to discover how stable the results from the Health strand are when different scoring and weighting systems are used.

Ordinal and interval scales

Technically, what MIPEX methodology does is to treat an ordinal scale as if it had interval properties. The benefits and risks of doing this have long been a subject of controversy in psychology and the social sciences, two disciplines in which ordinal scales are widely used. Knapp (1990) provides a succinct discussion of the conflict between 'conservatives' (who believe it should never be done) and 'liberals' (who regard it as acceptable under certain conditions). Good predictive value is often found for indicators which treat ordinal scales as if they have interval properties: this is why they are so often used.

Purely on mathematical grounds, it can be deduced that there are two conditions which reduce the risk that systematic errors (i.e. biased results) will be produced by adding up scores on a 3-point ordinal scale.

a) The larger the number of indicators, the better the chance that variations from the hypothetical 'true' values approximated by the score of 50 will tend to even out. The Health strand has 38 indicators, a reasonably large number for these purposes.

b) Concerning the weighting of different items in a section, or of different sections in the total score, the risk that assigning equal weights will create bias will depend on the statistical homogeneity of the scale in question. To illustrate this we can consider a topic in which different weightings make a lot of difference, such as the quality of health care or university education. Over the years a number of scales have been developed which claim to show which health care system or university offers the 'best' quality. However, the rankings they yield depend to a large extent on the weight they attach to different dimensions of quality. For example, is health care for children regarded as more important than care for the elderly? Is it more important for a university to teach students to be creative or to reason logically? The different rating scales available reflect different assumptions about such questions.

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The important issue here is the degree to which different components of a scale are correlated with each other. Consider the limiting case of a scale with 100% homogeneity: in such a case, it would not matter how the items are weighted, because each item is a perfect predictor of every other item. The lower the degree of homogeneity, the more the overall ranking will depend on the weighting chosen. The homogeneity of the MIPEX health strand is fairly high (Cronbach's alpha = .86), although it varies within different sections. (Section IV.A explores issues of reliability, validity and structure in more detail.)

To examine the robustness of the MIPEX Health strand, i.e. the degree to which results depend on the scoring system and the weights chosen, three types of computer simulation have been carried out.

a) Firstly, the score of 50 for the middle category has been replaced in turn by 20 and 80. We have then examined how this affects the ranking of countries on the total Health strand score. (Ranks are reduced to a 5-point scale with 6-7 countries in each interval, as on the map at the beginning of this report). Increasing the score for the middle category from 50 to 80 makes no difference to the rankings; decreasing it to 20 changes the rankings of 9 out of 34 countries, but never by more than one point.
     We then examine the correlation between key background variables and the total Health strand scores. With the midpoint scored at 20, 50 and 80, the correlation (r) with GDP becomes .53, .52 and .51 respectively; the correlation with the number of third-country migrants in the country becomes .50, .49 and .47. If this pattern were repeated it would suggest that a score of 20 would lead to marginally better predictions than a score of 50, but the differences are so minute as to be negligible.

b) Next, we have examined the effects on the rank ordering of countries of weighting the four different sections of the Health strand differently. At present the weights are equal: we have calculated the total score when the weight of sections A, B, C and D is doubled in turn, and finally for A + B (Access) and C + D (Quality). When the rankings are reduced to a five-point scale as described above, some countries change their position but never by more than one point. Doubling the weight for section A and for Access makes most difference to the final rank: in both conditions, 10 countries change position.

These simulations show that although MIPEX methodology depends on a number of untested assumptions, scores are not drastically affected when these assumptions are replaced by different ones. A more accurate approach to measuring the 'migrant-friendliness' of integration policies will have to await the production of data about the effects of these policies in real life. Even then, some fairly arbitrary assumptions will have to be made about the relative importance of different effects. This is only to say that measuring integration policies, like much else in social science, is not an exact science and never could be.

In the end, the decision to use instruments like MIPEX is based on pragmatic considerations. If no attempt is made to construct scales, the study of migrant integration will forever remain the study of dozens of different indicators, with little possibility of making general statements about them. Constructing scales makes much more powerful analyses possible, though it is always open to biases which might produce misleading results. However, if scale construction is ruled out *a priori,* there will be no possibility of systematically comparing countries, categories of migrant, dimensions of integration, and policies at different times.

II. CONTENT OF THE MIPEX HEALTH STRAND QUESTIONNAIRE

A. Entitlement to health services

What is meant by 'entitlement'?

Following the CoE Recommendations, the Health Strand makes a clear-cut distinction between the 'entitlements' which migrants enjoy and the 'accessibility' of services. These two issues are usually combined without distinction in the single concept of 'access'. However, entitlements are almost always laid down in national legislation, while other aspects of accessibility are regulated at a variety of levels.

The term 'entitlement' concerns the *affordability* of care: it refers to the coverage of health care costs under a risk-sharing system. The costs of necessary health care can easily exceed an individual's ability to pay them: in the worst case these costs can become 'catastrophic'. Individuals or their families can avoid being financially devastated by illness or injury by insuring against these costs.

Voluntary private health insurance (VPI) is the least equitable type of coverage. Premiums usually take no account of financial circumstances and will therefore represent a greater burden for poorer people than for richer ones. Insurance companies may refuse to cover pre-existing medical conditions, or charge higher premiums for people who suffer from them. Third-country nationals in the EU/EFTA are often obliged to take out VPI if they wish to safeguard against catastrophic health costs. Without government regulation, such policies can be highly disadvantageous.

Statutory (state-regulated) systems of coverage have evolved in order to improve equity and increase the percentage of the population with health care coverage. They do this either by regulating the terms of insurance policies ('Bismarck' system) or by financing health costs through taxation ('Beveridge' system). In this study the two types of system are labelled as SHI (social or statutory health insurance) or NHS (national health service)[21]. Often the two systems are combined – for example, unemployed and low-income people are covered from tax revenue but others from premiums (Kutzin, 2011). Such mixed systems are becoming increasingly common because "in a globalized economy, as the share of labor decreases relative to that of capital, wage income is increasingly insufficient to cover the rising cost of care" (Iliopoulos & Goranitis, 2016). In Europe, ageing is also reducing the economically active population and increasing the number requiring expensive care, so that the funding generated by the contributions of working people and their employers becomes increasingly inadequate for covering the entire population.

An essential feature of statutory systems is that joining them – in contrast to VPI – is not optional. Whether contributions to a risk-sharing scheme are made through premiums or taxation, they are continuous and do not start only when one is ill: for this reason they are often called 'up-front' contributions). 'Risk-sharing' means that people with many health problems are subsidised by those with fewer problems. To the extent that financing is

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[21] Greece refers to its health system as the 'national health system (NHS)', although it is mainly financed by social health insurance. In this report the 's' in NHS stands for 'service' rather than 'system'.

progressive (i.e. contributions are matched to ability to pay), rich people will also subsidise poor ones. A person with the *right* to participate in the statutory system of risk-sharing usually also has the *obligation* to do so – an obligation which, as President Obama discovered when introducing 'Affordable Care' in the USA, may be strongly resented by the healthy and wealthy.

All EU/EFTA countries except Cyprus now have statutory systems of coverage. For migrants, it makes a lot of difference if they are allowed to participate in this system (or can transfer the coverage they have in their home country). As we shall see, this is far from always being the case, so that they either have to use VPI or pay for health costs as they arise.

How is entitlement measured?

The extent of coverage for migrants is measured in the Health Strand with the help of the WHO model of coverage.[22] In this model, coverage has three dimensions:

1. Who is covered?
2. Which services are covered?
3. What do people have to pay out-of-pocket?
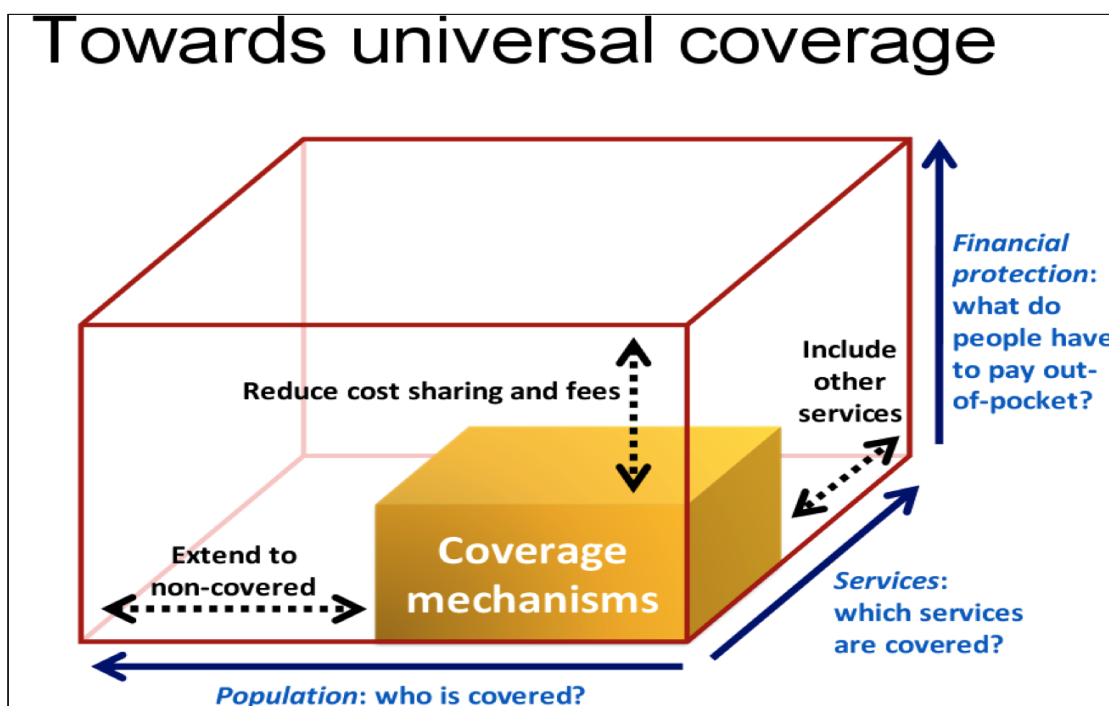
The first dimension (left to right) concerns the extent of inclusion in the statutory system of coverage. Is coverage unconditional, or do only certain migrants qualify for it, or none at all? The second dimension (front to back) concerns the 'basket of services' which is covered. Does it contain only emergency care, a few additional services, or all the services that nationals enjoy?

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[22] http://www.who.int/health_financing/strategy/dimensions/en/

The WHO model's third dimension (vertical) concerns the extent of 'out-of-pocket' (OOP) payments or 'co-payments', such as charges to the patient for prescriptions or consultations. Such payments undermine the very principle of 'coverage', because they place certain costs outside the scope of insurance. Although it was originally intended to include OOP charges in the MIPEX Health strand, it soon became obvious that too much research would be required to obtain the necessary information. The *total* percentage of health expenditure financed by OOP payments is readily available from WHO or OECD databases, but this figure is based on all users. Our interest is in the OOP payments that affect migrants in each of our three categories. Obtaining this information is difficult enough, but we would also have to take into account concessions designed to make OOP payments more equitable (exemptions, ceilings, refunds etc.), which vary enormously between countries.

Therefore, because OOP payments comprise on average only 19% of total health expenditure in the countries we studied, it was decided not to take them into account. The overall percentage of health expenditure covered by these payments is nevertheless an interesting variable, which has been included in the background data and statistical analyses.

Returning to the first two dimensions of the WHO cube (who is covered? which services are covered?), we also need to take into account exemptions from restrictions that apply in certain special cases. These cases concern either 'vulnerable groups' or conditions regarded as a threat to public health: for example, care relating to pregnancy and childbirth, children, or infectious diseases. Exemptions provide a 'back door' into the system for those who are not entitled to enter through the 'front door'. Generally, they also apply to national citizens who do not have coverage (for example, those in SHI systems who are uninsured because they have not paid the compulsory contributions).

Section A addresses the following issues for legal migrants, asylum seekers and UDMs. Scores for this section can be extracted separately for each category. (In sections B, C and D separate scores are not calculated, though information about the different groups is asked for in certain questions.)

Questions in Section A

Numbers in brackets after certain questions refer to the number of indicators which are averaged to make the score for that question.

1-3   Inclusion in health system, services covered, special exemptions
1. Legal migrants
2. Asylum seekers
3. Undocumented migrants

Each score for questions 1-3 is the average of the following three indicators:

(a) Conditions for inclusion in a system of health care coverage
   100 = unconditional inclusion, 50 = some conditions for inclusions, 0 = no inclusions.

(b) Extent of coverage
100 = same coverage as nationals, 50 = more than emergency care, but less than for nationals, 0 = emergency care only (or none if no inclusion)

(c) *Special exemptions*
Five grounds for exemption are listed:
- antenatal and/or perinatal and/or postnatal care
- infectious disease (e.g. TB, HIV/Aids)
- care for minors (or for unaccompanied minors if other minors are covered)
- care for vulnerable groups (e.g. victims of torture, trafficking or traumatisation)
- other (specify)

100 = three or more exemptions, 50 = one or two exemptions, 0 = no exemptions.

4-6   Administrative barriers to obtaining entitlement

While questions 1-3 describe the **legal entitlements** that each group of migrants enjoys, questions 4-6 cover the **administrative barriers** that may prevent them from exercising these entitlements. These barriers are included in Section A because they *directly* negate or undermine the legal entitlements given. For example, not knowing whether one can count on coverage is a powerful disincentive to seeking help, because the patient runs the risk of being forced to pay crippling medical bills.

These barriers are different in kind from the ones described in section B, which have to do with difficulties in reaching service providers. It was decided to include them in the section on entitlements because it is often found that the law provides UDMs (for example) with reasonably good entitlements, but obstacles are put in place at the administrative level which prevent UDMs from exercising them. In such cases it would be misleading to speak of a high level of entitlement.

Two types of administrative barrier are considered:
   A. administrative demands for documents which may be difficult for migrants to produce
   B. subjecting entitlements to discretionary decisions with an uncertain outcome.
   Scoring: 100 = neither, 50 = A or B, 50 = A & B

Note that questions 4-6 in fact measure 'freedom from administrative barriers'; a complete absence of barriers gets the highest score.

The score for section A is the average of the questions on legal entitlements and administrative barriers. Depending on requirements, scores can be calculated for a single migrants group or for the average of all three.

B. Policies to facilitate access

In this section, access barriers are investigated which have to do with the provision of necessary information, mediators to guide migrants through the health system, and the threat of sanctions against use of health services by UDMs.

Lack of information about entitlements is a serious barrier to exercising them: people who do not know their rights cannot claim them. Unfortunately this ignorance may not be confined to migrants, because staff are often inadequately informed about entitlements. This situation is made worse when legislation is complex and changes rapidly.

7. Information for service providers about migrants' entitlements

This question examines two issues:

A. Do service provider organisations receive up-to date information on migrants' entitlements?
B. Do organisations pass on up-to-date information about these entitlements to their employees?

Scoring: 100 = A & B, 50 = A or B; 0 = neither.

8. Information for migrants concerning entitlements and use of health services

Scores for this question are the average of three indicators:

(a) Method of dissemination
Five methods of dissemination are listed:
- websites
- brochures in public places
- 'one-stop shops'
- classes or individual instruction
- other (specify)
100 = more than one method, 50 = one method, 0 = no methods.

(b) Number of languages in which information for migrants is available (not including the official languages of the country or English)
100 = four or more, 50 = one to three, 0 = none

(c) Groups reached by information
A. Legal migrants
B. Asylum seekers
C. Undocumented migrants
100 = all three, 50 = only two, 0 = only one.
(This question is skipped if there is no method of dissemination)

9. Health education and health promotion for migrants

Scores for this question were calculated in the same way as for Question 8.

10. Practical barriers

This question was dropped for the reasons given in Section D.

11. Provision of 'cultural mediators' or 'patient navigators' to facilitate access for migrants

Scores for this question are the average of two indicators:

(a) Extent of provision

100 = guaranteed across the system or in major immigrant areas, 50 = on a smaller or *ad hoc* basis, 0 = not available.

(b) Groups reached by information
    A. Legal migrants
    B. Asylum seekers
    C. Undocumented migrants

100 = all three, 50 = only two, 0 = only one.
(Question b is skipped if there is no provision)

12. Is there an obligation to report undocumented migrants, and are there any sanctions against helping undocumented migrants?

This question is only relevant to one of the three groups studied, but it nevertheless gives an indication of the level of respect for the rights of migrants in a country. Scores are the average of two indicators:

(a) Are healthcare professionals or organisations required to report undocumented migrants to the police or immigration authorities?

100 = explicitly forbidden in law and/or professional codes of conduct
50 = no relevant legislation or professional codes of conduct
0 = explicitly required in law.

(b) Are there legal or organisational sanctions against healthcare professionals or organisations assisting undocumented migrants?

100 = no legal sanctions or other pressures on professionals to deter them from helping migrants who cannot pay
50 = only organisational sanctions exist (organisations discourage carers from helping migrants who cannot pay)
0 = legal sanctions exist against helping undocumented migrants.

C. Responsive health services

This section concerns steps that are taken to adapt services to migrants' needs. These needs may concern linguistic or cultural barriers or specialised knowledge about health conditions.

13. Interpretation services

Scores for this question are the average of two indicators:

(a) Availability of qualified interpretation services for patients with inadequate proficiency in the official language(s)
100 = interpreters are available free of charge to patients, 50 = interpreters are available but patients must pay all (or a substantial part) of the costs, 0 = no interpretation services available.

(b) Methods used for interpretation
Six methods of interpretation are listed:
- face-to-face
- telephone interpretation
- interpretation by video link
- Credentialed volunteers
- Employment of 'cultural mediators'
- Employment of competent bilingual or multilingual staff

100 = three or more methods available, 50 = one or two, 0 = none.

14. Availability of 'culturally competent' or 'diversity-sensitive' services

Indicator: Existence of standards or guidelines requiring that health services take account of individual and family characteristics, experiences and situation, respect for different beliefs, religion, culture, competence in intercultural communication.

A. Standards or guidelines exist on ''culturally competent' or "diversity- sensitive" services
B. Compliance with these standards or guidelines is monitored by a relevant authority

100 = both of these, 50 = one of these, 0 =neither.

15. Training and education of health service staff

Indicator: Policies exist to support training of staff in providing services responsive to the needs of migrants. Training may be part of basic professional education and/or in-service professional development.

100 = at national level, 50 = at local or organisational level, 0 = neither

16. Involvement of migrants in information provision, service design and delivery

Only forms of migrant involvement that are explicitly encouraged by policy measures (at any level) should be mentioned.

   A. Migrants are involved in service delivery (e.g. through the employment of 'cultural mediators')
   B. Migrants are involved in the development and dissemination of information
   C. Migrants are involved in research (not only as respondents)
   D. Migrant patients or ex-patients are involved in the evaluation, planning and running of services.
   E. Migrants in the community are involved in the design of services.

100 = 3-5 of these, 50 = 1 or 2, 0 = none.

17. Encouraging diversity in the health service workforce

Concerning this issue there is less consensus (Seeleman et al. 2015). Although American guidelines tend to emphasise the value of a culturally and linguistically diverse workforce, in Europe the idea of allowing ethnicity to play a role in recruitment is more controversial. There is no separate Council of Europe recommendation on this topic, but the desirability of a workforce which reflects the diversity of the general population is mentioned in the Guidelines and Explanatory Memorandum. Answers to the question give an indication of the extent to which health workers with a migrant background are seen in Europe as having a role to play in responsive care.

Indicator: Existence of recruitment measures (e.g. campaigns, incentives, support) to encourage participation of people with a migrant background in the health service workforce. (*This question does not concern policies aimed at recruiting or employing health care professionals from abroad because of a national shortage of staff.*

100 = at national level, 50 = at local or organisational level, 0 = neither.

18. Development of capacity and methods

While questions 13-17 were concerned with improving interactions between health workers and migrant patients, question 18 examines the adaptation of clinical procedures (diagnosis, treatment) to the needs of migrant populations.

Indicator: Diagnostic procedures and treatment methods are adapted to take more account of variations in the sociocultural background of patients.

