The MIPEX Health strand: a tool for measuring equitable health policies for migrants

This text is a condensed version of Sections 1C and 1D from IOM (2016), Summary Report on the MIPEX Health Strand & Country Reports. Brussels: International Organization for Migration (IOM) Regional Office Brussels, Migration Health Division (MHD) (available on SH-CAPAC website; mainly relevant to Topic A).

Starting in 2003, the Migrant Integration Policy Index (MIPEX – see www.mipex.eu) has measured policies on migrant integration at regular intervals in an growing number of countries. The different 'strands' of this instrument relate to topics such as labour market mobility, family reunion, education, and so on. Because inclusion in the health system is also an important aspect of integration, an eighth strand on Health was added to the index in 2015, in a joint project carried out by the developers of MIPEX (the Migration Policy Group, MPG) in collaboration with the International Organization for Migration (IOM), Migration Health Division and COST Action IS1103 ADAPT ('Adapting European Health Systems to Diversity').

The MIPEX Health strand set out to measure policies on migrants' health by asking the same questions in each of the countries studied and applying the same criteria for scoring the answers (as in the rest of MIPEX). Before 2015 there was no shortage of research studies on this topic, but it was difficult to combine information from multiple sources because studies covered different samples of countries, policy issues and categories of migrant. The MIPEX Health strand overcomes this limitation by collecting identical data on each country, using a standard list of 38 indicators and applying them to precisely defined categories of migrants. Indicators are grouped into four dimensions or scales, so that strong or weak policy areas in each country can be identified. Results on Health can be compared with those from other MIPEX strands, and because measurements will be repeated every 4 years, it will later be possible to study changes over time.

Countries studied In the main MIPEX study, data were collected on the EU28, Norway, Iceland, Switzerland, Turkey, Australia, Canada, New Zealand, the USA, Japan and South Korea. The MIPEX Summary Report omits the last two countries but adds the former Yugoslav Republic of Macedonia as well as Bosnia and Herzegovina. Statistical analyses were carried out only on 'European' countries (including Turkey).

Migrant categories In the EU28, Norway, Iceland and Switzerland MIPEX focuses on policies for 'third-country nationals' (TCNs), i.e. those who are not citizens of EU28 or EFTA countries. This is because policies for people migrating within this region tend to be more favourable and are to a large extent harmonised.

Some countries have reciprocal agreements with other countries, exempting migrants from those countries from restrictions on health coverage normally applying to migrants. These agreements have not been systematically listed in this project, but their existence should always be borne in mind.

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.

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, migrants who become naturalised will acquire the same entitlements as other nationals.

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 their country of birth than their 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.

Policies that affect migrants are not always targeted at migrants as such. Policies adapting services to differences between *ethnic groups* may improve the matching of services to the needs of migrants, so they are also considered in this survey. However, a drawback of policies based on 'ethnicity' is that they may 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.

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'.[1] Such measures can benefit migrants and ethnic minorities, but only if they encourage attention to the specific problems of these groups. A 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. Because many different kinds of migrants fall into this category, this study focuses on the rules that apply to *migrant workers* (usually the largest group). These rules 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').

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 'irregular migrants'.

---

[1] 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

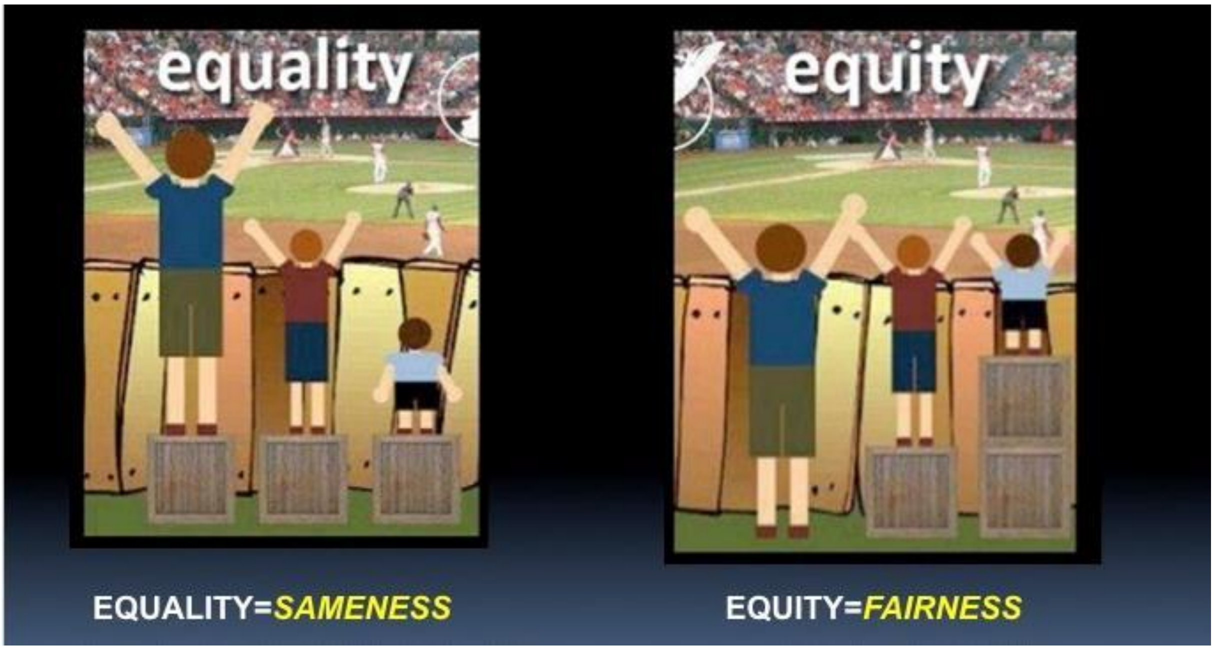
In some countries, entitlements and health services for asylum seekers differ according to where they live. Provisions for those living in state-run reception centres may be different than for asylum seekers living in the community. In such cases, scores are based on the provisions that apply to *most* 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. Irregular migrants (IMs)

