

Symposium: Flucht und Migration Herausforderungen für Gesundheitsversorgung und –forschung

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The refugee crisis: a challenge to health systems

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Summary

Current panic about ‘the refugee crisis’ tends to overlook recent history. In 1992, as a result of violent conflicts in the Balkans, the EU also experienced a drastic rise in asylum applications, which it managed to deal with without political, cultural or financial collapse. The current influx via Greece has been building up since 2011, but only now are serious measures being taken to deal with it. Unfortunately, most of the solutions proposed are either purely rhetorical, unworkable, or illegal.

The popularity of Germany as a destination country is structural: it owes little to anything that Chancellor Merkel might have said in August 2015. It is asylum seekers themselves who choose their destination country, and international law prevents governments from denying them the right to claim asylum on arrival. In that sense, borders cannot be ‘sealed’ – though *reaching* borders can be, and is, systematically obstructed.

Numbers of asylum applications can be predicted with reasonable accuracy from a country’s population size and wealth. There seems to be a balance between the demand for asylum and a country’s capacity to provide it. Statistical analysis can reveal which countries are receiving fewer or more asylum seekers than would be expected from their population size and wealth.

Concerns about health relate not only to asylum seekers, but also to the large number of undocumented migrants that will result from the rejection of many asylum claims. The MIPEX results show that as long as Germany maintains its exclusionist policies, it cannot hope to deal adequately with the health needs of all these newcomers. The same applies in most EU countries to undocumented migrants.