100 = policies exist to encourage the adaptation of diagnostic procedures and treatment methods to sociocultural diversity
50 = adaptation of diagnostic procedures and treatment methods is to a limited extent tolerated, but not encouraged
 0 = policies are exclusively focused on standardising diagnostic procedures and treatment methods

D. Measures to achieve change

This section concerns measures which support the process of improving responsivity ('flanking measures') or provide leadership to initiate change processes.

19. Collection of data on migrant health

All approaches stress the importance of data collection and research to in order to strengthen the knowledge base concerning migrant health. There is widespread concern about shortcomings in this area.

Indicator: Data on migrant status, country of origin or ethnicity is included in medical databases or clinical records. (*Choose Option 1 if linkage between medical databases and national databases containing the above personal information is practically possible.*)

100 = inclusion of such information is mandatory, 50 = inclusion of such information is optional, 0 = such information is never included.

20. Support for research on migrant health

Funding bodies have in the past five years supported research on the following topics:

    A. occurrence of health problems among migrant or ethnic minority groups
    B. social determinants of migrant and ethnic minority health
    C. issues concerning service provision for migrants or ethnic minorities
    D. evaluation of methods for reducing inequalities in health or health care affecting migrants or ethnic minorities

100 = three or four topics, 50 = one or two, 0 = none

21. "Health in all policies" approach

This refers to attention for the health impact of all policies affecting migrants.

100 = Mandatory consideration of the impact on migrant or ethnic minority health of policies in other sectors than health
50 = *Ad hoc* consideration of the impact on migrant or ethnic minority health of policies in other sectors than health
 0   = No consideration taken of the impact on migrant or ethnic minority health of policies in sectors other than health.

22. Whole organisation approach

This question concerns the extent to which migrants' health is regarded as a concern throughout the health system, or only for specialised departments of organisations.

Indicator: Migrant or ethnic minority health is a priority throughout service provider organisations and health agencies ("integrated" versus "categorical" approach).

100 = commitment to providing equitable health care for migrants or ethnic minorities is present in all departments of service provider organisations and health agencies

50 = concern for migrant or ethnic minority health is regarded as a priority only for specialised departments or organisations

0 = no systematic attention is paid to migrant or ethnic minority health in any part of the health system. Measures are left to individual initiative

23. Leadership by government

A. Government publishes an explicit plan for action on migrant health
B. Policies are implemented to support these measures.

100 = A & B
50 = only ad hoc policies introduced on migrant health
0 = no policy measures introduced on migrant health.

24. Involvement of stakeholders / migrants' contribution to health policymaking

The final topics concern governance. Does the national government take the lead in changing the health system to improve migrants' health? Are there mechanisms for bringing together all the stakeholders who need to be involved in such an enterprise? Are migrants and their organisations represented in policy making? (NB: participation at service provider level is covered by q. 16). Scores for this question are the average of two indicators:

(a) What is the policy to involve stakeholders in the design of (national or regional) migrant health policies? Is there an advisory body or centre of expertise promoting cooperation amongst stakeholders on migrant health policy? *(This can be led by government, service-providers, or NGOs/institutes. Stakeholders include administrative and health authorities at various levels of governance, service providers, health insurers, professional bodies, universities, accreditation agencies, NGOs and commercial organisations.)*

100 = through structural cooperation (e.g. via advisory body or centre of expertise),
50 = through ad hoc cooperation (e.g. during consultations on new health strategy or law or through projects)
0 = none.

(b) Migrants' contribution to health policymaking at national or regional level. How do migrant stakeholders (e.g. NGO's and CSO's) participate in national policymaking affecting their health?

100 = through structural cooperation (e.g. involvement in advisory body or regular review of health legislation, services, and outcomes)
50 = Through *ad hoc* cooperation (e.g. during consultations on new health strategy or law or through projects)
0 = none.

III.   QUESTIONNAIRE SCORES

A. Entitlement to health services

Legal migrants

Policies analysed are mainly those applying to migrant workers. Entitlements for family members, students, pensioners and beneficiaries of international protection may differ.

Countries excluded from the analysis.
AU, CA, NZ and US are not included in the totals below, because the main aim is to provide an overview of the EQUI-HEALTH sample. MT cannot be scored on questions 1a, 1b and 1c, because no clear rules are laid down concerning the entitlements of legal TCNs.

Inclusion in health system and services covered

		A	B	C
1a	**Legal migrants: conditions for inclusion in a system of health care coverage** A. Inclusion is unconditional B. Some conditions for inclusion C. No inclusion (costs must be paid in full by the user or by a commercial insurance policy) Please specify any conditions for obtaining health care coverage, such as length of stay, residing in a State facility, etc. (Ignore the conditions which have to be satisfied in order to be classed as a 'migrant' rather than a 'visitor'.)	**10** BE, DK, FR, MK, DE, IT, LU, NL, SE, CH	**22** AT, BH, BG, HR, CZ, EE, FI, GR, HU, IS, IE, LV, LT, NO, PL, PT, RO, SK, SI, ES, TU, UK	*1* CY
1b	**Legal migrants: extent of coverage** A. Same coverage as nationals B. More than emergency care, but less than for nationals C. Emergency care only (or none if no inclusion)	*32* all countries (excluding Malta)	*0*	*1* CY

Question 1a: Conditions of coverage

Unconditional inclusion in the national system of coverage is granted to legal migrants by 10 countries. They are covered for the same basket of services as nationals. At the other end of the scale, Cyprus has four separate systems of health care coverage and legal migrants qualify for none of them. Only emergency care is provided by the state.

Conditional inclusion is granted by 22 countries. If the conditions are satisfied, the same services are covered as for nationals. If not, legal migrants must pay health costs (other than for emergency care) out of pocket or through VPI. The most important conditions concern **duration of residence permit** and **employment**. In the guidelines accompanying the CoE Recommendations particular concern is expressed about these two conditions:

8. Special attention should be paid to the entitlement of migrants to health service provision in the following cases:
  a. migrants who have not stayed long enough in a country to qualify for health care coverage;
  b. migrants whose insurance premiums are not paid by an employer.

The table below shows the main conditions for inclusion in a system of health care coverage, listed separately for the two types of health system (NHS and SHI). Countries which acceded to the EU since 2000 are marked in yellow.

Five countries apply two conditions: in CZ, HU and SI entitlement is granted if **one** of these conditions is satisfied, while in LT and CA **both** conditions must be satisfied. Countries which acceded to the EU after 2000 are marked in yellow.

	NHS (14)	**SHI (19)**
Unconditional inclusion	DK, IT, SE	BE, CH, FR, DE, LU, NL, MK
Miscellaneous conditions	ES[a,b], IS[c], PT[b,d]	
Inclusion if employed or self-employed		AT, CZ, HR, HU, LT, PL[e], SI, GR, BH[e]
Inclusion with 'temporary' residence permit (usually 1–5 yrs.)	IE, NO	HU, LT, TR
Inclusion only with 'permanent' residence permit (usually ≥ 5yrs)	UK, FI[b], LV	BG, CZ, EE, RO, SK, SI
No inclusion	CY	

  a. In ES inclusion is granted if a legal migrant is affiliated to the social security system and paying all necessary contributions, or earning less than €100,000 a year.
  b. In ES, PT and FI registration of residence is required
  c. In IS entitlements cannot be exercised during the first 6 months.
  d. In PT entitlements cannot be exercised during the first 3 months.
  e. In BH and PL a legal migrant may join the SHI system by paying contributions voluntarily.

NHS systems never impose conditions related to employment, but only 3 offer unconditional inclusion. We will now examine each of the types of inclusion in turn.

Unconditional inclusion
This is granted by 3 countries with a NHS system and 7 with SHI. Apart from MK, all are EU15 countries which have received migrants on a large scale since the 1950s.

Miscellaneous conditions
In PT and IS (both countries with NHS systems), legal migrants are not allowed to exercise their entitlements during the first 3 or 6 months of residence. Presumably this policy is intended to discourage 'health tourism' – coming to a country primarily in order to get treatment for a pre-existing health problem. However, just as when inclusion depends on the duration of the residence permit (see below), such measures are unjust because they oblige migrants to pay taxes for services they are not allowed to use during a certain period. In ES entitlement is dependent on being affiliated to the social security system and paying all necessary contributions, as well as not having too high an income.

Inclusion dependent on employment

SHI systems have evolved from the stage in which coverage was limited to those in employment and their dependents. In most such systems, coverage is now virtually universal. When only economically active migrants are covered, this has more to do with immigration policy than with the way the health system is financed.

How fair is it to base entitlement on employment? A work visa is by definition tied to employment: migrant workers can only obtain a residence permit if they have a guarantee of work. In the countries which link coverage to employment, we may surmise that being unemployed is seen as a breach of the conditions under which the migrant was admitted.

From this narrow viewpoint, it is logical that migrants cannot make use of the safety-net (including health care benefits) which is provided to national citizens in case of unemployment or low income. The threat of losing entitlement to health care encourages the migrant to work hard, hold on to their job, and get a new one quickly if they lose it. This suggests that the migrant is primarily regarded as a productive unit. Moreover, such a policy can only be deemed fair on the assumption that it is up to the individual whether he has a job. In reality, employment rates are strongly influenced by macro-economic conditions, while TCNs are overwhelmingly more vulnerable to unemployment than national citizens or EU migrants (WHO 2013: xxx). Finally, denying health care coverage to unemployed migrants is particularly inequitable because they in a worse position to pay extra costs than employed migrants.

In countries that deny full coverage to unemployed migrant workers, the discrimination is often indirect rather than direct. Coverage may be available for persons receiving state benefits, but migrants often do not qualify for unemployment benefit, often because of conditions that apply in relation to previous payment of social security contributions. When assessing health care entitlements it is therefore important to note whether the criterion applied is 'being unemployed' or 'receiving unemployment benefit'.

Inclusion dependent on length of permit

As can be seen from the table, two categories of countries can be distinguished depending on whether they require a 'temporary' or a 'permanent' residence permit. However, the boundaries of these categories are somewhat blurred: the concepts used, and their exact meanings, vary between countries. For example, the criterion may concern either the actual or the permitted length of residence, and it may not always be necessary to wait 5 years in order to get a 'permanent' residence permit.

What is clear is that in most countries imposing such conditions, entitlement is granted only to migrants whose stay is (or is intended to be) very long – so long, in fact, that in many countries they would become eligible to apply for national citizenship. Denying entitlements for such a long period is grossly inequitable, because in a tax-based system there is no possibility of exemption from the portion of taxes which goes to financing the health system. Legal migrants excluded from a SHI system suffer less from this form of discrimination: they may have to cover their own health costs, but at least they are exempt from paying SHI contributions. As we noted earlier, however, all SHI systems are nowadays subsidised to a certain extent by government financing, so part of the taxes paid by the migrant will still go to financing a system from which they are excluded.

Differences between EU15 and post-2000 accession countries

The table above shows that the 13 post-2000 accession countries impose more exclusive conditions on entitlement for legal migrants than EU15 countries. This difference is highly significant (p < .0001 by Fisher's Exact Test, two-tailed). Analysis of the background data collected for this study shows that EU15 member states have higher GDPs, percentages of foreign-born and foreign national residents, and scores for tolerance of migrants. Health systems in the EU15 are much more generously financed than in the post-2000 accession countries, especially in terms of health expenditure per capita, and as a result, the EHCI index of health care quality is also higher.

Each of these factors, and probably others too, might be related to the poorer entitlements for legal migrants in these countries. The serious underfinancing of health services is likely to encourage policymakers to adopt exclusive rather than inclusive policies for migrant workers. However, further analysis is necessary to unravel the influence of different factors.

Another factor which may undermine equitable policies for migrant workers is the political influence of the commercial health insurance sector. In Malta the government issues inconsistent information about legal health entitlements (see Country Report). Access to the NHS is said to be available to all who pay social security contributions – but to obtain an Employment Licence for a TCN, employers are required to show proof of private health insurance to cover the full duration of employment. In the Czech Republic, reforms of the system which have been strenuously advocated by human rights groups and migrant organisations – and even by some government departments – have been successfully resisted by the commercial health insurance lobby, supported by the Ministry of Health (see Country Report).

Question 1b: Limitations on the basket of services provided

As can be seen in the above table, for legal migrants only two levels of coverage were found: complete coverage or none at all. Emergency care is provided in all countries, though the obligation to pay for it afterwards varies: this issue is not dealt with here.

Question 1c: Special exemptions from restrictions

These exemptions provide a mechanism through which health systems can mitigate some effects of exclusion from the statutory system of coverage. They are designed to protect vulnerable groups and/or to reduce public health risks.

1c	Legal migrants: special exemptions	Three or more exemptions	One or two exemptions	No exemptions
	A. antenatal and/or perinatal and/or postnatal care B. infectious disease (e.g. TB, HIV/Aids) C. care for minors (or for unaccompanied minors if other minors are covered) D. care for vulnerable groups (e.g. victims of torture, trafficking or traumatisation) E. other (specify) Score Option 1 if full coverage for this group is granted anyway (Option 1 in 1a and 1b)	**11** BG, EE, GR, RO, SI, CY, HR, NO, PT, ES, UK	**10** AT, CZ, HU, LT, PL,TU, FI, IS, IE, LV	**2** BH, SK

The issue of exemptions does not arise for the 10 countries granting complete unconditional inclusion to legal migrants, because none are necessary. In the remaining 23 countries analysed (i.e. excluding the 'traditional countries of immigration" and Malta, which has no clear legislation), the distribution of these exemptions was as follows. This information should not be regarded as precise: it was difficult to count exemptions because of variations in the definitions used.

Probability of exemption existing

Category	Value
Vulnerable groups (e.g. victims of torture, trafficking or traumatisation)	~0.65
Antenatal and/or perinatal and/or postnatal care	~0.56
Minors (or unaccompanied minors if other minors are covered)	~0.52
Infectious disease (e.g. TB, HIV/Aids)	~0.48
Others	~0.17
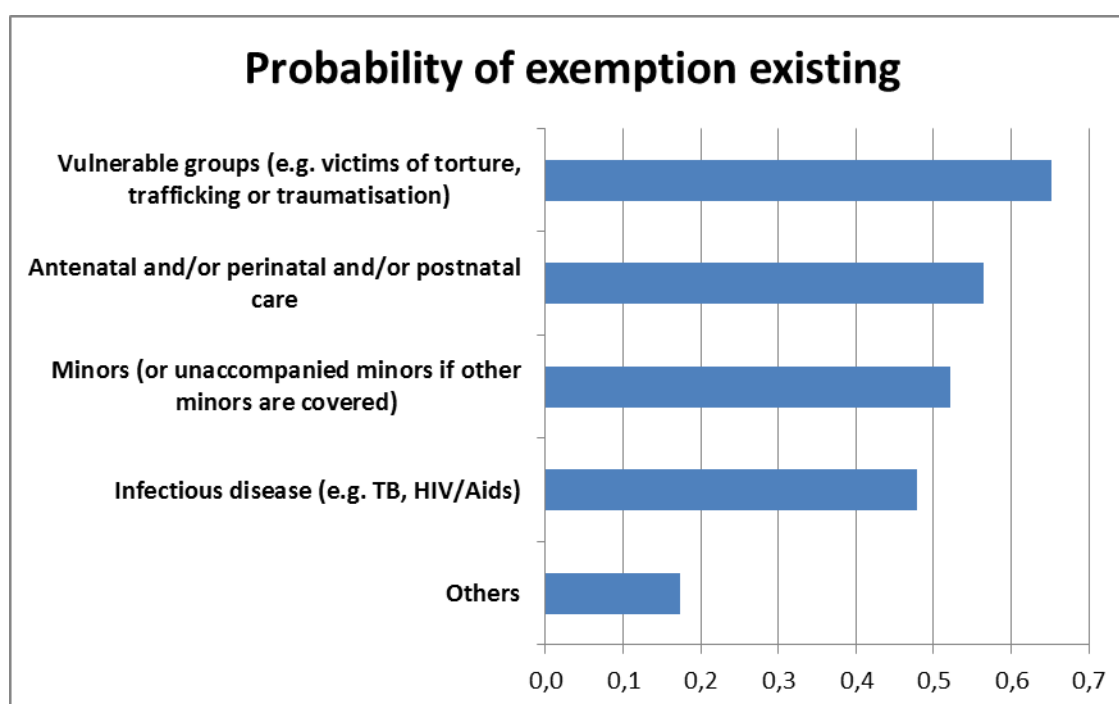
Question 4: Administrative barriers

4	Administrative discretion and documentation for legal migrants	Neither	A or B	A and B
	A. Administrative demands for documents which may be difficult for migrants to produce B. Coverage for migrants may depend on decisions with uncertain outcome. *Examples of A:* proof of low income on the basis of tax returns; identity documents available only from the police; proof of address from local authority records. *Examples of B*: Decisions made by administrators (receptionists, managers or committees), health workers making clinical judgements about criteria for entitlement such as 'urgency', financial departments deciding how rigorously to pursue unpaid bills, etc.	**15** AT, BE, HR, FI, FR, DE, IS, NL, NO, PL, SK, SE, CH, TU, BH	**12** **Only A (8):** BG, CZ, GR, HU, IT, LT, LU, RO **Only B (4):** DK, IE, LV, MT	**7** CY, EE, PT, SI, ES,UK MK,

The following table shows the score for each country that results from aggregating legal entitlements and [absence of] administrative barriers to obtaining entitlement (negative). The coloured part of the line shows the portion of the score which is due to legal entitlements (Question 1); the grey part shows the portion due to the absence of) barriers (Question 4). A country can only score 100% if there are full entitlements and no administrative barriers.

Entitlement score - legal migrants
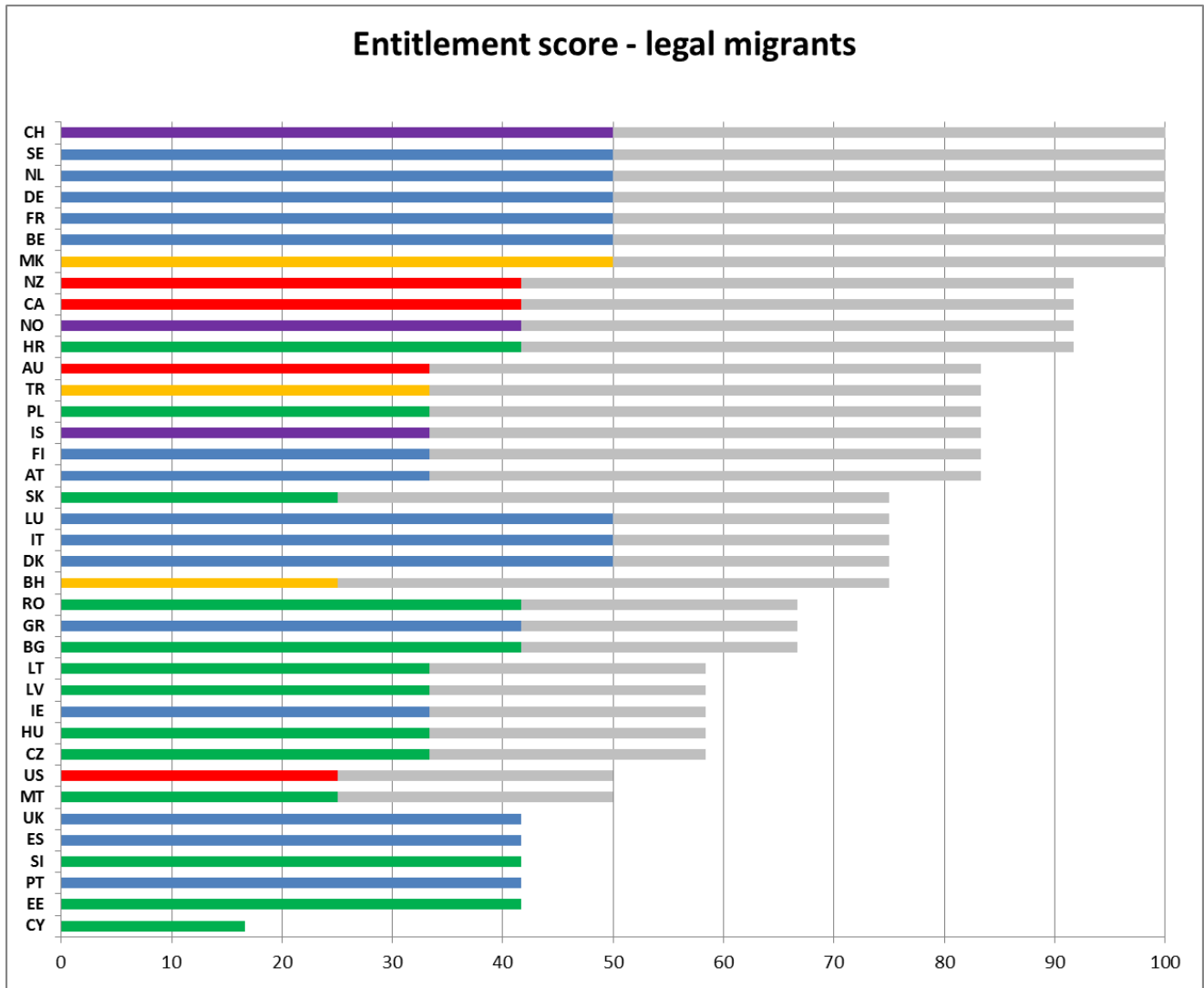
'Traditional countries of immigration' have been included in this graph for purposes of comparison. We may note firstly the contrast between most EU15 countries (blue) and most post-2000 accession countries (green). Outliers in a downward direction are UK, ES and PT. The latter two countries previously had universal coverage, but introduced new conditions and barriers in 2011 and 2012 in the context of 'austerity' measures. The UK had an even longer tradition of universal coverage, but severe restrictions were imposed on TCNs in the 2014 Immigration Act. Outliers in an upward direction are PL and HR, which have the best coverage of all the recent accession countries.