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 'undocumented migrant'. 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). MIPEX scores apply to IMs who are not in detention.

Policy issues studied

In order to measure how equitable policies are, one must have a concept of what they should ideally be. What are the most important policy changes required to make service delivery for migrants equitable? Sometimes equity (i.e. fairness) can be achieved by simply having the same policies for both groups, but 'equity' is not always the same as 'equality'. The illustration below sums up the difference:[2]



Equity in *legal entitlements to care* can usually be achieved simply by giving migrants the same entitlements as native citizens. In other cases, however, achieving equity requires creating differences, as the right-hand picture shows above: if needs are different (for example if migrants often need the help of an interpreter), 'one size fits all' is not an equitable policy.

---

[2] Source: http://on.fb.me/1nsh5mG

What ‘fair’ migrant health policies would look like has been debated intensively for several decades. This is not simply a matter of the policies which give better clinical outcomes: priorities for change cannot be established purely on an empirical basis. Some priorities are based on normative principles: 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, although 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 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 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 supportive 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”.[3]

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”. Four of the recommendations studied were aimed at service provider organisations, but two considered the whole health system. One of these, the *Recommendation of the Council of Ministers to member states on Mobility, migration and access to health care* (Council of Europe, 2011) was chosen as the basis for the MIPEX Health strand.

The background to the Council of Europe’s recommendations was a series of policy initiatives, most of them at European level. They were drawn up by a Committee of Experts

---

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

including 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 final document contained 14 recommendations, explained in 23 guidelines and divided into 6 categories:

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 were incorporated in the MIPEX Health Strand, but since a MIPEX strand only has four dimensions, categories 1 and 2 were combined with category 6. This resulted 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 is measured by six questions, some of which had two or more components. One question had to be dropped, so there were 23 questions, comprising 38 indicators.

Concept of 'policy' underlying the Health strand

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.[4] 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, because 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, civil society orgnaisations, 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

---

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

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 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 high degree of ‘top-down’ control. Central control tends to be tighter in tax-based National Health Systems than in ‘Bismarckian’ social health insurance based systems, although 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 regarded as the most important. In this way, the bias produced by the procedure followed in countries with strong regional differences is to some extent counteracted.

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 (OOP) payments (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. Because regulations tend to be very complicated, it was not possible to essess the burden of OOP charges for migrants. However, on average these payments only account for 19% of total health expenditure in the countries we studied.

The role of NGOs

The MIPEX Health strand concerns the ‘mainstream’ health system in a country. If deficiencies are compensated for by NGOs or other CSOs this is only taken into account when the activities in question can be regarded as integrated in the mainstream – for example, 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.

Co-funded by
the Health Programme
of the European Union

This document is part of the project '717275 / SH-CAPAC' which has received funding from the European Union's Health Programme (2014-2020).

The document uses contents produced under the EU Health Programme (2008-2013) in the frame of service contract nr. 20136209 with the Consumers, Health, Agriculture and Food Executive Agency Unit (Chafea) acting under the mandate from the European Commission: Project "Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma – MEM-TP" carried out by the Andalusian School of Public Health, EASP (Spain) as consortium leader and Faculty of Health and Medical Sciences of the University of Copenhagen (Denmark), Azienda Unità Sanitaria Locale Reggio Emilia (Italy) and Academisch Medisch Centrum bij de Universiteit van Amsterdam (The Netherlands).