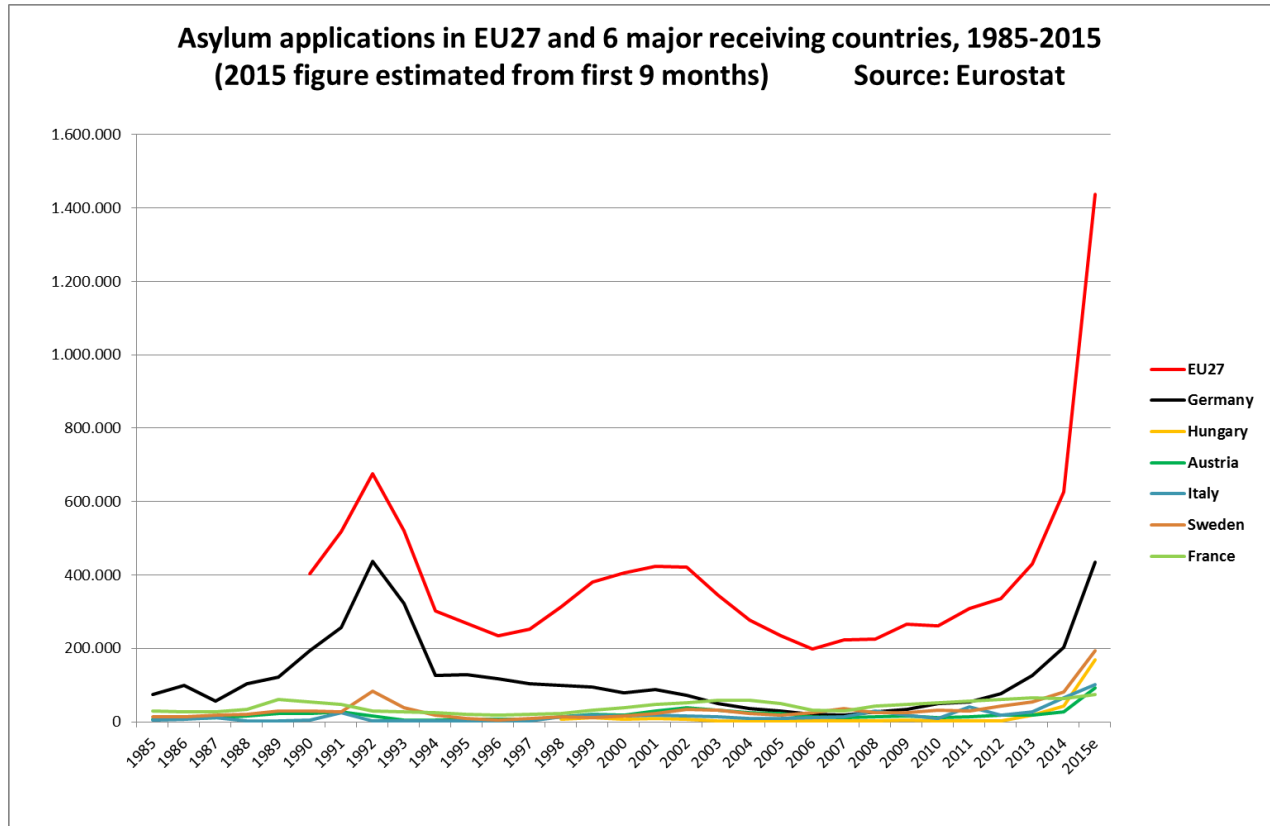
1. The anatomy of a crisis

The graph below shows asylum applications each year in EU27 countries from 1985 onwards. Figures for the year 2015 have been estimated from the first 9 months, on the assumption that the increase in the monthly figures will continue in the fourth quarter at the same rate as it did in the third. (Of course this assumption is speculative, but we will know the real figures soon enough.) These figures only relate to *registered applications*, not the number of people who entered a country in order to make an application. Germany evidently has a substantial backlog of applications, because the government estimates that about one million people entered in 2015, whereas less than half this number will have made an application by the end of the year. There are three important points to be made about this graph:

¹ E-mail: j.d.ingleby@uva.nl . This revision of the text incorporates new statistics from Eurostat and the German Government, as well as some methodological improvements.

1. This is not the first time the EU has had to deal with a lot of refugees

Many came in 1992 because of the Balkan wars. **By December 1st 2015, Germany had not yet reached the level of asylum applications made in 1992 (438,190).** The total for the countries that now make up the EU27 was smaller, but all of them were much less wealthy and many were still recovering from the after-effects of the disintegration of the Soviet Union.



In 1992 there may have been less opposition from the public, because most asylum seekers were perceived as ‘Europeans’ (even though many were Muslims). However, **it’s misleading to call the present influx “the biggest refugee crisis since WW2”**, even though it will probably become that. Moreover, a lot of expertise on health issues was developed in the 1990’s and many of the people working then are still working now.

2. The present influx of unauthorised arrivals in Greece began over five years ago.

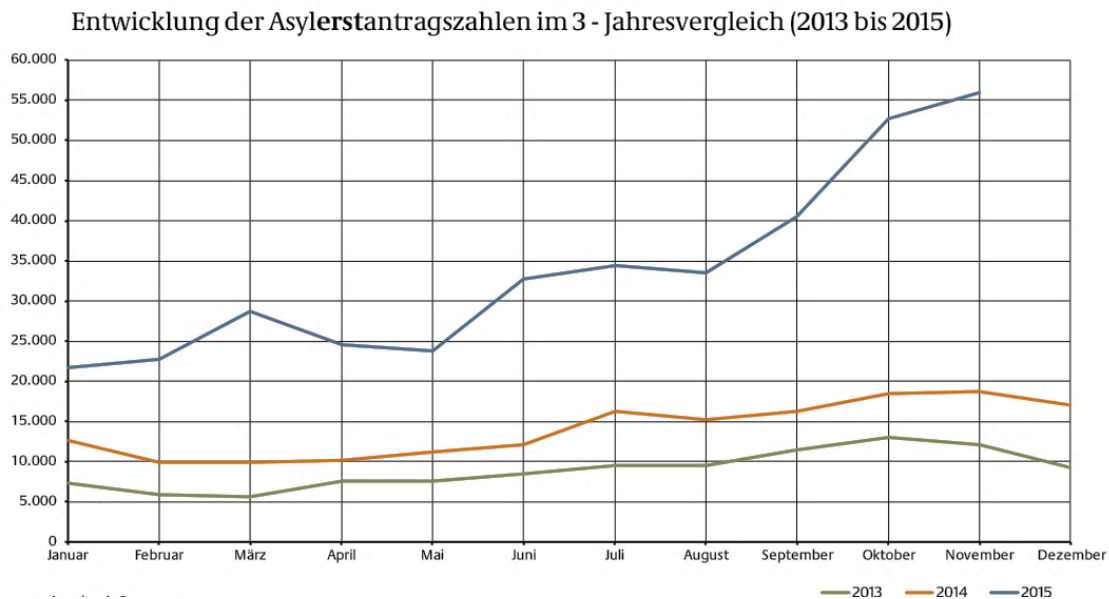
It was a result of the ‘friendship agreement’ between Berlusconi and Gaddafi in 2009, which stopped boats leaving Libya. This shifted the migration path to Turkey and Greece. Greece also tried to negotiate a ‘friendship agreement’ with Turkey in 2010, but Turkey refused.² It didn’t agree until the meeting in Brussels on November 30th 2015. This deal is purely pragmatic: stopping refugees from migrating is often illegal, so the EU doesn’t do it. Instead, it pays countries like Morocco, Libya and Turkey to do it. At the same time it provides Turkey with funds in partial compensation for the drastic shortfall in international donations.