Secondly, we can observe that three of the 'traditional 'countries of immigration – AU, CA and NZ – offer levels of entitlement to legal migrants that are comparable with those in most EU15 countries. The US, on the other hand, offers less – and prior to the 2010 Affordable Care Act, coverage for migrants was even more incomplete. Even now, during their first five years of residence migrants lose their state health insurance if they become unemployed; there are also serious administrative barriers.

Lastly, it is worth noting that the 'neighbour' countries MK and TR, although they have low GDPs and are not in the EU, nevertheless have scores that are comparable with those in EU15/EFTA countries. In both countries a drive towards universal coverage has taken place.

Conclusions

The *EC Report on Health Inequalities in the European Union, 9/2013,*[23] p.9, states:

> "…..since 2009, the EU has extended the right of migrants to **equal treatment in social security, including health care, to all third-country nationals** who apply to reside in or have been admitted to a Member State for the purpose of work, or who have been admitted for other purposes but are allowed to work and hold a residence permit" [our emphasis].

However, the 'Single Permit Directive' to which this source refers does not apply to health care, only to sickness benefits (payments made to a person incapacitated by illness). This Directive only concerns TCNs moving from one EU country to another; in any case, its provisions have only to a limited extent been implemented.

Our findings show that in reality, there are wide disparities between EU/EFTA countries regarding entitlements to health care for legally residing TCNs. Unconditional inclusion without administrative barriers (i.e. an overall score of 100) is only found in 6 countries: FR, SE, NL, CH, BE and DE. In post-2000 accession countries, as well as some EU15 ones such as PT, UK, ES, and IE, policies tend to be highly inequitable. This can be because entitlement depends on long-term residence and/or employment, or because of administrative barriers such as discretionary judgements and/or documentation that is difficult for migrants to obtain.

The conclusion from these findings is that although concern about migrants' entitlements has up to now been mainly focused on UDMs, exclusion and unfair costs are also suffered by migrants who presence is entirely legal.

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[23] http://ec.europa.eu/health/social_determinants/docs/report_healthinequalities_swd_2013_328_en.pdf

A. Asylum seekers

International legal requirements
In principle, the health care entitlements of asylum seekers should be more uniform than those of other (legal) migrants because they are linked to international treaties and EU directives. However, on closer examination the requirements are in many respects unspecific, which probably accounts for the fact that in reality, entitlements vary greatly between countries.

Requirements for the treatment of refugees were laid down by the 1951 Geneva Convention, but no distinction was made between asylum seekers and those who have been awarded protected status. Moreover, the Convention contained no clear provisions concerning health care. Article 24 conferred on "refugees lawfully staying in the territory" the right to "the same treatment as is accorded to nationals" in respect of social security – but it is unclear whether 'social security' should include health care in addition to sickness and disability benefits.

By contrast, the 2003 EU *Minimum standards on the reception of applicants for asylum in Member States,* which were updated and expanded in 2008, apply explicitly to health care and to asylum seekers. The 'recast' version of 2008 contains quite extensive provisions:

- Material reception conditions must provide a standard of living which protects asylum seekers' physical and mental health. (Art. 17)
- Asylum seekers must be told where they can get information on health care, in a language they are reasonably supposed to understand. (Art. 5)
- They must receive the necessary health care which shall include, at least, emergency care and essential treatment of illness or mental disorders. Those with special needs must receive medical or other assistance, including appropriate mental health care when needed, under the same conditions as nationals. (Art. 19)
- Even when material reception conditions are reduced or withdrawn, asylum seekers must have access to subsistence, emergency health care and essential treatment of illness or mental disorder. (Art. 20)
- Vulnerable persons such as minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children, victims of trafficking, persons with mental health problems and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence, shall always be considered as persons with special needs in the national legislation implementing the provisions of Chapter II relating to material reception conditions and health care. (Art 21).
- Minors who have been victims of any form of abuse, neglect, exploitation, torture or cruel, inhuman and degrading treatment, or who have suffered from armed conflicts, must have access to rehabilitation services. Appropriate mental health care must be developed and qualified counselling provided when needed. (Art. 22)
- The detention of a person with special needs can only take place if a qualified professional certifies that their health, including their mental health, and well-being, will not significantly deteriorate as a result of the detention. (Art. 11)
- Provision of health care can be made conditional on having insufficient means; a contribution can be required from an asylum seekers who have sufficient resources; contribution can be demanded retrospectively if it only appears later that the asylum seeker had sufficient resources (Art. 17).

Provision of health services

MIPEX measures "inclusion in a system of health care coverage", but the system concerned does not have to be the same as that used by nationals: what matters is its adequacy. Indeed, health services for asylum seekers are not always provided within the mainstream health system. Both the organisation of services and the way they are funded may be wholly or partly separate from the mainstream.

Organisation of services In most countries. health services for asylum seekers are provided partly within the regular system and partly outside it. When asylum seekers live in a reception centre **primary care** will usually be provided on site. On-site services may be regulated by a different authority (e.g. the Interior Ministry rather than the Health Ministry) and they may be outsourced to an NGO (e.g. the Red Cross in Denmark). **Specialist care**, on the other hand, will usually be provided in mainstream facilities, because concentration of resources is necessary in order to maintain care quality and an adequate range of specialties. Specialist care entails longer journeys for almost all patients, but this problem may be exacerbated for asylum seekers because of the remote locations in which they are often housed.

In some countries (e.g. NL, UK) there has been a shift from specialised ('categorical') services for asylum seekers to mainstream ('regular') ones, especially in the field of mental health. To some extent this has taken place for reasons of administrative streamlining, but it has also been supported by the realisation that the health needs of asylum seekers overlap to a large extent with those of the general population (Kramer 2009). This overlap concerns both the type of conditions that need to be treated and the manner of service delivery. Previously, it was widely assumed that asylum seekers require more expertise concerning imported infectious diseases and post-traumatic stress disorder than was available in mainstream services; today, both of these conditions are also considered to be mainstream problems. Concerning 'cultural competence', increasing diversity in the general population makes such skills necessary for any health worker. Despite this, however, it remains possible that specialised services for asylum seekers can draw on experience that enables them to respond better to the special needs of this group than mainstream ones.

Funding mechanisms Exempting asylum seekers from normal contributions to the health system can be done in different ways. Separately organised primary care facilities in the centres are available free of charge. When asylum seekers use mainstream services, they can be registered in the national system of coverage without having to pay contributions or taxes: for example, they can be given the same 'health card' as other users. In both types of system (NHS and SHI) they may also be granted exemption from OOP charges which nationals have to pay.

We may note in passing that although most asylum seekers pay no income tax, they are liable for sales tax (VAT). Like all migrants, in every country they contribute in this way towards the costs of the health system, though the burden involved is relatively slight and applies to everybody else as well.

Most countries do not allow asylum seekers to undertake paid work. However, in the small number of countries that do, they may then be required to pay income tax and/or health insurance contributions. We have not examined this issue because it seems unlikely that inequities will arise as a result of it. Indeed, it would arguably create inequities for everyone

else if asylum seekers were allowed to earn money without being subject to the usual deductions: this would amount to higher pay for the same work.

Although there are 9 countries which grant asylum seekers unconditional entitlement to the same range of services as nationals, other countries impose two kinds of limitation. Firstly, some treatments may be omitted from the standard package of services available; secondly, asylum seekers may under certain conditions be granted even less coverage. On the positive side, when restrictions exist there may be exemptions from them for certain conditions regarded as a public health threat, or for certain groups regarded as vulnerable. Finally, there may be administrative barriers which prevent the asylum seeker from enjoying the entitlements which the law provides: documentation may be required which is difficult to get hold of, and discretionary judgements may be made which limit access in unpredictable ways.

Through the combination of all these factors, there are large variations between countries in the coverage offered. It is difficult to decide when countries meet the requirements of the EU's *Minimum Standards* – a level that is "adequate for health and well-being" – because of the inherent vagueness of these requirements: but it is clear that asylum seekers are much better cared for in some countries than in others.

Inclusion in health system and services covered

	A) ENTITLEMENT TO HEALTH SERVICES	*Option 1*	*Option 2*	*Option 3*
2a	**Asylum seekers: conditions for inclusion in a system of health care coverage** A. Inclusion is unconditional B. Some conditions for inclusion C. No inclusion (costs must be paid in full by the user or by a commercial insurance policy) Please specify any conditions for obtaining health care coverage, such as length of stay, residing in a State facility, etc. (Ignore the conditions which have to be satisfied in order to be classed as a 'migrant' rather than a 'visitor'.)	A **15** BE, FR, IT, LU, NL, NO, ES, UK, DK, MK, IS, RO, SE, CH, HR, DE	B **18** AT, BG, BH, CY, CZ, EE, FI, GR, HU, IE, LT, LV, MT, PL, PT, SI, SK, TR	C **0**
2b	**Asylum seekers: extent of coverage** A. Same coverage as nationals B. More than emergency care, but less than for nationals C. Emergency care only (or none if no inclusion)	A **15** FR, TU, GR, AT, CZ, IE, IT, LU, NL, NO, ES, BG, HU UK, EE	B **17** BE, DK, MK, IS, RO, SE, CH, BH, CY, FI, LV, LT, MT, PL, PT, SK, SI	C **2** HR, DE

The responses to these questions are cross-tabulated in the following table:

		2a Conditions of coverage		
		1 - unconditional	2 – some conditions	3 – no inclusion
2b Extent of coverage	1 - Same as nationals	**7** FR, IT, LU, NL, NO, ES UK	**8** AT, BG, CZ, EE, GR, HU, IE, TU	**0**
	2 - Less than nationals, more than emergency care	**7** BE, DK, CH, MK, IS, RO, SE	**10** BH, CY, FI, LT, LV, MT, PL, PT, SK, SI	**0**
	3 - Emergency care only	**2** HR, DE	**0**	**0**

Question 2a: Conditions of coverage

The different kinds of conditions which may determine entitlement are shown in the following table. Post-2000 EU accession countries are marked in yellow: we can see that they tend to impose more conditions.

	no.	Countries
Unconditional inclusion	17	BE, FR, IT, LU, NL, NO, ES, UK, NZ, DK, MK, IS, RO, SE, CH, HR, DE
Must remain in centre	7	AT[a], BG, BH, EE, FI, LT, SK
Means test	7	CY, CZ, GR, HU, MT, IE, PT
Care in selected locations	3	LV, PL, PT

[a] Full coverage only available if asylum seeker remains in 'designated area of residence'

It is possible that a means test is applied in more countries than those listed here. Discretionary judgements play a large role in the access to care for asylum seekers, so it might be the case that the asylum seeker's financial situation is taken into account in these judgements.

Other conditions
BG: asylum seekers must first register in the National Health Insurance System and find a GP, which is sometimes difficult.

TR: full coverage is available for Syrian asylum seekers both inside and outside the camps, but for other asylum seekers coverage outside the camps is more limited.

Question 2b: Limitations on the basket of services provided

Fifteen countries grant the same range of services to asylum seekers as to national citizens, while 17 provide coverage that goes beyond emergency care but is less than the complete package and 2 provide emergency care only.

A wide range of terms is used to describe the services that can be used. At the restrictive end of the scale (e.g. in FI, IS, RO, SE, SI), terms like 'urgent', 'life-threatening' and 'essential' are used: this comes close to the criterion of 'emergency care'. In many countries the care must be 'necessary' or 'appropriate' in the view of the service provider or relevant authority, without further specification of what precisely is meant (e.g. BH, CH, CY, LT, LV, MK, MT, PT, RO, SK). At the more generous end of the scale there are countries (e.g. DK, NL, PL) which cover the full package of basic health care available to national citizens, excluding only a handful of treatments which are regarded as not being strictly necessary in medical terms (for example *in vitro* fertilisation, cochlear implants, gender reassignment operations) or considered to be of uncertain medical value (chiropractic care, long courses of physiotherapy, sanatorium and spa therapy).

Emergency care

Two countries (DE and HR) limit entitlement to emergency care, though exemptions from this restriction are granted for certain conditions regarded as a public health threat and for groups regarded as vulnerable. CY requires asylum seekers to access treatment via emergency departments, but this does not mean that only 'emergency treatment' can be given. (It is quite common in many countries for non-urgent conditions to be treated in emergency departments, especially when other pathways to care are problematic.)

The case of DE is particularly worth examining because this country has recently received the largest numbers of asylum seekers in Europe. German law makes a sharp distinction between asylum seekers who have been in the procedure for a longer or shorter period than 15 months. A procedure lasting more than 15 months should only be necessary to decide the most complicated cases: we have therefore decided to consider the rules that apply in the first 15 months, because they will apply to the vast majority of asylum seekers.

In DE, we have coded entitlement as 'unconditional' because all asylum seekers are subject to the same policy during this period. Regarding the basket of services covered, only in case of acute pain and illness do they have access to necessary medical and dental treatments. Aside from this emergency care, they are granted access to vaccinations and pregnant women are provided with maternal care. However, chronic illnesses (such as high blood pressure or diabetes) and mental health problems are only covered exceptionally in acute cases and even then, only after special authorization has been obtained.

Question 2c: Special exemptions from restrictions

Asylum seekers: special exemptions A. antenatal and/or perinatal and/or postnatal care B. infectious disease (e.g. TB, HIV/Aids) C. care for minors (or for unaccompanied minors if other minors are covered) D. care for vulnerable groups (e.g. victims of torture, trafficking or traumatisation) E. other (specify) Score Option 1 if full coverage for this group is granted anyway (Option 1 in 1a and 1b)	Three or more exemptions **14** BG, EE, GR, TU, BE, DK, RO, SE, CY, FI, PT, SI, CA, HR	One or two exemptions **12** AT, BG, CY, CZ, NZ, RO, DE, GR, IE, LT, SI, US	No exemptions **2** MT,SK

We have not attempted to tabulate these exemptions as was done for legal migrants, because legislation does not always make clear whether the exemption applies to other groups. Where this is the case, this indicator is less reliable.

Question 5: Administrative barriers

Most of these barriers concern administrative discretion: this is found in 26 countries, compared with 12 countries in the case of legal migrants (difference significant at p < .003 by Fisher's Exact Test, 2-tailed). Where asylum seekers are concerned, it seems that countries want to be able to exercise a considerable degree of discretion regarding the treatments that are allowed and the asylum seekers who may receive them.

5	**Administrative discretion and documentation for asylum seekers** A. Administrative demands for documents which may be difficult for migrants to produce B. Coverage for migrants may depend on decisions with uncertain outcome. *Examples of A:* proof of low income on the basis of tax returns; identity documents available only from the police; proof of address from local authority records. *Examples of B*: Decisions made by administrators (receptionists, managers or committees), health workers making clinical judgements about criteria for entitlement such as 'urgency', financial departments deciding how rigorously to pursue unpaid bills, etc.	Neither **7** AT, FR, GR, PL, RO, SK, TU	A or B **17** **A (3)** IT, NO, ES **B (14)** BE, BH, BG, CH, CZ, DK, FI, MK, HU, IS, IE, LU, NL, SE	A and B **10** HR, CY, EE, DE, LV, LT, MT, PT, SI, UK

Finally we present a table of the summed scores (positive entitlements – coloured; freedom from barriers - grey) for all countries. The reader is reminded that no attempt has been made to give different weights to different restrictions or concessions, and the same total score can be arrived at in different ways. The total scores should only be regarded as a rough-and-ready estimate of the generosity or restrictiveness of entitlements for asylum seekers.

Key to colours:
Blue: EU15 countries, purple: EFTA countries, green: post-2000 accession countries,
Yellow: EU neighbour countries, red: non-European countries.
Grey refers to (freedom from) administrative barriers.

Entitlement score - asylum seekers
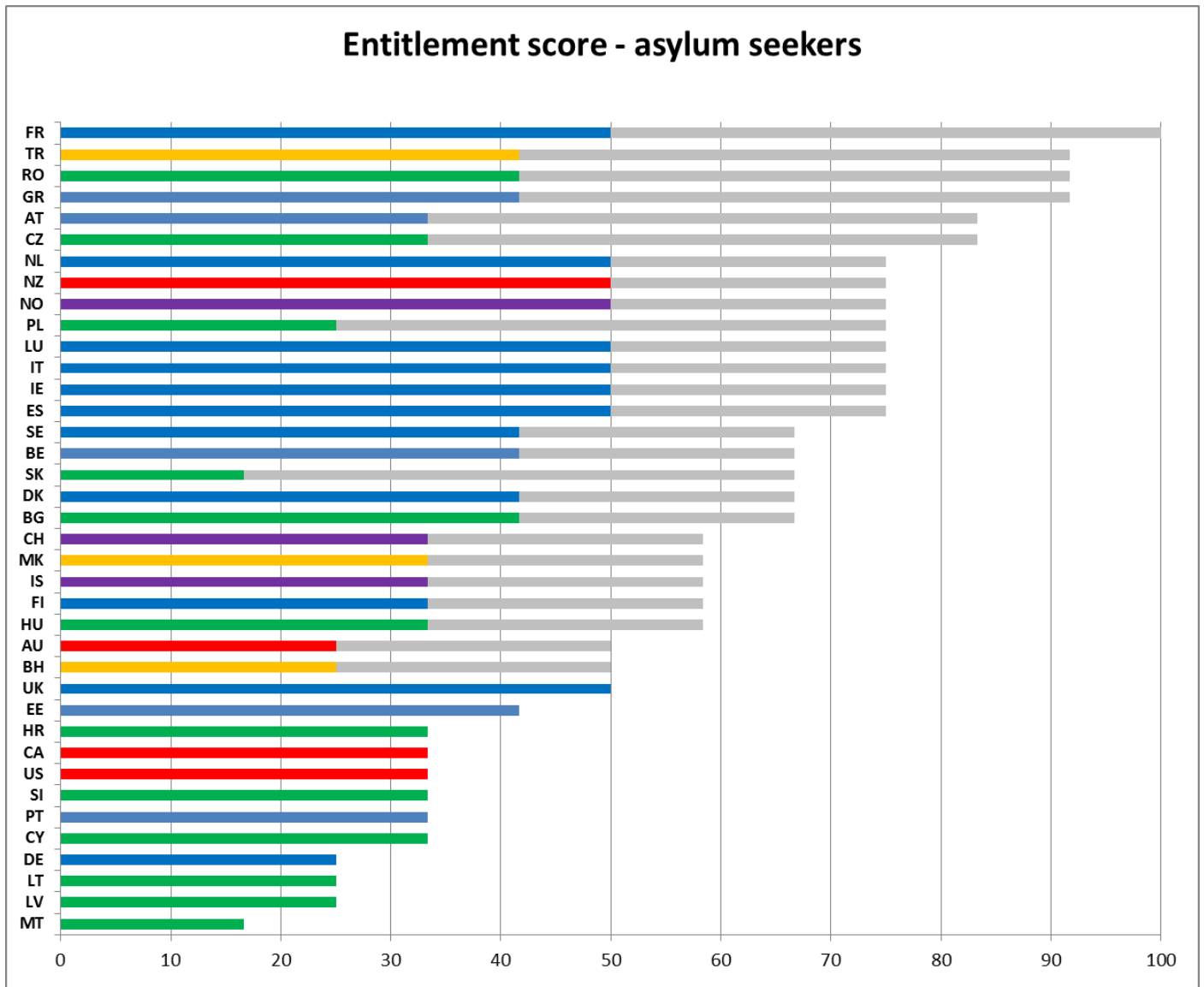
As with legal migrants, we see that there is a predominance of EU15 countries at the top end of the scale and post-2000 accession countries at the bottom. This is disappointing, because if the entitlements of asylum seekers are subject to international standards they should be less strongly linked to differences in wealth and the other factors that distinguish post-2000 accession countries from the EU15. (It should be remembered that scores represent not the absolute standard of health care provisions, but the *discrepancy* between provisions for nationals and those for asylum seekers.) RO, CZ and PL stand out for their equitable treatment of asylum seekers, and the UK, EE, PT and DE for their restrictive policies.

