5.G. Workshop: Health for All: Health policy making for refugees and other migrants: context, capacity, competences

Organised by: EUPHA section on Migrant and ethnic minority health, EUPHA section on Public mental Health and EUPHA section on Public health practice and policy
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Chairperson(s): Allan Krasnik - Denmark, Marleen Bekkers - The Netherlands

Objectives

Increase the capacity and knowledge of delegates around the latest scientific research, relevant policies or innovative programmes to implement and advocate for better public health and health systems in their countries

What shapes policies on the health of refugees and other migrants? This workshop brings together findings from the Migrant Integration Policy Index (MIPEX) study and practice experience in two countries, Norway and the Netherlands, investigating the relations between refugee and migrant health policies, other migration related policies and wider socio-political trends; experiences and recommendations regarding policy development involving the identification and inclusion of health needs of vulnerable groups will be presented. The aim is to increase understanding and management of enabling and constraining factors for exerting policy influence within the public health academic, professional or policymaker range of influence as well as the wider and less controllable context. It might be of vital importance that more policy analysts, political scientists and policymakers get involved. The workshop evolves towards formulating an agenda for research and action at the level of public health services and policymakers at municipal, national and European levels.

Key messages:

- Health policy for migrants are shaped by societal and political factors rather than health needs
- Appropriate healthcare for migrants require broad support for development of national policies

Access to health service for migrants: what are the policy challenges? Lessons from the MIPEX study

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The MIPEX Health strand study is a collaborative project carried out from 2013-2016 by three partner organisations: the International Organization for Migration (EQUI-HEALTH project), COST Action IS1103 ADAPT (Adapting European Health Services to Diversity), and the Migrant Policy Group, publishers of the Migrant Integration Policy Index (MIPEX).
MIPEX measures seven 'strands' of a country's integration policy, such as access to the labour market, education, etc. The aim of the project was to add an eighth strand on Health. Many studies of migrant health policy have been carried out, but all make different selections of countries, policy issues and categories of migrant. Because of this, it is difficult to make systematic comparisons and carry out quantitative analyses. To overcome this problem, a questionnaire measuring 38 indicators of policy concerning migrant health was constructed on the basis of the Council of Europe's 2011 Recommendations on mobility, migration and access to healthcare.
Analyses of the structure of the MIPEX Health strand showed a high degree of homogeneity (Cronbach's alpha = .86), but three factors could be distinguished within it: (1) legal entitlements to health care coverage, (2) other factors affecting access, and (3) a factor which combined the responsiveness of services to diversity and the measures taken to achieve change. Results from the MIPEX Health strand are still being analysed. There are large differences between the legal entitlements of different categories of migrants. The percentage of migrants in a country is related to GDP per capita, and both are correlated with MIPEX Health strand scores. The 13 countries which joined the EU after 2000 are much less wealthy than the EU15, but their scores are even lower than would be expected purely on the basis of wealth. Tax-based systems did not appear to be more inclusive that insurance-based ones, but they seem to make more effort to adapt services to diversity.

Influencing strategies and trends on health policy for refugees and other migrants in Norway

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Migration to Norway from Non-European countries is a relatively new phenomenon dating back 40 years. Migrants to Norway have increased from 1% in 1970 to over 15% in 2015, numbers doubled in the last decade. While rapidly increasing migration could result in opportunities such as improved demography, increased labor and innovation it could challenge the welfare state universalism and its resilience.
In Norway, health policies are explicit about equity in terms of availability, utilization and results. In The White paper - Report to the Parliament nr.17 (1996-97) 'on immigration and the multicultural Norway', the Government stated that 'a multicultural society means that services must be adapted in order to provide equitable health care to a more diverse user group' and that there is a need for adapting services and public health to immigrant groups. In 2013, the Norwegian Immigrant Health Strategy was launched and in 2015 Norway ranked fourth in the MIPEX score.
Research should inform evidence-based policy, but this is not always the case for migrant health. Migrant health policies are often fragmented and concentrate on particular areas such as female genital circumcision or on groups, such as asylum seekers or undocumented migrants.
This presentation will examine

- If the research generated on the public health challenges of immigrants in Norway has translated into concrete actions in the national health policies, strategies and plans. Margaret Whitehead's framework (1998) of the action spectrum on inequalities of health will be used to illustrate this point.
- To what extent the use of law and policy has been enabling for achieving progress in the field of migrant health in Norway.
- If and how the health care system in Norway has adapted to the challenges and whether the recommendations from researchers and stakeholders in particular users have influenced these actions
- If rights and entitlements to health care guarantee access to quality care.

National strategies and trends for refugee and migrant health in the Netherlands

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This presentation will address the main experiences and challenges with respect to (public) health policies and practice for asylum seekers and refugees in the Netherlands. Asylum seekers in the Netherlands are housed in asylum seekers centres. The costs for all services, including health care, are covered by the Ministry of Justice. Public health services for refugees with a residence permit, though, are the responsibility of the municipality and at national level the Ministry of Health.
In 2015 the number of asylum requests increased rapidly in 2015. This increase in combination with societal and political developments and a major process of decentralisation in the social domain resulted in interesting challenges and opportunities. How did and do these changes affect health care policies and practice at the national and local levels? What roles did the different stakeholders play? What was the influence of scientific studies? How does this relate to general migrant and undocumented migrant health policies? What are the remaining challenges?
Dr. Simone Goosen will briefly present the organisation of the health system for asylum seekers and refugees in the Netherlands and address abovementioned questions. Dr. Goosen has been involved in research on the health of asylum seekers and refugees as well as in public health policy development and implementation as from 2001.

Development of policies to address health needs of migrants– how do we identify vulnerable groups

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This talk will address the identification of vulnerable refugee and asylum seeker groups in relation to their health related needs, and how these needs should be addressed. The European Council Directive 2003/9/EC from 2003 laying down minimum standards for the reception of refugees and asylum seekers, addresses the protection of migrants with special needs. Member States should ''take into account the specific situation of vulnerable persons such as minors, unaccompanied minors, disabled people, pregnant women, single persons with minor children and persons who have been subjected to torture, rape or other serious forms of

psychological, physical or sexual violence'' by implementing the healthcare needed. The International Rehabilitation Council for Torture Victims has published a position paper based on a comparative study in 10 EU countries demonstrating that torture survivors are more difficult to identify than other vulnerable refugee and asylum seeker groups. It appears necessary to prescribe in more depth and detail the ways in which the special needs of the most vulnerable groups can be identified and addressed in all stages of the asylum process. This talk therefore aims 1) to review minimum criteria for health care of vulnerable refugee groups, especially for torture survivors; 2) propose standards for identification of vulnerable refugee groups across Europe and 3) to set a benchmark for good practice in dealing with these groups. Standards are required for regulating what constitutes adequate medical and psychological assistance and counselling and a proper identification and response to the needs of vulnerable groups among refugees and asylum-seekers; and for the development of appropriate techniques to identify the groups and their specific health needs in order to offer proper health care, based on cultural, age and gender awareness and inter-cultural skills and use of specialized staff.