Migrants who arrive in Greece don’t want to stay there, because it has nothing to offer them – not even a proper asylum system. It can hardly look after its own citizens. Greece doesn’t want the migrants to stay either, so it lets them move on to other countries. It used to be the same with Italy, but now on a much smaller scale.

² http://www.economist.com/node/16847278?story_id=16847278

3. The reason why Germany has become so popular is not just something Angela Merkel said in August 2015.

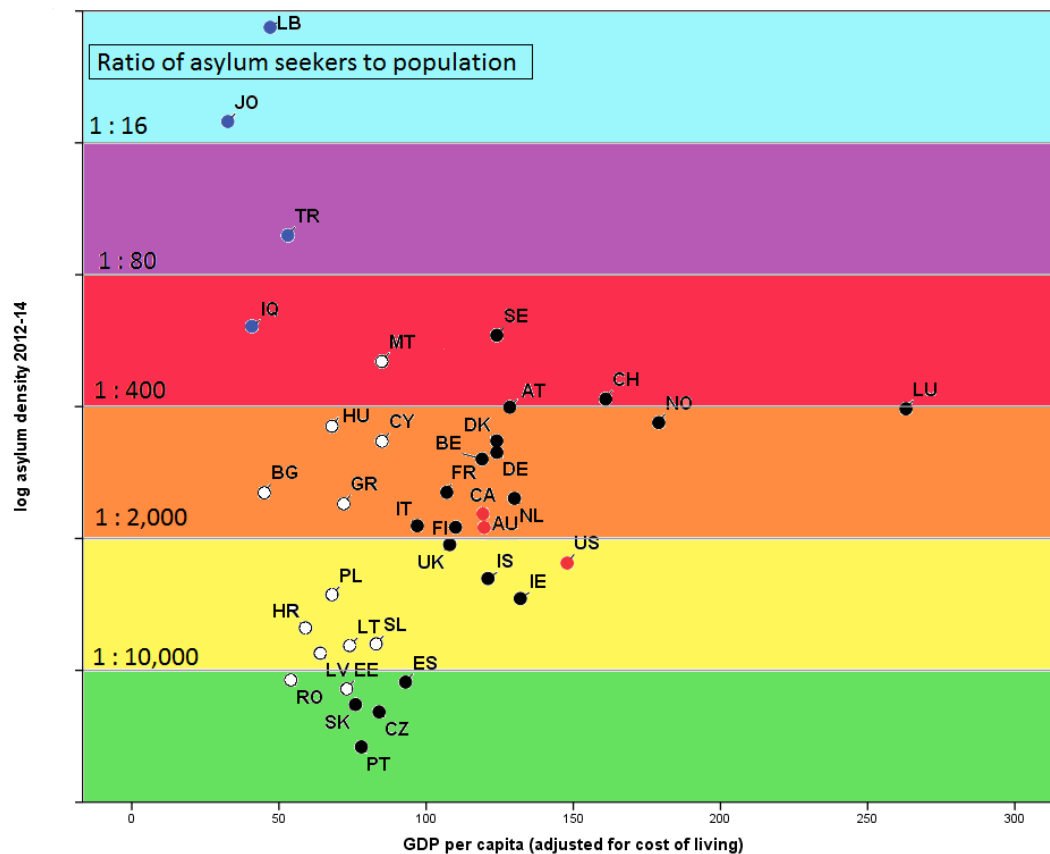
As we just saw, Germany's popularity with asylum seekers has been rising steadily since 2011. Below we see the recent changes in more detail (source: BAMF)