Among EU 'neighbour countries', TR gives remarkably complete coverage (especially to Syrian asylum seekers), though there have been some critical reports about the actual availability of care. The negative effect of recent policy changes is clearly visible in CA and AU, though in CA change for the better is currently expected.

Has the EU's 'minimum standards directive' achieved harmonisation of health policies affecting asylum seekers? Although there are countries that have still not transposed it into national legislation, it is of course only a 'minimum' standard, requiring only the provision of 'emergency care and essential treatment'. A more appropriate standard would emphasise *primary care*, which human rights and public health principles (as well as cost-benefit considerations: see Bozorgmehr and Razum, 2015) regard as having crucial importance.

C. Undocumented migrants

Access to health care for UDMs – in particular their limited legal entitlements, the great variations in the way they are applied, and the many administrative barriers – is currently an issue of great concern. The MIPEX study confirms that UDMs almost everywhere have a very low level of entitlement. Indeed, it was a challenge to develop a scoring system that would make it possible to use the same 3-point scales with both UDMs and legal migrants. If the items discriminated well at the top of the scale, they did not do so at the bottom, and vice versa. (The problem was eventually solved by dividing up different components of legal entitlement into the three indicators used in questions 1, 2 and 3.)

One major political problem and two technical ones seem to stand in the way of improvements to the entitlements of UDMs. The political problem is that many countries severely limit entitlements in the hope of encouraging UDMs to leave the country and deterring others from coming ('internal migration control': see WHO, 2013:107). The protection of health is often subordinated to this motive. But there also technical problems:

1. Incorporating UDMs in the mainstream health system can jeopardise their confidentiality and thus their security. To give good care, their address and medical records must be available to other health workers. Only then is continuity of care and integrated service delivery possible. However, for UDMs it is risky to be too easily traceable, as long as the possibility exists that information from health services can be passed on to immigration authorities.

2. BE and FR operate separate systems for undocumented migrants, perhaps in order to bypass the problems of integrating them in the mainstream. However, the Belgium system in particular is cumbersome and inefficient (Roberfroid et al. 2015).

3. There is a risk of creating inequities for all other groups in society if health care for one group of migrants is made completely free. Nationals are usually obliged to pay contributions to the national system through insurance premiums and/or income tax. In the case of asylum seekers, it is generally accepted that they will not be able to pay, especially where they are forbidden to work. Free health care for asylum seekers with insufficient means is generally accepted as equitable. For UDMs, however, the equity problem remains a thorny issue. Most countries operate a 'means test' for them; some have introduced charges (usually relatively low ones).

Many countries detain UDMs. In those cases, the above problems do not apply: health care in detention is different from that available to UDMs living in the community. In principle it can be more accessible and offer better continuity, but provisions vary greatly between countries (see the forthcoming Country Reports).

Inclusion in health system and services covered

Twenty-six countries limit the services available to UDMs to 'emergency care' (ignoring special exemptions which may be available for certain groups and conditions).[24] However, the precise definition of an 'emergency' and the conditions under which it is covered vary greatly. The MIPEX instrument allows us to distinguish the following four situations:

    a. Coverage of emergency care available for all UDMs (unconditional inclusion).
    b. Coverage of emergency care available only for UDMs who are unable to pay the bill (conditional inclusion).
    c. Emergency care provided, but it must always be paid for afterwards (no inclusion in the system of coverage). In some cases a UDM who cannot pay will not be forced to, but there must be explicit rules governing this. Letting people off their bills on an arbitrary discretionary basis does not count as 'coverage'.
    d. A nominal out-of-pocket charge (much lower than the real cost in serious cases) may be made for emergency care.

These distinctions have not always observed in previous reports, but they are very important to migrants in practice.

3a	**Undocumented migrants: conditions for inclusion in a system of health care coverage**
	  A. Inclusion is unconditional
	  B. Some conditions for inclusion
	  C. No inclusion (costs must be paid in full by the user or by a commercial insurance policy)
	
	Please specify any conditions for obtaining health care coverage, such as length of stay, residing in a State facility, etc. (Ignore the conditions which have to be satisfied in order to be classed as a 'migrant' rather than a 'visitor'.)
		A
		
		11
		AT, EE, FI, DE, GR, IT, LT, RO, SI, SE, SK
			B
			
			16
			BE, BH, HR, CY, DK, FR, HU, IS, IE, LU, MT, NL, PT, ES, CH, UK
				C
				
				7
				BG, CZ, LV, MK, NO, PL,TU

3b	**Undocumented migrants: extent of coverage**
	  A. Same coverage as nationals
	  B. More than emergency care, but less than for nationals
	  C. Emergency care only (or none if no inclusion)
		A
		
		5
		BE, CH, FR, LU, NL
			B
			
			7
			DK, ES, IE, IT, MT, RO, SE,
				C
				
				22
				AT, BH, BG, CY, CZ, DE, EE, FI, GR, HR, HU, IS, LT, LV, MK, NO, PL, PT, SI, SK, TU, UK

The answers to questions 3a and 3b are cross-tabulated in the following table:

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[24] Our results may differ from those of other surveys, in which what we call 'exemptions' are included in the concept of 'coverage'.

		3a Conditions of coverage		
		1 - unconditional	**2 – some conditions**	**3 – no inclusion**
3b Extent of coverage	**1 - Same as nationals**	**0**	**5** BE, CH, FR, LU, NL	**0**
	2 - Less than nationals, more than emergency care	**3** IT, RO, SE	**4** DK, ES, IE, MT	**0**
	3 - Emergency care only	**8** AT, EE, FI, GR, DE, LT, SI, SK	**7** BH, HR, CY, HU, IS, PT, UK	**7** BG, CZ, MK, LV, NO, PL, TU

The bottom row of this table corresponds to the situations a, b and c described above. It can be noted that 9 countries allow emergency care but insist that it must be paid for.

Question 1a: Conditions of coverage

The different conditions which may be imposed on coverage are summarised below:

	no.	Countries
Unconditional inclusion (if only for emergency care)	11	AT, EE, FI, DE, IT, LT, RO, SI, SK, SE, GR
Inability to pay own medical bills	11	BE, BH, HR, DK, FR, HU, IS, IE, NL, PT, UK
Must join SHI and pay premiums	2	CH, LU
Must have resided longer than 3 months	2	FR, PT
Payment of €10 euros per consultation	1	CY

Question 1b: Limitations on the basket of services provided

Apart from the special exemptions described in question 3c, 22 countries (71% of the total) cover only emergency care. Seven provide more than emergency care, while 5 cover all services.

- *Emergency care* is defined in various ways. For example, in CY it refers to care obtained at an emergency department (which, as we saw in the case of legal migrants, may not necessarily be 'acute' or 'life-saving'). In NO it refers to emergency treatment and "absolutely essential medical assistance, defined as health care that cannot be delayed for more than 3 weeks without endangering life, risk of permanent, severe loss of function, serious injury or strong pain."

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- *More than emergency care, but less than full coverage* includes 'further care' after an emergency admission in DK, 'essential care' (in practice interpreted as emergency care, but in principle broader) in IE, and 'urgent and essential' care in IT, defined as follows:

  - **urgent care** means the treatments that cannot be delayed without endangering the lives or causing damage to the health of individuals;
  - **essential care** means the healthcare, diagnostic and therapeutic services relating to pathologies that are not dangerous immediately and in the short term, but that over the time might determine a higher risk for human health or lives (complications, chronic conditions or worsening).
    Furthermore, the principle of the continuity of urgent and essential care was reaffirmed, in the sense of providing patients with a complete therapeutic and rehabilitative cycle relating to the possible elimination of the disease.

In ES the basket of services allowed to UDMs varies between regions and service providers, while in MT coverage is at the discretion of the service provider. In RO UDMs may access "family medicine, family planning and consultations for serious diseases", while in SE only "care that cannot be postponed" is provided.

- 'Same as nationals' includes the basket of services regarded as necessary for national citizens (i.e. not requiring supplementary insurance), although there may be some relatively minor limitations. In CH and LU UDMs are included in the national SHI system and enjoy the standard coverage. In FR *in vitro* fertilisation and some prostheses are excluded, while in NL care for a UDM who is about to be deported can be confined to that which is immediately necessary. In BE the name of the system for UDMs refers to 'Urgent Medical Aid', but in reality coverage is not confined to urgent cases and can include the full range of services available to nationals. (In some cases, e.g. treatment of trafficked persons, it may include even more.) However, in BE all coverage is at the discretion of a physician.

We see from the above that countries have exercised great creativity in the definition of coverage for UDMs, but the definitions remain elastic and urgently in need of harmonisation. The unpredictability of coverage can be a serious barrier to making use of it, because UDMs accessing health care run the risk of being saddled with potentially catastrophic health costs if they make a wrong estimate of their eligibility for coverage.

Question 1c: Special exemptions from restrictions

3c	Undocumented migrants: special exemptions	Three or more exemptions	One or two exemptions	No exemptions
	A. antenatal and/or perinatal and/or postnatal care B. infectious disease (e.g. TB, HIV/Aids) C. care for minors (or for unaccompanied minors if other minors are covered) D. care for vulnerable groups (e.g. victims of torture, trafficking or traumatisation) E. other (specify) Score Option 1 if full coverage for this group is granted anyway (Option 1 in 1a and 1b)	**15** BE, BG, CY, DK, EE, ES, GR, HR, IT, NO, PT, RO, SE, SI, UK	**16** AT, BH, CZ, DE, FI, FR, HU, IE, IS, LT, LU, LV, MK, NL, PL,TU	**3** MT, CH, SK

These exemptions refer to conditions in which restrictions are suspended on humanitarian or public health grounds. We have not given a breakdown of the frequencies of differences because of the limitations already noted (definitions are variable and legislation is sometimes unclear about whether an exemption applies to undocumented migrants).

Question 5: Administrative barriers

| 5 | Administrative discretion and documentation for undocumented migrants
A. Administrative demands for documents which may be difficult for migrants to produce
B. Coverage for migrants may depend on decisions with uncertain outcome.
Examples of A: proof of low income on the basis of tax returns; identity documents available only from the police; proof of address from local authority records.
Examples of B: Decisions made by administrators (receptionists, managers or committees), health workers making clinical judgements about criteria for entitlement such as 'urgency', financial departments deciding how rigorously to pursue unpaid bills, etc. | Neither

1
CH | A or B

13
A (3):
FR, LU,TU

B (10):
CY, CZ,GR, HU, IS, IT, NL, NO, PL, SE | A and B

20
AT, BE, BH, BG, HR, DK, EE, FI, MK, DE, IE, LV, LT, MT, PT, RO, SK, SI, ES, UK |

These barriers are significantly more frequent for UDMs than for asylum seekers or legal migrants (see lower table on next page).

B. Documents required to obtain health care coverage vary greatly and it is not always easy to estimate how difficult they will be for UDMs to provide. At one extreme, HR and LV require the UDM to present an official ID, which in HR can only be obtained from the police. In LV the government's view is that this should encourage undocumented migrants to register with state authorities (which often means detention). Since 2011, UDMs in PT have to prove their 'financial need' (*and* that of all family members) using documents that they are very unlikely to possess. At the other end of the scale, the requirement to provide an address may simply intended to make follow-up care possible, though for a UDM it is always potentially dangerous to reveal where they live. Moreover, health systems today are increasingly automated, and access without an electronic 'health card' can present a substantial barrier.

C. Discretion most often concerns a clinical judgement about whether a situation constitutes an 'emergency' (or a similar criterion). However, discretion may also enter into judgements about financial need. The predictability of coverage for UDMs is undermined by this sort of discretionary judgement in no less than 30 out of 34 countries (88%). In NL the care allowed is (in theory) not subject to discretionary judgements, because all care belonging to the basic package is allowed: here, the administrative discretion concerns the amount of effort which a service provider puts into chasing up unpaid bills.

On the next page is a graph showing scores for UDMs on Section A for all 38 countries. It can be seen that scores are much lower than those of legal migrants (on average, only half). There is also an extremely wide range of values: from 8 in MK and LV to 75 in CH. As with the

other categories of migrant, EU15 countries usually give more generous entitlements than post-2000 accession countries. Positive exceptions to this rule are CY, RO and HU; negative ones are UK, PT, DE, FI and AT. There are wide variations in the 'traditional countries of immigration', with very low scores for US

Key to colours:
Blue: EU15 countries
Purple: EFTA countries
Green: post-2000 accession countries
Yellow: EU neighbour countries

Entitlement score - undocumented migrants
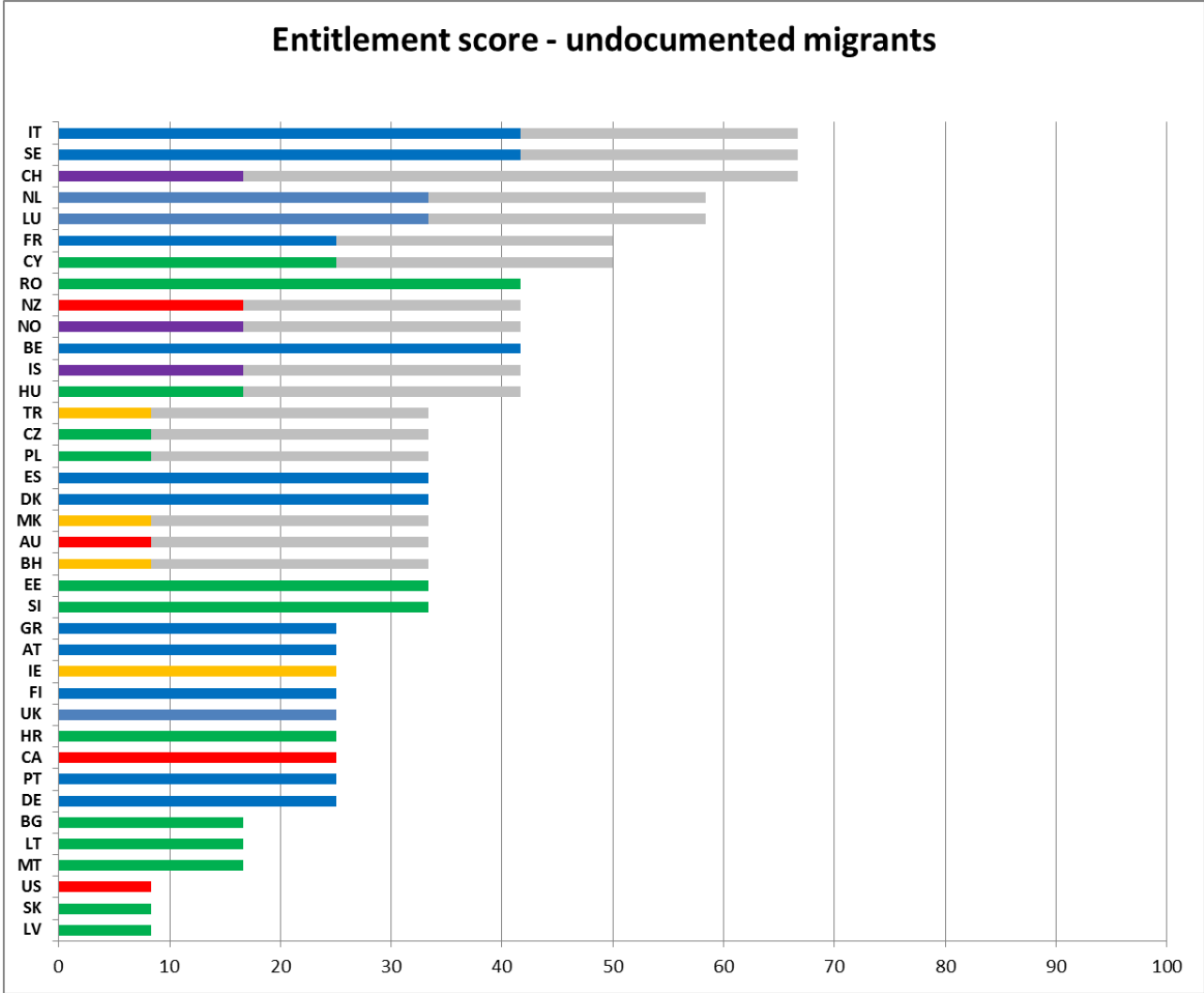
Results for all groups

The following graph shows that administrative barriers make a major contribution to the drop in entitlement scores across categories of migrants. For undocumented migrants, the problem lies just as much in the higher administrative barriers as in the lower legal entitlements.

Contributions of legal entitlement and administrative barriers to to scores on Section A (Entitlement) for three groups of migrants

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Average of all groups
It makes sense to average entitlements for all groups because there is a degree of intercorrelation between the scores of legal migrants, asylum seekers and UDMs (Cronbach's alpha = .61). As discussed in Section E, however, there is no particular reason why the scores for the three groups should be given equal weight in calculating the average.
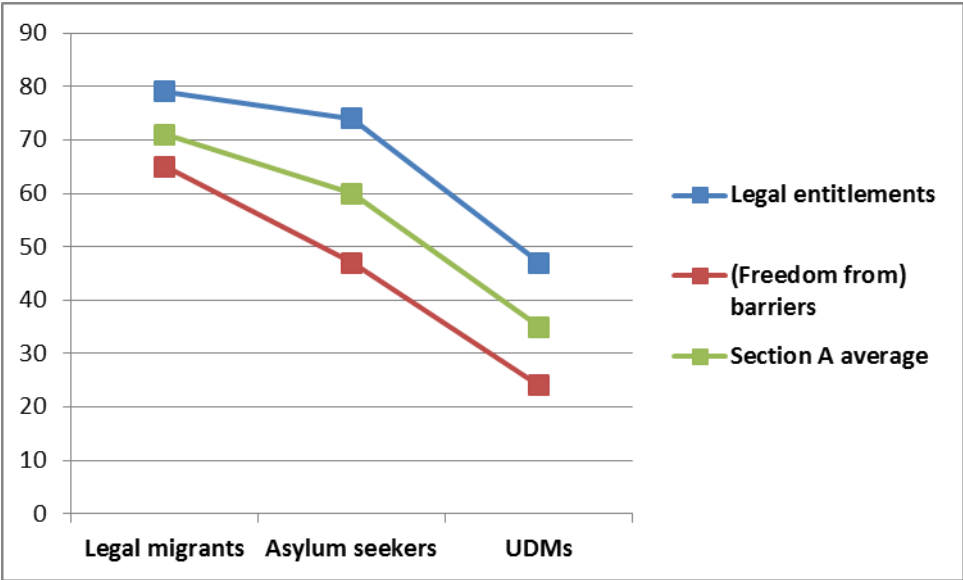
Key to colours:
Blue: EU15 countries
Purple: EFTA countries
Green: post-2000 accession countries
Yellow: EU neighbour countries

Entitlement score - average of all groups
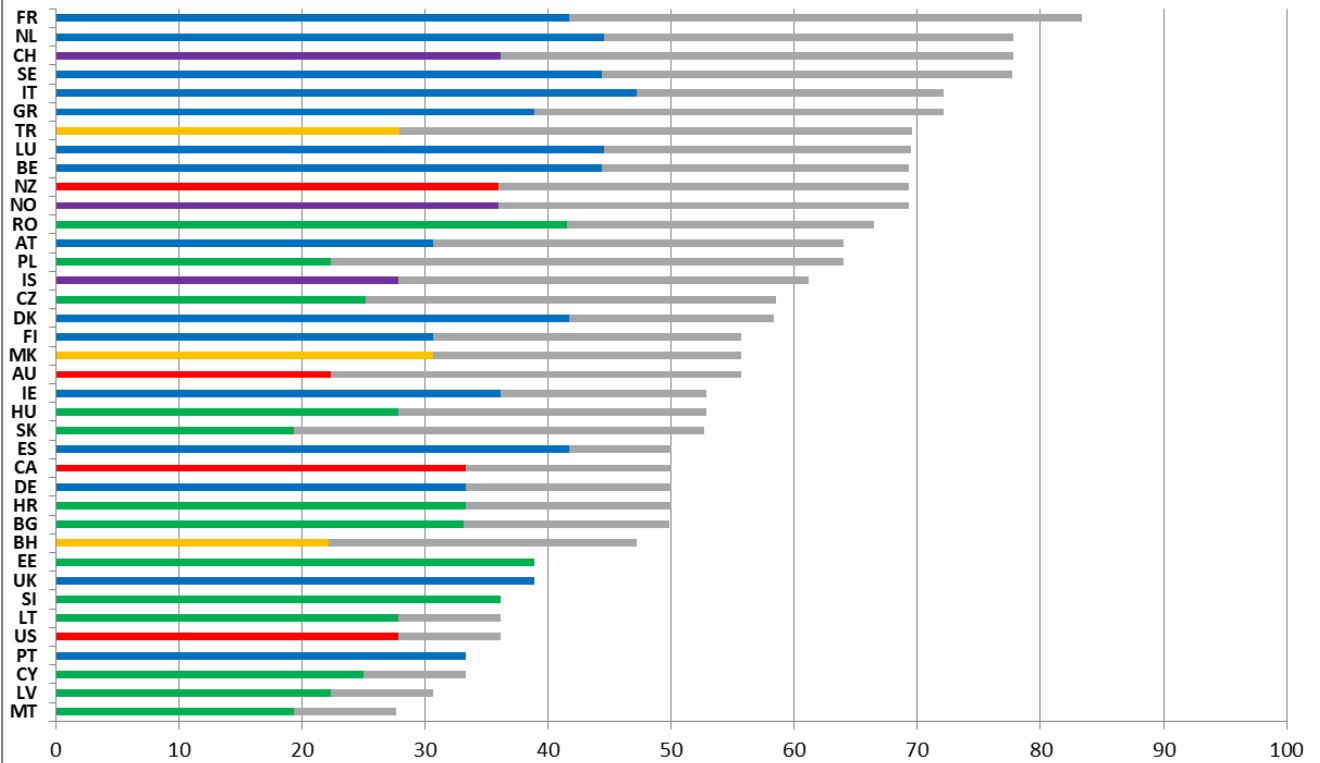
B. Policies to facilitate access

In contrast to Section A, scores on other sections are not presented separately for the three migrant groups. Some differences between groups in levels of provision were noted which will be are described below, but after experimenting with separate scores for Section B it was decided that a single score would suffice. This is because scores for the three groups were quite strongly intercorrelated: a country with a high score for legal migrants on Section B tended also to have a high score for asylum seekers or undocumented migrants (Cronbach's alpha = .86). Whether combined or separate scores were used had little effect on a country's rank on Section B.

Nevertheless, it should be borne in mind that the level of information provision for undocumented migrants (questions 8 and 9) is not as good as it is for legal migrants, although for asylum seekers it is at least as good if not better. It should also be borne in mind that it is difficult to give accurate separate scores on provision of information, because information intended for legal migrants (e.g. on websites) may also be read by undocumented migrants. UDMs are also slightly less well provided with intercultural mediators than the other two group. The advantage of separate scores is that question 12 on reporting on undocumented migrants is not included in the section total for other migrants. However, since question 12 has a reasonable item-total correlation with the rest of Section B (.40), this is not likely to distort total scores to a significant extent.

Scores on individual questions

Since it has been frequently reported by other studies that service providers appear to be badly informed about migrants' entitlements to care, **question 7** addressed this issue.

7	**Information for service providers about migrants' entitlements** A. Service provider organisations receive up-to date information on migrants' entitlements. B. Organisations pass on up-to-date information about these entitlements to their employees.	*Both A and B* **4** BH, FI, MK HU	*Only one of these (please specify)* **16** BE, HR, CY, CZ, EE, FR, GR, IT, NL, NO, PT, RO, ES, SE, CH, UK	*Neither* **13** BG, DK, DE, IS, IE, LV, LT, LU, MT, PL, SK, SI, TU

When only one answer was checked, it was usually because information was available to service providers but not systematically passed on to employees. Only four countries were regarded as satisfying both conditions, so it is clear that improved policies are badly needed.

Question 8 examined the provision of information about entitlements for migrants:

8a	Information for migrants concerning entitlements and use of health services
	
	Method of dissemination
	  A. websites
	  B. brochures in public places
	  C. 'one-stop shops'
	  D. classes or individual instruction
	  E. other (specify)
		More than one of these (specify)
		
		22
		AT, BE, CH, ES, FR, IE, IS, PT, SI, CY, MT, NO, RO, SE, BH, CZ, EE, LU, LV, PL, TU, NL
			One of these (specify)
			
			11
			IT, FI, GR, SK, DE, DK, HR, LT, UK, BG, MK
				None of these
				
				1
				HU

Only Hungary appears not to provide any information for migrants about their entitlements. The following graph shows the relative popularity of different methods (i.e. the probability that a country will use them):
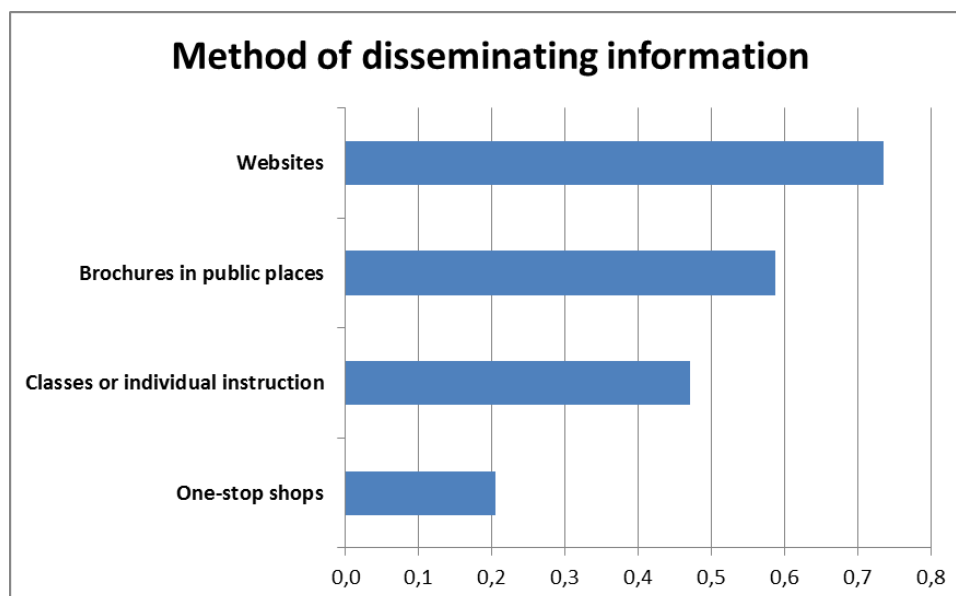
The next table speaks for itself:

8b	Number of languages in which information for migrants concerning entitlements and use of health services is available (not including the official languages of the country or English)	*Four or more languages (specify)* **22** AT, BE, CH, CY, DK, ES, FI, FR, GR, HR, IE, IS, IT, MT, NO, PL, PT, RO, SE, SI, SK, UK	*1 – 3 languages (specify)* **8** BG, CZ, DE, EE, LT, LU, LV, TU	*None* **4** BH, HU, MK, NL

Lastly, **question 8c** looks at the provision of information about entitlements to different groups of migrants.

8c	**Groups reached by information for migrants on entitlements and use of health services** A. Legal migrants B. Asylum seekers C. Undocumented migrants *Skip this question if answered Option 3 to question 8a*	*All three groups*	*Only two groups (please specify)*	*Only one group (please specify)*
		10 BE, BH, CH, ES, FR, IE, IS, IT, PT, SI	**18** AT, CY, CZ, DE, EE, FI, GR, LT, LU, LV, MK, MT, NL, NO, RO, SE, SK, TU	**5** BG, DK, HR, PL, UK

This table shows the number of countries providing information for each group:

Legal migrants	**27**
Asylum seekers	**29**
UDMs	**13**

We see that UDMs are less than half as often targeted as the other two groups.

Question 9 has exactly the same structure, but investigates health education and health promotion. Later it was discovered through factor analysis that this question would have been equally at home in Section C on the responsiveness of health services, but it has been left here (see section IV.A of this report).

9a	**Health education and health promotion for migrants** ***Method of dissemination*** A. websites B. brochures in public places C. 'one-stop shops' D. classes or individual instruction E. other (specify) (Please mention in the Comments box whether content is adapted to take account of cultural differences, and if so how.)	*More than one of these (specify)*	*One of these (specify)*	*None of these*
		13 AT, BE, CH, DK, FI, IE, IS, LU, MT, PT, RO, SE, TU	**14** BG, BH, CY, DE, EE, ES, FR, IT, LT, NL, NO, PL, SK, UK	**7** CZ, GR, HR, HU, LV, MK, SI

Health education and promotion are less often provided than information about entitlements, but the relative popularity of different methods of dissemination is roughly the same, so we have not reproduced the analysis reported above for question 8.

The next two sub-questions address the number of languages used and the migrants groups which are targeted:

9b	**Number of languages in which health education and health promotion are available** (not including the official languages of the country or English)	*Four or more languages (specify)*	*1 – 3 languages (specify)*	*None*
		14 AT, BE, BH, CH, DK, ES, FI, FR, IE, IS, IT, MT, NO, PL, PT, SE, UK	**8** BG, DE, EE, LT, LU, NL, RO, TU	**9** CY, CZ, GR, HR, HU, LV, MK, SI, SK
9c	**Groups reached by health education and health promotion** A. Legal migrants B. Asylum seekers C. Undocumented migrants *Skip this question if answered Option 3 to question 9a*	*All three groups*	*Only two groups (please specify)*	*Only one group (please specify)*
		13 AT, BH, CH, ES, FI, FR, IE, IS, IT, PT, SE, SK, UK	**10** BE, CY, DE, LT, LU, MT, NL, NO, RO, TU	**4** BG, DK, EE, PL,

Seven countries offer no health education or health promotion. The number of countries providing it for each group (out of 34) is as follows:

Legal migrants	23
Asylum seekers	25
UDMs	15

Question 10 on practical barriers had to be dropped from the questionnaire (see Part D above). **Question 11** concerns the use of 'cultural mediators' or 'patient navigators' to help migrants find the way to health care.

11a	**Provision of 'cultural mediators' or 'patient navigators' to facilitate access for migrants**	*Guaranteed across the system or in major immigrant areas*	*On a smaller or ad hoc basis*	*Not available*
		2 BE, IS	**15** AT, BH, CH, CZ, DE, DK, FI, FR, IT, LT, LU, MT, NL, SE, SK	**17** BG, CY, EE, ES, GR, HR, HU, IE, LV, MK, NO, PL, PT, RO, SI, TU, UK

Cultural mediation seems to be used in only half of the 34 countries. It is not (or hardly) used in DK, IE, RO, NO, SE, ES and PT, even though these countries score above the median on Section B. In ES and PT this is due to cuts resulting from austerity measures.

The number of groups for which cultural mediators are provided is as follows:

| 11b	Groups for which cultural mediators are provided A. Legal migrants B. Asylum seekers C. Undocumented migrants *Skip this question if answered Option 3 to question 11a*	*All three groups* **5** CH, FR IS, IT, LU	*Only two groups (please specify)* **10** AT, BE, BH, CZ, DE, LT, MT, NL, SE, SK	*Only one group (please specify)* **2** DK, FI

In terms of groups reached the totals are:

Legal migrants	15
Asylum seekers	13
UDMs	9

Question 12 applies only to undocumented migrants: the table speaks for itself. Legal deterrents for UDMs seeking medical help and health workers aiding them must be regarded as a serious matter even where it is claimed that they are seldom or never used.

12a	No obligation to report undocumented migrants Are healthcare professionals or organisations required to report undocumented migrants to the police or immigration authorities?	*Explicitly forbidden in law and/or professional codes of conduct* **10** CH, CZ,DK, ES, FR, IS, IT, NL, NO, PT	*No relevant legislation or professional codes of conduct* **18** AT, BE, BG, CY, EE, FI, MK, GR, HU, IE, LV, LT, LU, MT, PL, RO, SK, TU	*Explicitly required in law* **6** BH, HR, DE, SI, SE, UK
12b	No sanctions against helping undocumented migrants Are there legal or organisational sanctions against healthcare professionals or organisations assisting undocumented migrants?	*No legal sanctions or other pressures on professionals to deter them from helping migrants who cannot pay* **23** AT, BG, BH, CH, CY, CZ, DK, EE, ES, FI, FR, HU, IE, IS, IT, LV, MT, NO, PL, PT, RO, SE, SK	*Only organisational sanctions exist (organisations discourage carers from helping migrants who cannot pay)* **7** BE, LT, LU, MK, NL, SI, UK	*Legal sanctions exist against helping undocumented migrants* **4** DE, GR, HR, TU

Graph showing scores on scale B (Accessibility)
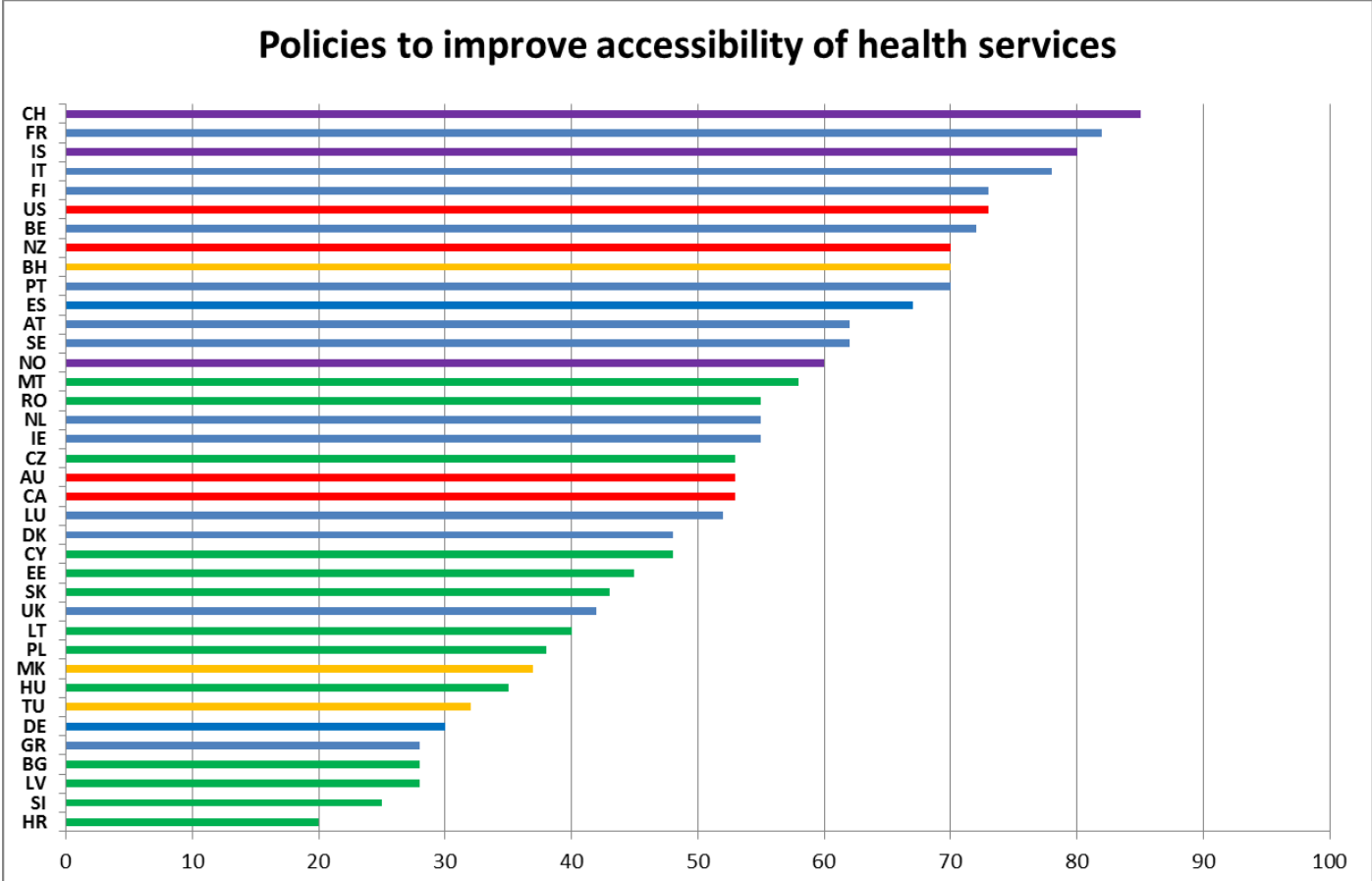
Policies to improve accessibility of health services

Key to colours:
Blue: EU15 countries
Purple: EFTA countries
Green: post-2000 accession countries
Yellow: EU neighbour countries
Red: Non-European countries

Conclusion

As with Entitlements, it is noticeable that the EU15 countries tend to score much better than post-2000 accession countries. The overall impression from this section is that there are serious gaps in information provision, not just to migrants but also to the service providers and health workers themselves. Relatively simple and inexpensive measures could make services much more accessible for migrants by disseminating up-to-date information about entitlements, how and when to use health services, and how to look after one's own health. Although websites need to be made available in several different languages, they are an obvious way of disseminating this information to large numbers of migrants. The development of 'apps' for mobile telephones is also a promising line of innovation.

C. Responsive health services

This section measures the extent to which health services are adapted to meet the special needs of migrants. This mainly involves tackling linguistic barriers and improving understanding between migrants and health workers. **Question 13** deals with interpretation:

13a	**Availability of qualified interpretation services** for patients with inadequate proficiency in the official language(s)	*Interpreters are available free of charge to patients*	*Interpreters are available but patients must pay all (or a substantial part) of the costs*	*No interpretation services available*
		15 AT, BE, DK, FI, DE, IS, IE, IT, LU, NO, PT, ES, SE, CH, UK	**5** CZ, FR, HU, MT, NL	**14** BH, BG, HR, CY, EE, MK, GR, LV, LT, PL, RO, SK, SI, TR
13b	**Methods used for interpretation** a. Face-to-face b. Telephone interpretation c. Interpretation by video link d. Credentialed volunteers e. Employment of 'cultural mediators' f. Employment of competent bilingual or multilingual staff	*Three or more methods are available (please specify)*	*One or two methods are available (please specify)*	*None of these methods are available*
		14 AT, BE, CH, CZ, DE, FI, IE, IT, LU, MT, NL, NO, SE, UK	**6** DK, ES, FR, HU, IS, PT,	**14** BG, BH, CY, EE, GR, HR, LT, LV, MK, PL, RO, SK, SI, TR

Only in 20 countries is interpretation offered, to any extent, as a matter of policy. The following graph show the probability that a given method is used in these countries:

Methods of interpretation
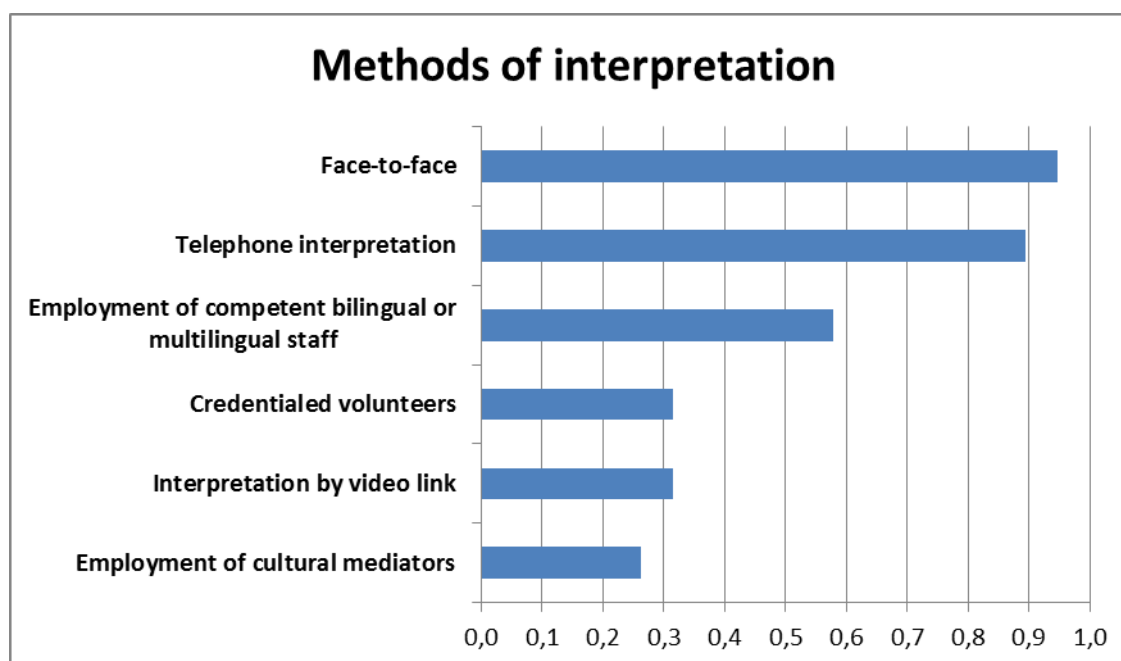
Question 14 deals with requirements for 'culturally competent' or 'diversity-sensitive' services. Over half (19) of the countries in the sample have no such requirements; in none of the countries that have them, standards are never monitored by a relevant authority (as is the case, incidentally, in AU, NZ and US).

Question 15 shows that 15 countries have no provision for training staff in the necessary skills. This includes BH, BE, IS and HU, despite the existence of (local) standards or guidelines in these countries which staff are supposed to follow..

14	**Requirement for 'culturally competent' or 'diversity-sensitive' services** Standards or guidelines require that health services take account of individual and family characteristics, experiences and situation, respect for different beliefs, religion, culture, competence in intercultural communication. A. Standards or guidelines exist on "culturally competent' or "diversity- sensitive" services B. Compliance with these standards or guidelines is monitored by a relevant authority	*A and B* **0**	*Only A* **15** AT, BE, BH, CH, DE, DK, FI, HU, IE, IS, IT, MT, NL, RO, UK	*Neither of these* **19** BG, CY, CZ, EE, ES, FR, GR, HR, LT, LU, LV, MK, NO, PL, PT, SE, SI, SK, TU
15	**Training and education of health service staff** Policies exist to support training of staff in providing services responsive to the needs of migrants. Training may be part of basic professional education and/or in-service professional development (please specify which)	*At national level* **3** CH, NO, UK	*At local or organisational level* **16** AT, CY, CZ, DE, DK, ES, FI, FR, IE, IT, LU, MT, NL, PT, RO, SE	Neither of these **15** BE, BG, BH, EE, GR, HR, HU, IS, LT, LV, MK, PL, SI, SK, TU

Question 16 concerns the involvement of migrants in health services. In today's Europe, many health workers are themselves migrants; however, this question only concerns activities they carry out as a result of policies to increase migrant involvement. However, just over half the countries surveyed do not involve migrants in such ways.

16	**Involvement of migrants in information provision, service design and delivery** A. Migrants are involved in service delivery (e.g. through the employment of 'cultural mediators') B. Migrants are involved in the development and dissemination of information C. Migrants are involved in research (not only as respondents) D. Migrant patients or ex-patients are involved in the evaluation, planning and running of services. E. Migrants in the community are involved in the design of services. *Mention only forms of migrant involvement that are explicitly encouraged by policy measures (at any level)*	*Three to five of these (please specify)* **3** AT, IE, UK	*One or two of these (please specify)* **13** CH, CZ, DE, DK, ES, FI, HU, IT, MT, NL, NO, RO, SE	*None of these* **18** BE, BG, BH, CY, EE, FR, GR, HR, IS, LT, LU, LV, MK, PL, PT, SI, SK, TU

This graph shows the probability, in the 16 countries that do involve migrants, of their being involved in different ways.

How are migrants involved in health services?
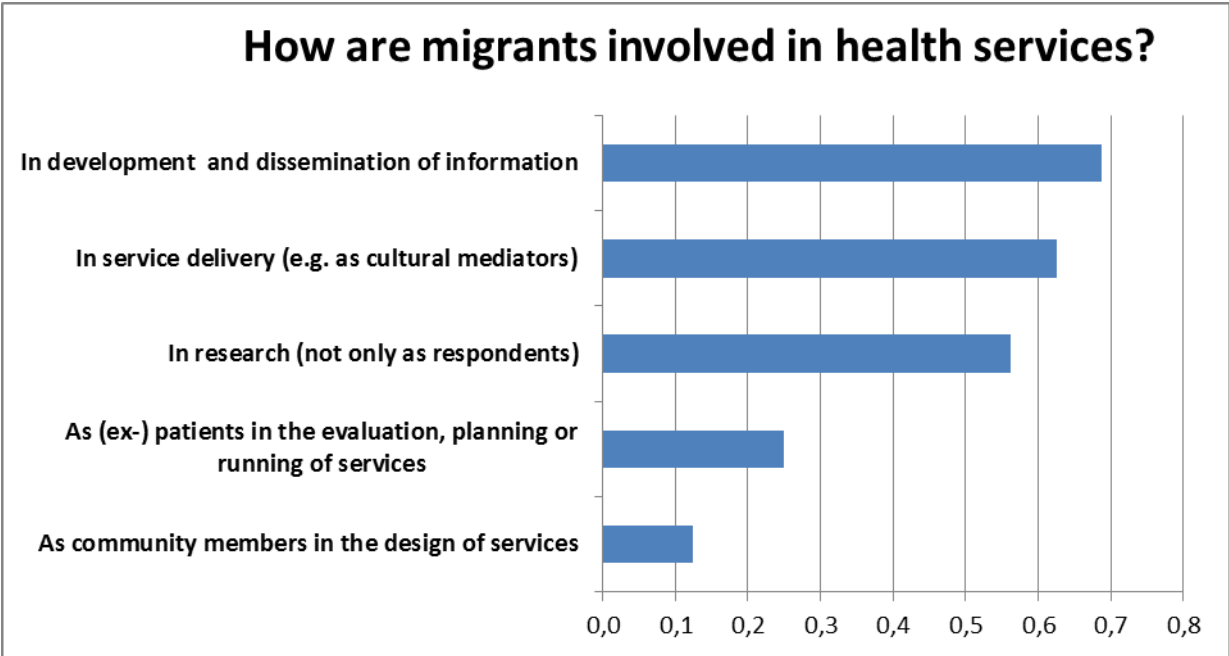
The answers to these questions can be compared with those to question 24b on migrants' contribution to health policymaking at national or regional level. There is a slight but significant correlation between the answers to these two questions.

Question 17 concerns measures to increase the diversity of the health service workforce. Only a quarter of the countries had such measures and respondents were often unsure about the precise reasons for their existence.

17	Encouraging diversity in the health service workforce Recruitment measures (e.g. campaigns, incentives, support) to encourage participation of people with a migrant background in the health service workforce: *This question does not concern policies aimed at recruiting or employing health care professionals from abroad because of a national shortage of staff.*	*At national level* **2** SE, UK	*At local or organisational level* **7** AT, BE, DE, HU, LT, LU NO	*Neither of these* **25** BG, BH, CH, CY, CZ, DK, EE, ES, FI, FR, GR, HR, IE, IS, IT, LV, MK, MT, NL, PL, PT, RO, SI, SK, TU

All the other adaptations described in the section concerned improvements to the way services are delivered, but **question 18** examined the willingness to vary diagnostic procedures and treatment methods. Most countries fell in the middle category: adaptations were tolerated but not encouraged.

| 18a	Development of capacity and methods Diagnostic procedures and treatment methods are adapted to take more account of variations in the sociocultural background of patients	*Policies exist to encourage the adaptation of diagnostic procedures and treatment methods to sociocultural diversity* **2** CH, UK	*Adaptation of diagnostic procedures and treatment methods is to a limited extent tolerated, but not encouraged* **18** AT, BE, BH, CY, DE, DK, ES, FI, FR, HU, IE, IT, LU, MT, NL, NO, PT, SE	*Policies are exclusively focused on standardising diagnostic procedures and treatment methods* **14** BG, CZ, EE, GR, HR, IS, LT, LV, MK, PL, RO, SI, SK, TU

18b	Specific forms of the above Policies exist to encourage: A. Development of treatments for health problems specific to certain migrant communities (e.g. female genital mutilation, effects of torture, rare import diseases, genetic risk factors) B. Adaptation of standard treatments for routine health problems in order to better serve migrant communities C. Use of complementary and alternative 'non-Western' treatments for physical and mental health problems	*All three of these (please specify)* **2** AT, UK	*One or two of these (please specify)* **18** BH, CY, FR, PT, ES, BE, HU, LU, DK, MT, NL, FI, IT, SE, DE, NO, IE, CH	*None of these* **14** BG, CZ, EE, GR, HR, IS, LT, LV, MK, PL, RO, SI, SK, TU

Among the 20 countries in which methods are adapted, the following table shows the probability of finding each of the three different types:

Adapting diagnostic methods and treatments

63
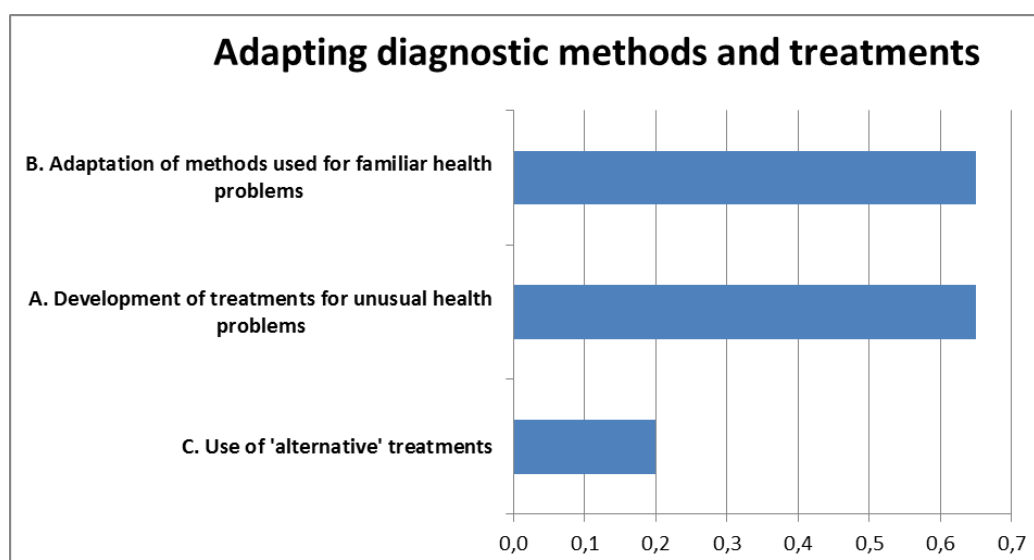
Graph showing scores on scale C (Responsiveness)
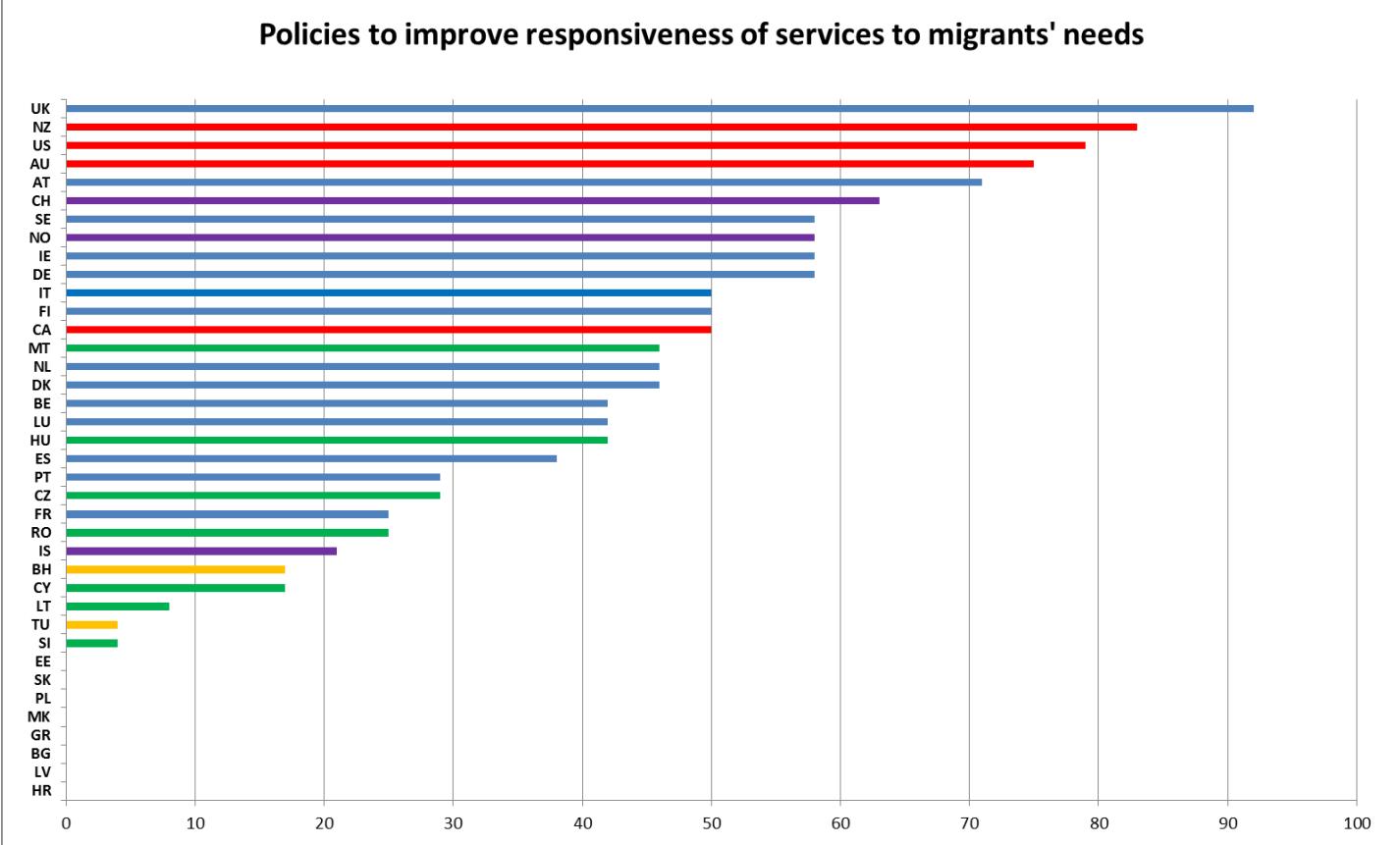
Policies to improve responsiveness of services to migrants' needs

Key to colours:
Blue: EU15 countries
Purple: EFTA countries
Green: post-2000 accession countries
Yellow: EU neighbour countries
Red: Non-European countries

The wide range of this scale is striking. At the bottom are 8 countries that score zero, while 6 score over 70. It is notable that the English-speaking countries, where the concept of 'cultural competence' has been known for decades, all have high scores (except for Canada, where the last government rolled back some 'multicultural' programmes).

D. Measures to achieve change

This section deals with measures taken to stimulate and coordinate improvements in policies on migrant health and with 'flanking measures' necessary to support good policies. **Questions 19 and 20** deal with data collection and research:

19	**Collection of data on migrant health** Data on migrant status, country of origin or ethnicity is included in medical databases or clinical records**.** Choose Option 1 if linkage between medical databases and national databases containing the above personal information is practically possible.	*Inclusion of such information is mandatory* **11** BG, BH, CH, DK, IT, MT, NL, NO, SE, SK, UK	*Inclusion of such information is optional* **15** AT, BE, CY, DE, ES, FI, GR, HU, IE, LT, LU, LV, MK, PT, RO	*Such information is never included* **8** CZ, EE, FR, HR, IS, PL, SI, TU
20	**Support for research on migrant health** Funding bodies have in the past five years supported research on the following topics: A. occurrence of health problems among migrant or ethnic minority groups B. social determinants of migrant and ethnic minority health C. issues concerning service provision for migrants or ethnic minorities D. evaluation of methods for reducing inequalities in health or health care affecting migrants or ethnic minorities	*Three or four topics (please specify)* **17** AT, BE, BG, CH, CZ, DE, DK, ES, FI, IT, MK, MT, NL, NO, PT, SE, UK	*One or two topics (please specify)* **12** BH, CY, EE, FR, GR, HU, IE, LT, RO, SI, SK, TU	*None of these topics* **5** HR, IS, LU, LV, PL

There are still countries in which data on migrant health is not routinely available and research is not supported. In the 29 countries where support is provided, the probability of research on a given topic being supported is as follows:
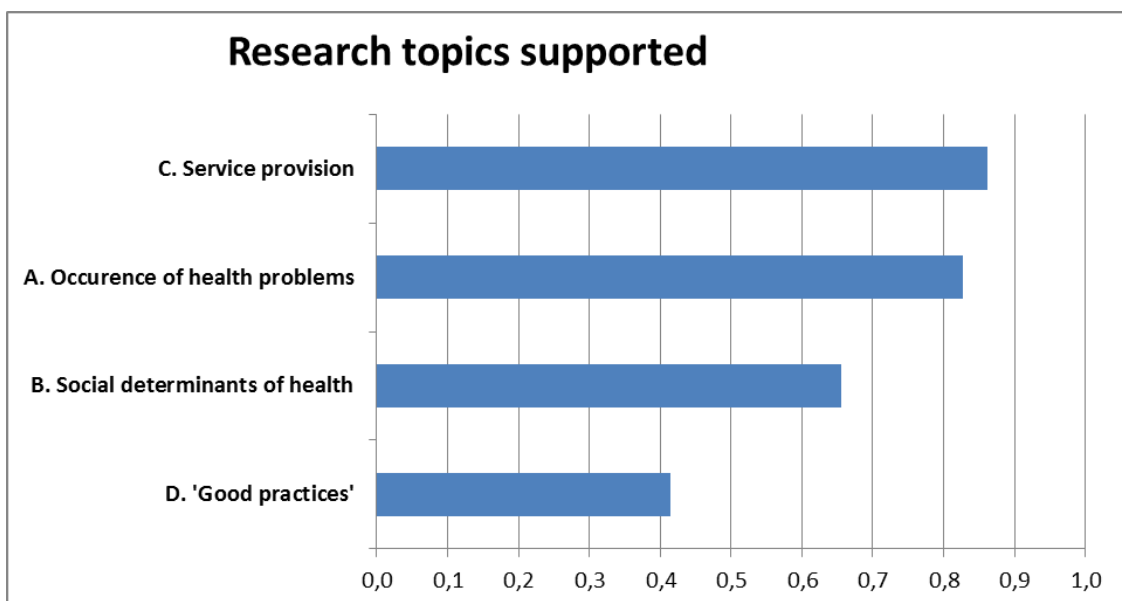
Question 21 reveals that a "health in all policies" approach is practically unknown in most countries:

21	**"Health in all policies" approach** Attention to the health impact of all policies	*Mandatory consideration of the impact on migrant or ethnic minority health of policies in other sectors than health*	*Ad hoc consideration of the impact on migrant or ethnic minority health of policies in other sectors than health*	*No consideration taken of the impact on migrant or ethnic minority health of policies in sectors other than health*
		1 UK	**6** AT, BH, ES, FI, IE, IT	**27** BE, BG, CH, CY, CZ, DE, DK, EE, FR, GR, HR, HU, IS, LT, LU, LV, MK, MT, NL, NO, PL, PT, RO, SE, SI, SK, TU

Question 22 addresses the issue of 'mainstreaming' versus categorical approaches to service provision for migrants. In the 38% of all countries (13) which pay systematic attention to migrant health issues, 9 regard them as only a priority for specialised departments or organisations, versus 4 for all organisations.

22	**Whole organisation approach** Migrant or ethnic minority health is a priority throughout service provider organisations and health agencies ("integrated" versus "categorical" approach).	*Commitment to providing equitable health care for migrants or ethnic minorities is present in all departments of service provider organisations and health agencies*	*Concern for migrant or ethnic minority health is regarded as a priority only for specialised departments or organisations*	*No systematic attention is paid to migrant or ethnic minority health in any part of the health system. Measures are left to individual initiative*
		4 IE, NO, SE, UK	**9** AT, BH, CH, DK, ES, IT, MK, MT, NL	**21** BE, BG, CY, CZ, DE, EE, FI, FR, GR, HR, HU, IS, LT, LU, LV, PL, PT, RO, SI, SK, TU

Question 23 examines the extent to which government gives leadership in achieving change. Only in IE and NO is a government plan published which is also implemented. In 15 countries policies are introduced ad hoc; a plan may be published, but it is not implemented (or not to a significant extent). In half the countries surveyed, governments show no leadership on matters relating to migrant health.

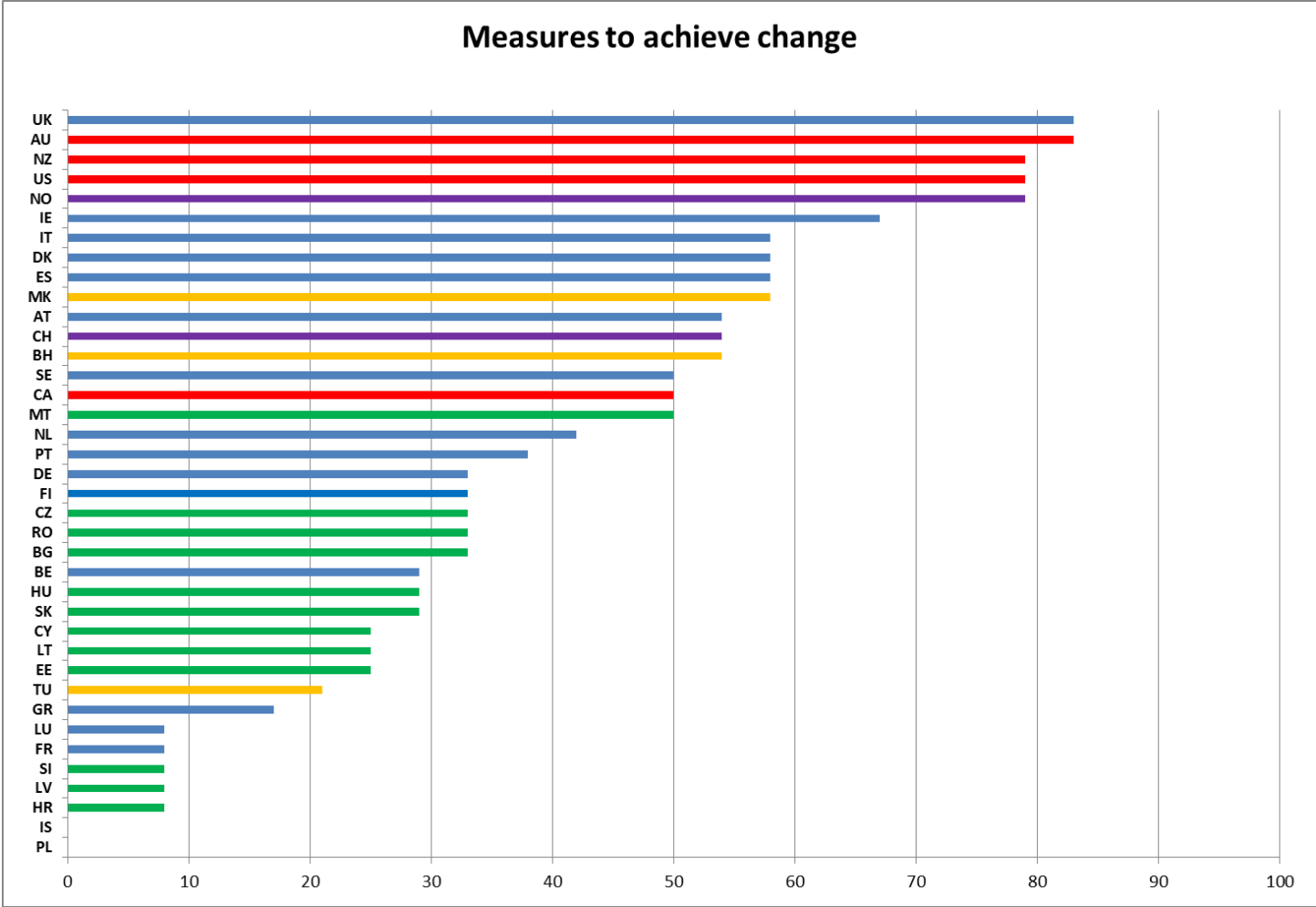| 23	**Leadership by government** A. Government publishes an explicit plan for action on migrant health B. Policies are implemented to support these measures	*A and B*	*Only ad hoc policies introduced on migrant health*	*No policy measures introduced on migrant health*
		2 IE, NO	**15** AT, BH, CH, CY, CZ, DK, EE, ES, HR, HU, MK, PT, RO, TU, UK	**17** BE, BG, DE, FI, FR, GR, IS, IT, LT, LU, LV, MT, NL, PL, SE, SI, SK

Finally, we examine whether stakeholders in general (**question 24a)** and migrant organisations in particular (**question 24b)** are involved in consultations and policymaking on migrant health.

24a	**What is the policy to involve stakeholders in the design of (national or regional) migrant health policies?** Is there an advisory body or centre of expertise promoting cooperation amongst stakeholders on migrant health policy? Note: This can be led by government, service-providers, or NGOs/institutes. Stakeholders include administrative and health authorities at various levels of governance, service providers, health insurers, professional bodies, universities, accreditation agencies, NGOs and commercial organisations. *NB: participation at service provider level is covered by q. 16)*	*Through structural cooperation (e.g. via advisory body or centre of expertise)*	*Through ad hoc cooperation (e.g. during consultations on new health strategy or law or through projects)*	*None*
		3 DK, MK, NO	**18** AT, BE, BH, CH, CZ, DE, EE, ES. HU, IE, IT, LT, MT, PT, RO, SK, TU, UK	**13** BG, CY, FI, FR, GR, HR, IS, LU, LV, NL, PL, SE, SI

In 13 countries there is no consultation with stakeholders, in 3 there are structural bodies which bring stakeholders together, and in 18 there are only ad hoc consultations. The next question shows that structural involvement of migrants themselves is even less common.

24b	**Migrants' contribution to health policymaking at national or regional level** How do migrant stakeholders (e.g. NGO's and CSO's) participate in national policymaking affecting their health? *NB: participation at service provider level is covered by q. 16)*	*Through structural cooperation (e.g. involvement in advisory body or regular review of health legislation, services, and outcomes)*	*Through ad hoc cooperation (e.g. during consultations on new health strategy or law or through projects)*	*Immigrant organisations are not explicitly consulted on health policy.*
		1 MK	**11** CZ, DE, EE, ES, IE, IT, LT, MT, NO, RO, UK	**22** AT, BE, BG, BH, CH, CY, DK, FI, FR, GR, HR, HU, IS, LU, LV, NL, PL, PT, SE, SI, SK, TU

Graph showing scores on scale D (Achieving change)

Measures to achieve change

Key to colours:
Blue: EU15 countries, purple: EFTA countries, green: post-2000 accession countries,
Yellow: EU neighbour countries, red: non-European countries.

What is not clearly visible on the above graph is the association between scores on this section and the way a country finances its health system (taxation or social insurance contributions). This difference is significant at $p < .02$ by T-test.

	N	Score
Tax-based	13	46.8
Insurance-based	21	28.8

This difference could reflect a tendency towards more 'top-down' forms of health system governance in countries with a tax-based system. Alternatively, it may be an indirect relationship, caused by the fact that more concern for equity and the introduction of a tax-based system both reflect some feature of national ideology. It is not caused by a confounder such as GDP or the period in which the country joined the EU, because type of financing is not associated with these variables.

IV.   STATISTICAL ANALYSES

A. Reliability, validity and structure of the scales

How homogenous is the MIPEX Health Strand in the statistical sense? To what extent do all its items 'measure the same thing'? These two questions should not be confused with each other. Researchers often attempt to deal with the second question by answering the first – by calculating the internal reliability of a scale, i.e. the extent to which the items in the scale are correlated with each other. However, this only measures their tendency to vary together. This reflects the extent to which they are affected by the same *determinants,* but it does not tell us whether they have the same *effects.*

To make a valid instrument for MIPEX, however, it is more important that the policies measured should have the same effects than the same determinants. The aim of integration policies in the fields of labour, education, health etc. is to reduce inequities between migrants and nationals in those fields. In theory, the obvious way to validate a collection of policy items would be to examine the extent to which each of the items contributes to reducing the disadvantage of migrants. Indeed, the effects of the policies which MIPEX studies are increasingly being investigated. However, this work is hampered by the well-known problems of all research into the effects of policies: they usually need time to have an effect, and the effect can be obscured by many other uncontrollable factors. In the case of the Health strand, the shortage of good data on unmet needs and utilisation of health services among migrants is a particular obstacle to validation. Nevertheless, such validation should definitely be a goal of future research.

In the meantime, measuring the homogeneity of the scale is the only way we have of estimating whether its items, in some sense, 'measure the same thing'. The limitations of this approach are immediately obvious when we examine section A on Entitlements. This part of the Health strand measures both the healthcare benefits which the law grants to migrants, and the administrative barriers which stand in the way of their claiming these benefits. In general, laws are made by parliaments but administered by subordinate authorities (in this case, the Health Ministry or regional health authorities). All too often, disjunctions arise which complicate the implementation of the law: often, the rights which Parliament has granted to migrants cannot be exercised because of administrative barriers arising at a lower level. The administrative arrangements are also policies, so the 'implementation gap' results from a clash between policies at different levels.

As we will see later, in our sample of countries legal entitlements and administrative barriers do not correlate statistically with each other. They both impinge on the same target (furthering or frustrating the migrant's right to health care), but their determinants do not seem to be related. This is probably because they are produced by different agencies. (They might, of course, be related in a Machiavellian way: the administrative barriers might sometimes be deliberate, allowing a government to claim that its laws are generous in principle while making sure that little is given away in practice.) Although entitlements and administrative barriers are uncorrelated, it seems logical to combine them in a single score if we want to predict migrant's chances of getting equitable health care coverage.

Another example is found in Section B. Policies to inform service providers about migrants' entitlements show only a weak statistical relationship with other policies designed to make it easier for migrants to reach health services. Here too, different agencies are presumably involved: policies of the first kind are usually a government responsibility, while the second kind are often carried out by NGOs or at a local level. Nevertheless, policies of both kinds affect migrants' knowledge of their entitlements.

Section C contains another item which is only weakly related to the rest of the scale. Question 17 asks about the existence of 'policies to encourage diversity in the health service workforce', but the presence or absence of such policies appears to be only weakly related to others that aim to make services responsive to migrants' needs. According to respondents, such policies are mainly connected with avoiding discrimination in recruitment procedures. Nevertheless, diversity in the workforce can still be regarded as 'migrant-friendly'. Section D has no items with a particularly low item-total correction[25]. This table shows the reliabilities of each section.

Section	No. of items	Alpha
A - Entitlements	6	.54[a]
B - Accessibility	5	.52[b]
C - Responsiveness	6	.87[c]
D –Achieving Change	6	.77

[a] Alpha is .78 for questions 1,2 and 3 on legal rights; for questions 4, 5 and 6 on administrative barriers it is .63.

[b] Alpha rises to.69 if question 7 (Policies to inform health workers about migrants' entitlements) is omitted.

[c] Alpha rises to .88 if question 17 (Encouraging diversity in the health service workforce) is omitted.

The homogeneity of all 23 questions turns out to be high (Alpha = .86). However, this tells us nothing about the structure of the list. To explore this we have to examine the correlations between the four sections, i.e. the degree to which the section totals covary:

B	.38*		
C	.22	.48**	
D	.00	.29	.67**
	A	B	C

*. Correlation is significant at the 0.05 level (2-tailed).
**. Correlation is significant at the 0.01 level (2-tailed).

There is a tendency for each section to correlate with neighbouring sections, while the correlation between sections A and D is zero. This is very interesting, because it suggests that

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[25] In all statistical analyses reported here, the sample is confined to the 34 European countries in the Equi-Health study. To enable comparisons to be made, however, the positions of 4 non-European countries (AU, CA, NZ and US) are also shown on some figures.

measures to achieve change (D) are not related to legal entitlements and administrative barriers; rather, they are strongly related to the responsiveness of health services (section C).

Section D is concerned with the 'flanking measures' that have to be introduced to promote equity in health service provision (data collection, research, prevention, mainstreaming improvements, leadership by government, coordination of efforts and involvement of migrant groups). The lack of correlation between D and A suggest that such measures are not aimed at improving legal entitlements and the way they are implemented. In other words, D is concerned with increasing the responsiveness of health services to migrants' needs (Section C, $r < .67^{**}$), but not to the legal entitlements and administrative procedures which would give more migrants the right to use those services. This suggests that the policies in section D tend to focus on *technical* questions about adapting services better to migrants' needs, rather than *political* questions about improving coverage. This was also a conspicuous feature of the 'cultural competence' movement in the USA towards the end of the twentieth century. The problem that so many migrants and minority group members lacked health insurance was 'the elephant in the room' whose existence was seldom mentioned.

Factor analysis

More insight into the structure of the MIPEX Health strand can be obtained by carrying out a factor analysis on the 23 questions. Principal component analysis was performed on the correlation matrix and the resulting factors were subjected to Varimax rotation. As above, the four 'traditional countries of immigration' were not included in this analysis.

The scree plot suggested that a 3-factor solution is preferable to 2 factors. The percentage of total variance explained by these three factors is 28%, 12% and 9% (total: 49%). This percentage mainly reflects the number of questions that load on each factor, i.e. it mainly reflects the way the scale was constructed. The rotated component matrix for the 3-factor solution is shown below.

- The **first component** includes the items in sections C and D, which together we label 'Quality'. However, question 17 (Encouraging diversity in the workforce) is not included: as we mentioned earlier, this variable is not very strongly related to the rest of Section C.

- The **second component** relates to barriers to access: it combines questions 4,5 and 6 (relating to barriers to claiming entitlement), with questions 8-12 (relating to barriers to reaching services). We saw already that question 7 (information for service providers about entitlements of migrants) does not correlate strongly with other items in Section B and it is not included in this factor.

- The **third component** relates to legal entitlements (questions 1, 2 and 3).

The factor analyses suggests that 'quality' can be treated as a single issue, but that barriers to obtaining entitlement can be distinguished from barriers to reaching services when they are needed. Question 9 (Health education and health promotion for migrants) loads on both access and quality.

Rotated Component Matrix

	Component		
	1	2	3
1	,041	,050	,783
2	,204	,025	,644
3	,130	,033	,759
4	-,088	,519	-,068
5	-,068	,501	-,184
6	-,090	,553	,146
7	,234	-,178	,067
8	,121	,528	,057
9	,558	,578	,145
11	,006	,753	,268
12	,286	,497	-,268
13	,647	,421	,428
14	,553	,290	,070
15	,757	,226	,259
16	,855	,043	,076
17	,338	-,164	,516
18	,774	,196	,348
19	,580	,005	,164
20	,655	-,028	,238
21	,673	-,115	,019
22	,810	-,032	,117
23	,560	-,272	-,352
24	,542	-,322	-,182

Bearing in mind the results from factor analysis, but also the different issues addressed by policies in the four sections, it seems justifiable to simplify matters by dividing the questionnaire in two halves and giving each country two scores.

- The first score, for 'Access', is the sum of Sections A and B. It is concerned with giving migrants the right to use the health system and the ability to reach the services they need.

- The second , for 'Quality'), is the sum of sections C and D. It must be remembered that we are not concerned with the *absolute* level of quality in health services: the aim of the policies measures here is to reduce inequities in service delivery by making services more responsive to migrants' needs.

By creating these two new variables, 'Access' and 'Quality', we can examine the relative priority given in each country to each of these two aspects of migrant health policy. Displaying these scores on the following graph shows that while they are slightly related to each other ($r = .35$, $p < .05$ two-tailed), countries often score extreme values on one variable

but not on the other. (Again, the statistics reported are based only on the 34 countries in the Equi-Health European sample, but the graph also shows the positions of the four non-European countries.)
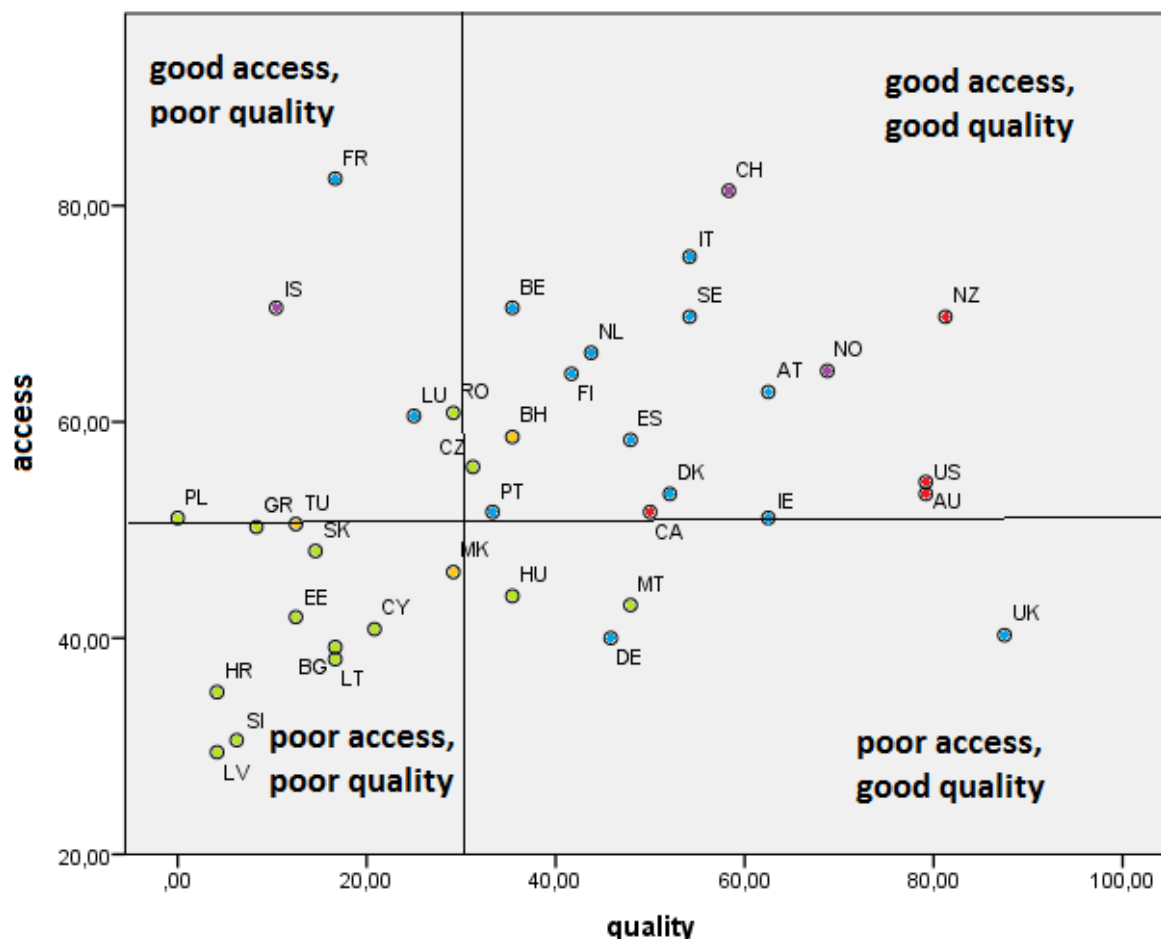
Key to colours
Blue: EU15 countries, Green: post-2000 accession countries. Purple: EFTA countries
Yellow: EU candidate countries. Red: Non-European countries

The horizontal and vertical grid lines are placed at the median value on each axis. The contrast between FR and UK is particularly striking. FR scores highest on Access, but very low on Quality: for ideological reasons, attention to diversity is discouraged in the French health system (see Country Report). The UK presents a mirror image: nowhere else is so much attention paid to quality, in the sense of adapting services to the needs of migrants (viewed as 'minority ethnic groups'). However, the UK's 2014 Immigration Act made it more difficult for many migrants to use these services. (Interestingly, six years ago the UK would have gained a higher score for Access and the US a lower one: whereas the UK legislation *reduced* health care coverage for migrants, the 2010 Affordable Care Act in the US *increased* it). Most other countries lie closer to the diagonal, i.e. there are not such striking discrepancies between the two scores. Nevertheless, AT, IE, NO, NZ, US and AU are (like the UK) stronger on quality than on access, while IS resembles FR in having the opposite priorities.

B. Relation of MIPEX Health strand scores to other variables

The results in this section should be regarded as exploratory in nature, because more research will be required to answer these questions properly. A number of country characteristics were found to correlate quite highly with Health strand scores: GDP per capita (adjusted for cost of living); the percentage of non-EU/EFTA migrants; total health expenditure per capita (adjusted for cost of living); the type of health system (insurance-based or tax-based); the average score on other MIPEX strands; and whether a country was a member of the EU15 or acceded to the EU after 2000 (ignoring EFTA countries). Values for 2014 were used except in the case of health expenditure, which was measured for 2013. Correlations (*r*) significant at *p* < .01 are marked with two stars, at *p* < .05 with one.[26]

Key to colours:
Blue: EU15 countries, purple: EFTA countries, green: post-2000 accession countries,
Yellow: EU neighbour countries, red: non-European countries.

|	Total	Access	Quality
GDP	.75**	.51**	.69**
% non-EU/EFTA migs.	.45*	.30	.42*
Health expenditure	.71**	.57**	.60**
NHS health system	.39*	-.05	.50**
Other MIPEX	.61**	.54**	.48*
Accession status	-.76**	-.61**	-.64**

However, as the following matrix shows, many of these variables are quite strongly correlated with each other, and this makes it difficult to decide which of them are most important.

% non-EU/EFTA migs	.69**				
Health exp PC	.94**	.70**			
NHS health system	-.29	-.28	.11		
Other MIPEX	.57**	.46*	.60**	.31*	
Accession status	-.79**	-.68**	-.82**	-.34	-.76**
	GDP	migs	H exp	NHS	Other M

One of the most surprising findings is that whether a member state belongs to the EU15 or the 13 post-2000 accession countries is a strong predictor of Health strand scores. In the next table we see that there are large differences between these two groups of countries on a number of indicators that are related to the Health strand. This table summarises those differences (significances calculated by *T*-test). Underneath the table is a graph showing GDP. EU15 countries are coloured blue, accession countries green; apart from severely crisis-hit GR and PT, we see that accession countries occupy all the lowest places.

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[26] Luxembourg is omitted from all analyses involving GDP because its score of 264 is an outlier that drastically reduces the correlations.

Indicator	EU15	Accession 13	% diff	Significance p <
GDP per capita[27]	121	71	59	.001
% non-EU/EFTA migrants[28]	7,6	3,3	43	.001
Tolerance of migrants[29]	44	37	84	.05
Health exp. as % of GDP[30]	10,0	7,2	72	.001
Health expenditure PC [31]	2927	1304	45	.001
% with NHS system[32]	53%	23%	43	.001[33]
EHCI (2014) [34]	753	593	79	.001
MIPEX Health strand	52	31	60	.001
MIPEX other strands	61	42	69	.001
Access	60	43	72	.001
Quality	45	18	40	.001

GDP per capita (2014), adjusted for cost of living

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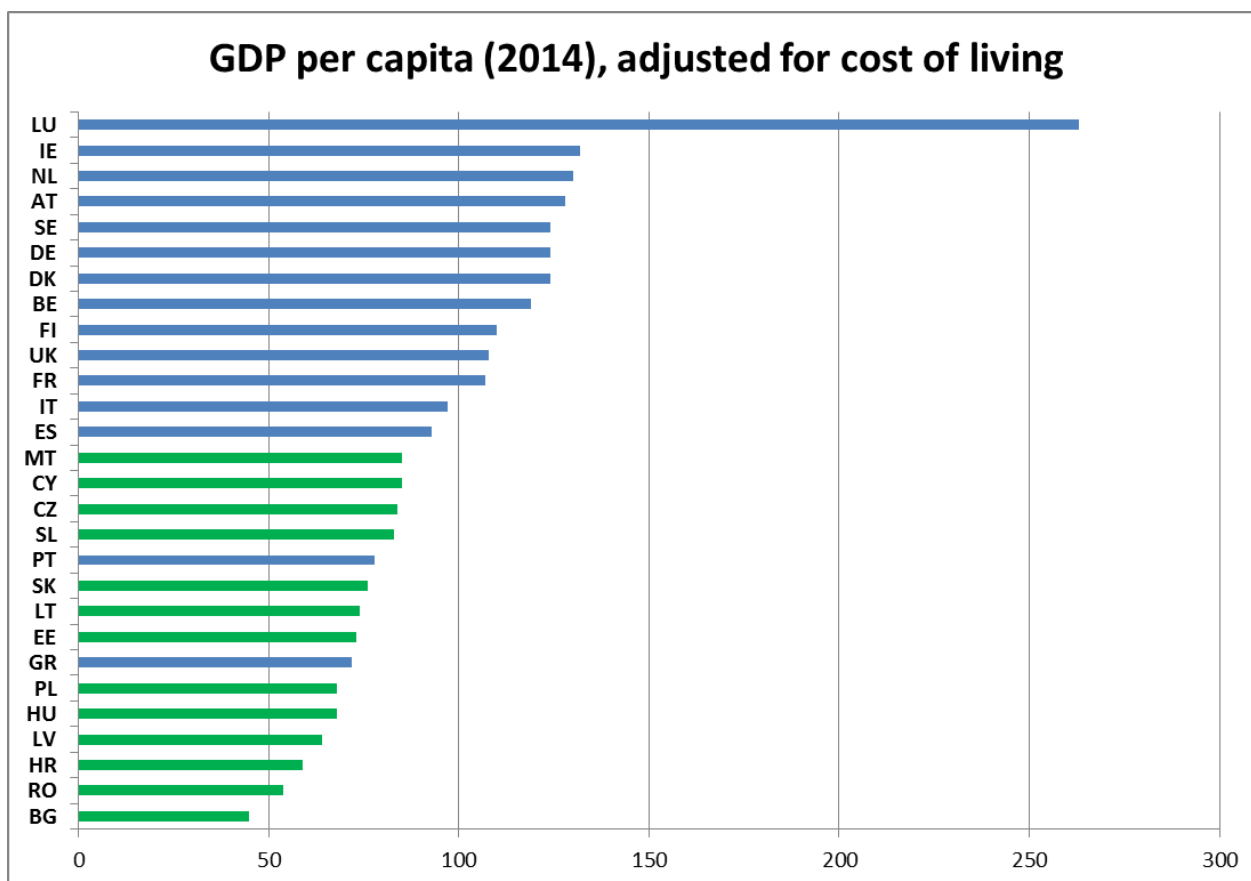
[27] GDP per capita 2014, adjusted for cost of living. (All figures are for 2013)

[28] Figures for HR, EE and LV adjusted to take account of long-standing 'statistical migrants' from the USSR.

[29] Scale EB62 from the Eurobarometer (2013)

[30] WHO health databank (2013)

[31] Expenditure per capita in euro's (Eurostat 2013, supplemented by data from WHO)

[32] A NHS system is one in which health costs are mainly financed from taxation and other government sources, rather than social health insurance (SHI) contributions.

[33] Fisher's Exact Test

[34] Euro Health Consumer Index 2014.

The economic differences seen above are to a certain extent to be expected. The economic situation of most countries with joined the EU after 2000 was weak, sometimes grave: all of them except Cyprus and Malta had been seriously affected by the turmoil following the collapse of the Soviet Union. It was hoped that sharing in the prosperity generated by the "free movement of goods, services, capital and persons" would quickly regenerate their economies, but the 2008 financial crisis and the slow, erratic recovery which followed have held back the growth of these 13 countries.

Directly related to this is the fact that post-2000 accession countries attract very few migrants born in non-EU/EFTA countries. (It is necessary to discount the minorities in HR, EE and LV who were born in other parts of the USSR but did not return there after these countries became independent, as well as those fleeing from other Balkan countries to Croatia in the 1990's). Indeed, in 2013 the outward flow of migrants exceeded the inward flow in HR, BG, RO, CY, PL, EE, LT and LV[35]. Many populations are shrinking an wages and benefits are low. Migrant workers as they are known in the EU15 are relatively rare in these countries and their needs enjoy little priority, as can be seen from the figures for Health as well as the other strands of MIPEX.

In any case, health care in the accession countries is seriously underfinanced, resulting in low scores on the EHCI. These countries spend a smaller percentage of their GDP on health and their GDP is low to start with, so their average spending per capita is very low (45% of the EU15 average). The next graph shows the GDP's of EU15 countries (blue) and post-2000 accession countries (green): apart from severely crisis-hit GR and PT, we see that accession countries occupy all the lowest places.

These extreme, across-the-board inequalities within the EU make it difficult to identify the variables that have the greatest influence on the Health strand scores. Many of these variables are strongly correlated with each other, which makes it hard to discover which of them have the most direct influence.

Such a statistical problem is usually tackled by using multivariate analysis, but it may be unwise to rely on results from these methods because they require many assumptions about the data to be satisfied. In the table on the previous page we saw which variables correlate most strongly with the MIPEX Health Strand. To begin with, it would be unwise to include both GPD and Health expenditure in a regression equation, because their very high correlation (.94) could lead to unstable results. We therefore opted to keep GDP, because it is a better predictor of most of the Health strand scores examined.

When GDP, migrant stock, type of health system and accession status are inserted into a stepwise multiple regression, the following variables emerge as the best predictors:

Dependent variable	Independent variables	r	Significance (p)
Total health strand	Accession status	.75	<.0005
Access	Accession status	.62	<.0005
Quality	Accession status NHS health system	.70	<.0005 <.03

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[35] See http://ec.europa.eu/eurostat/statistics-explained/index.php/Migration_and_migrant_population_statistics
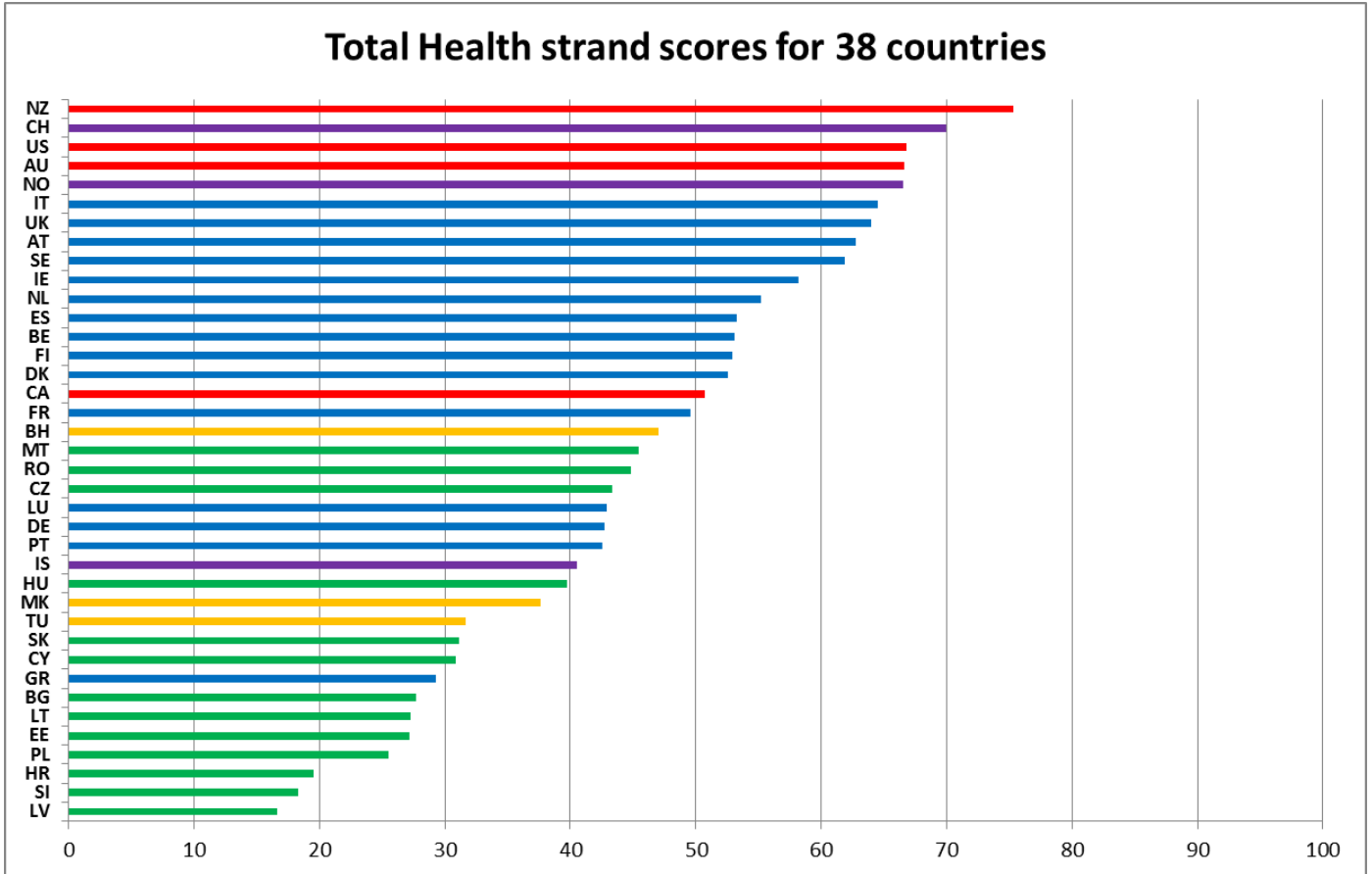
What do these findings mean? Firstly, the fact that 'accession status' is selected in all of the analyses means that the predictive power of this variable exceeds that of all the other independent variables examined. This is a very important finding: it suggests that the best predictor of migrant health policies is simply whether or not the country in question is an 'old' or a 'new' EU Member State. This suggests that accession status *in its own right* is associated with a negative policy climate for migrant health, i.e. not just because of its connection with other influential variables.

Perhaps this should not come as a surprise: most countries acceding to the EU have experience of emigration, but not of immigration. In most of them, policies concerned migrants and their rights are in a early stage of development, and this is particularly true for policies on inclusive health coverage and equitable service delivery. Moreover, the negative economic climate of recent years will have made it harder for them to implement reforms quickly. A recent study of policy coordination by Eurofound (2015) found that nearly all Central and Eastern European countries have only moderate or low scores on policy coordination for third-country nationals. Although policies were supposed to be harmonised with the rest of the EU, measures to ensure this was done have only had partial success.

When it comes to Quality, accession status is joined as a predictor by the type of health system (NHS or SHI). This is contrary to expectations: NHS systems are generally assumed to provide better *access* to health care, rather than better *quality*. However, as we saw when reviewing the results on entitlement from Section A, NHS countries are just as likely as SHI ones to restrict coverage for migrants.

Yet NHS systems in the EU do seem to put more effort into adapting services to the needs of migrants. This may be because they tend to have more 'top-down' systems of governance, making it easier to introduce ideas such as 'cultural competence' or 'sensitivity to diversity' across the system. Another explanation might be that *both* the NHS system *and* the 'migrant-friendly' policies have common origins in a political tradition of egalitarianism on the country. More definitive answers to the above questions will have to await further analyses of the MIPEX Health strand results, which are expected to show interesting relationship with a wide range of other variables too.

C. Graph showing overall results

Total Health strand scores for 38 countries

Country	Score (approx.)
NZ	75
CH	70
US	66
AU	66
NO	66
IT	64
UK	64
AT	63
SE	62
IE	58
NL	55
ES	53
BE	53
FI	53
DK	52
CA	51
FR	50
BH	47
MT	46
RO	45
CZ	43
LU	43
DE	43
PT	42
IS	40
HU	39
MK	37
TU	31
SK	31
CY	31
GR	29
BG	28
LT	27
EE	27
PL	25
HR	19
SI	18
LV	16

Key to colours:
Blue: EU15 countries
Purple: EFTA countries
Green: post-2000 accession countries
Yellow: EU neighbour countries
Red: Non-European countries

The highest scores are obtained by non-European countries – with the exception of CA, where the government that was removed from office by the voters in 2015 weakened many 'migrant-friendly' measures. The wealthy EFTA countries CH and NO also occupy top positions. Perhaps because of its remote geographical position, EFTA country Iceland is not well adapted to the needs of migrants.

EU15 countries, with the exception of LU, DE, PT and GR, occupy fairly high positions. Post-2000 accession countries have the lowest scores; the candidate country BH scores better than all of them, while MK and TU have scores around the mean of the accession countries.

Appendix 1 - Names of researchers and peer reviewers

COUNTRY	RESEARCHER(S)	PEER REVIEWER(S)
Australia	Michal Morris, Bernice Murphy	Lidia Horvat
Austria	Ursula Trummer	Sonja Novak-Zezula, Martin Sprenger
Belgium	Marie Dauvrin	Vincent Lorant, Hans Verrept, Ilse Derluyn
Bulgaria	Neda Deneva	Milen Petrov, Maria Samuilova
Canada	Mandana Vahabi, Belinda Smith	Ilene Hyman
Croatia	Mitre Georgiev	Helga Špadina, Sunčana Roksandić Vidlička
Cyprus	Panagiotis Petrou, Chrystalla Pithara	Christina Kouta
Czech Republic	Helena Hnilicova, Karolína Dobiášová	Pavel Cizinsky
Denmark	Natasja Koitzsch Jensen, Allan Krasnik	Morten Sodemann
Estonia	Kristina Kallas	Elena Jurado
Finland	Maili Malin	Minna Saavala
France	Paul Dourgnon	Gesine Sturm
Germany	Michael Knipper, Theda Borde, Silke Brenne, Oliver Razum, Inessa Markus	Ulrike Kluge
Greece	Elli Ioannides	Ioanna Kotsioni
Hungary	Sándor Illes	Atilla Dobos
Iceland	Bjarney Fridriksdottir	Guðrún Pétursdóttir
Ireland	Anne MacFarlane, Diane Nurse, Una Rafferty	Jane Pillinger
Italy	Margherita Giannoni	Antonio Chiarenza
Japan	Atsushi Kondo	Keizo Yamawaki, Claudia Ishikawa, Jun-ichi Akashi
Lativa	Ilmārs Mezs	Aiga Rurane
Lithuania	Linas Šumskas	Daiva Bartušienė, Ginterė Guzevičiūtė
Luxembourg	Serge Kollwelter	Laurence Hever
Malta	Sandra Buttigieg	Marika Podda Connor
Netherlands	David Ingleby	Walter Deville
New Zealand	Grace Wong	Anne Mortensen
Norway	Bernadette Kumar	Arild Aambo
Poland	Ela Czapka, Anna Kosińska	Ola Chrzanowska
Portugal	Beatriz Padilla, Sonia Hernández Plaza	Claudia de Freitas
Romania	Alexe Irese	Stefan Leonescu
Slovakia	Daniela Kallayova	Marek Majdan
Slovenia	Uršula Lipovec Čebron	Jelka Zorn
South Korea	Kwang-Il Yoon	Young-Lan Kim
Spain	Manuel Garcia Ramirez, Tona Lizana	Daniel La Parra
Sweden	Slobodan Zdravkovic, Carin Björngren Cuadra	Peter Bevelander
Switzerland	Paolo Ruspini, Buelent Kaya	Milena Chimienti, Patrick Bodenmann, Sandro Cattacin
Turkey	Seval Akgun	Coskun Bakar
United Kingdom	Mark Johnson	Hiranthi Jayaweera
United States	Westy Egmont,Tanya Broder	Leighton Ku

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