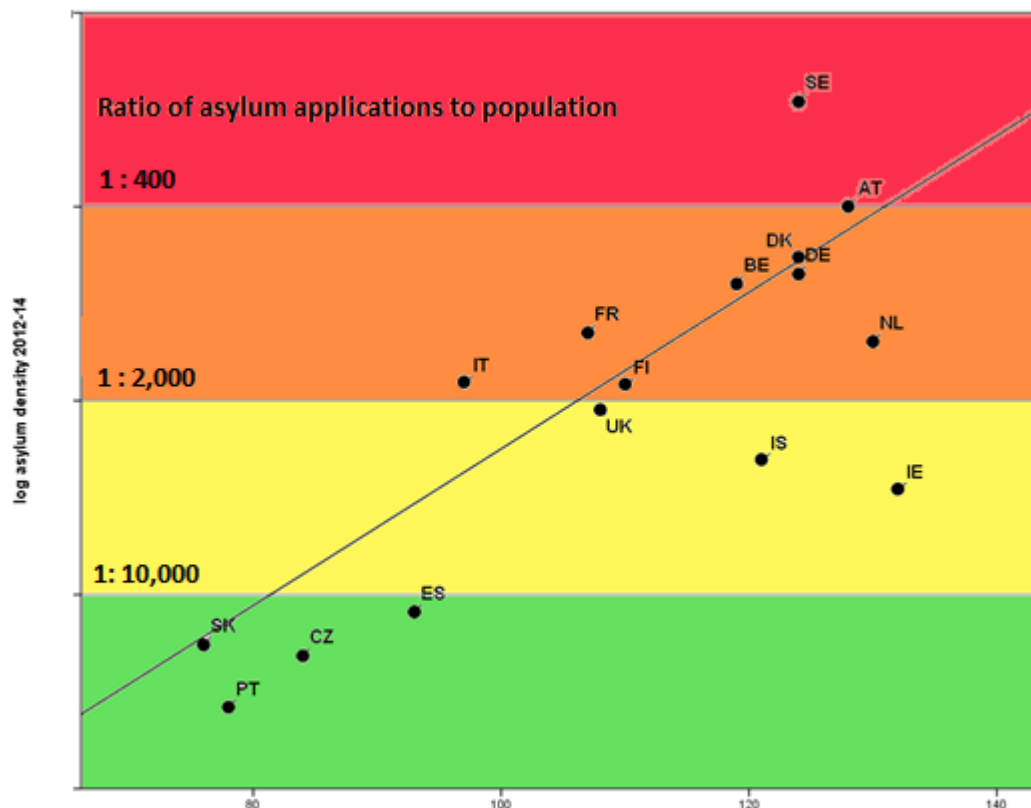
So why are so many asylum seekers coming to Germany? The most important point is that **countries themselves don't have much influence over the number of asylum seekers they take in**. Every applicant with a claim that looks serious has to be admitted. So the destination countries are selected by the asylum seekers, or to be more precise, by whoever plans their journeys. A country's track record in granting protected status may play a role, as well as (possibly) the conditions for asylum seekers: some countries have toughened their policies in the hope of deterring more from coming, and some have even been spreading negative publicity about themselves outside the EU. We know little about how asylum seekers think.

The first reason for Germany's popularity is rather obvious: it's the largest country in Europe. In order to compare countries it's better to look at the **ratio** of asylum seekers to the total population, the 'asylum-seeker density'. The most obvious determinant of this is GDP per capita (a country's wealth). The first graph below plots asylum-seeker density (average number of applications) over the last three years (2012-2014) against GDP per capita in 2014. 'Transit countries' (see below) have white dots; Turkey, Lebanon, Iraq and Jordan blue ones; Canada, USA and Australia (see notes on p. 9) red ones. To make the values easier to display we apply a logarithmic transformation to asylum-seeker density. This also makes intuitive sense, because it is likely to be differences in the *ratio* of asylum seekers to the population that affect behaviour, rather than the absolute figures. Using a logarithmic scale, a doubling of the density (for example) is represented by the same distance, regardless of population size.

However, to examine the statistical relationship between numbers of asylum applications and GDP, we first need to exclude the 'outliers' LU, NO and CH, which have extremely high GDPs. (In LU and CH these are inflated by the contribution of cross-border commuters, in NO by the proceeds of the oil industry). Next, we should exclude 'transit countries' in which a large proportion of the applicants are really *en route* to another country. This proportion is very hard to ascertain with certainty: here, we have excluded the following countries: BG, HR, CY, EE, GR, HU, LV, LT, MT, PL, RO and SL. AT and IT are not excluded, because they appear to be genuine destination countries for the majority of applicants.



With the reduced set of 16 European countries, the graph looks like this:



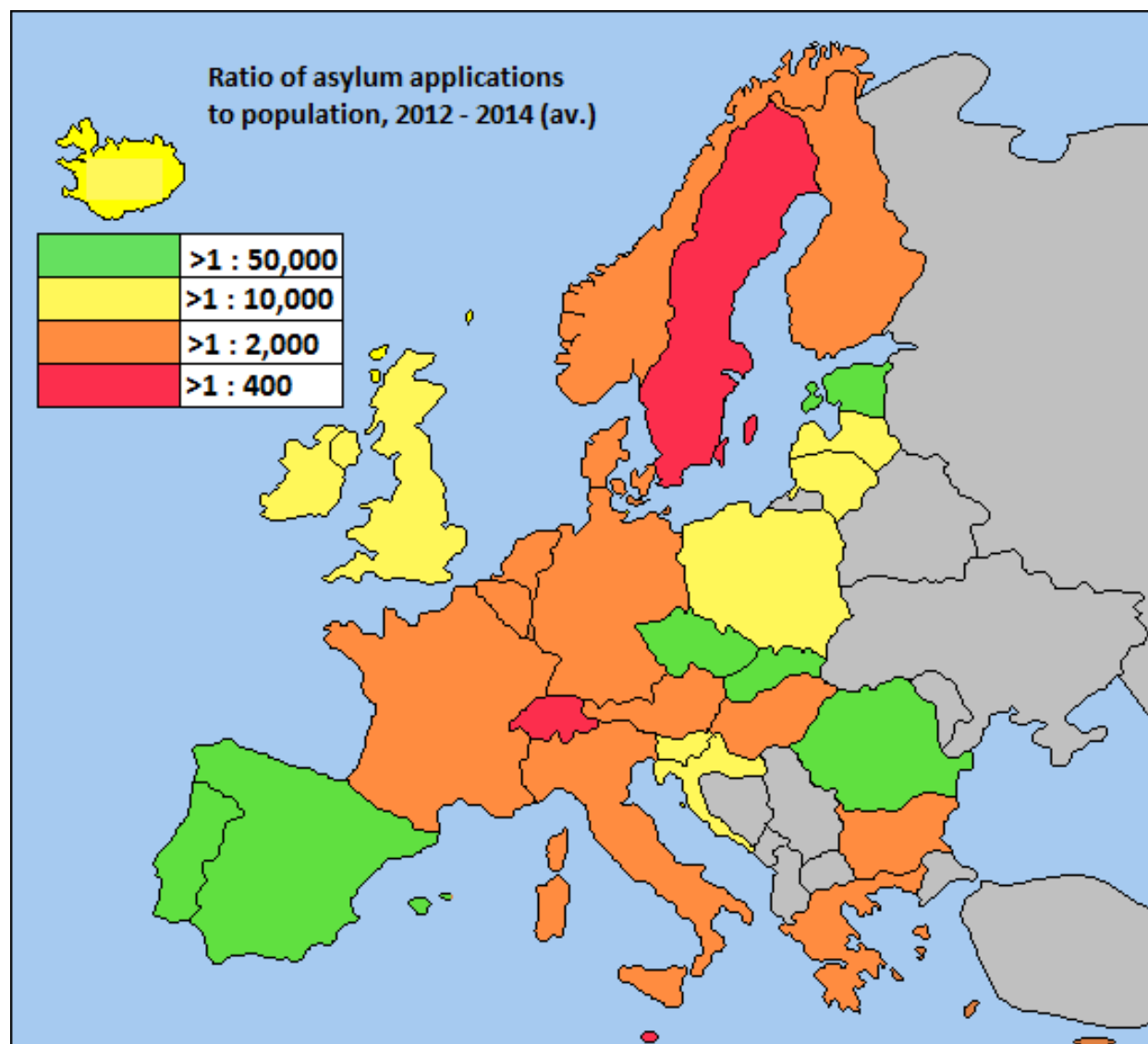
To estimate the regression line, countries have been weighted according to the size of their population. The correlation (r) between asylum-seeker density and GDP is .82, which means that two-thirds of the variation in the former can be explained by the latter. This should not surprise us: **for asylum seekers there is little point in applying to a country which cannot look after them properly and cannot offer them a future.** However, some countries deviate

from the line: SE, AT, FR and IT attract more asylum seekers than would be predicted from their GDP, and IE, IS, NL, ES, PT and CZ fewer.

It is tempting to speculate about the causes of these deviations. For IT and AT, the raised figures may have to do with their simultaneous role as transit countries; FR may also act as a transit country to the UK. Conversely, IE is hard to reach and has a poor track record in caring for and settling asylum seekers, as do ES and PT. Iceland is very inaccessible; CZ has strict policies and NL may be unpopular because of the prominence of xenophobic politicians. Most relevant to us is the fact that **Germany received almost precisely the number of asylum applications that would be expected on the basis of its GDP and population.**

What this graph shows is that there is generally a balance between a country's capacity to deal with asylum seekers and the number who come. The 'Juncker plan' to redistribute asylum seekers away from Greece, Italy and Hungary was an attempt to restore the balance in the case of these transit countries. (The EC formula also took unemployment rates into account, but this factor does not seem to significantly influence asylum seekers' choices.)

We can look at this picture another way:

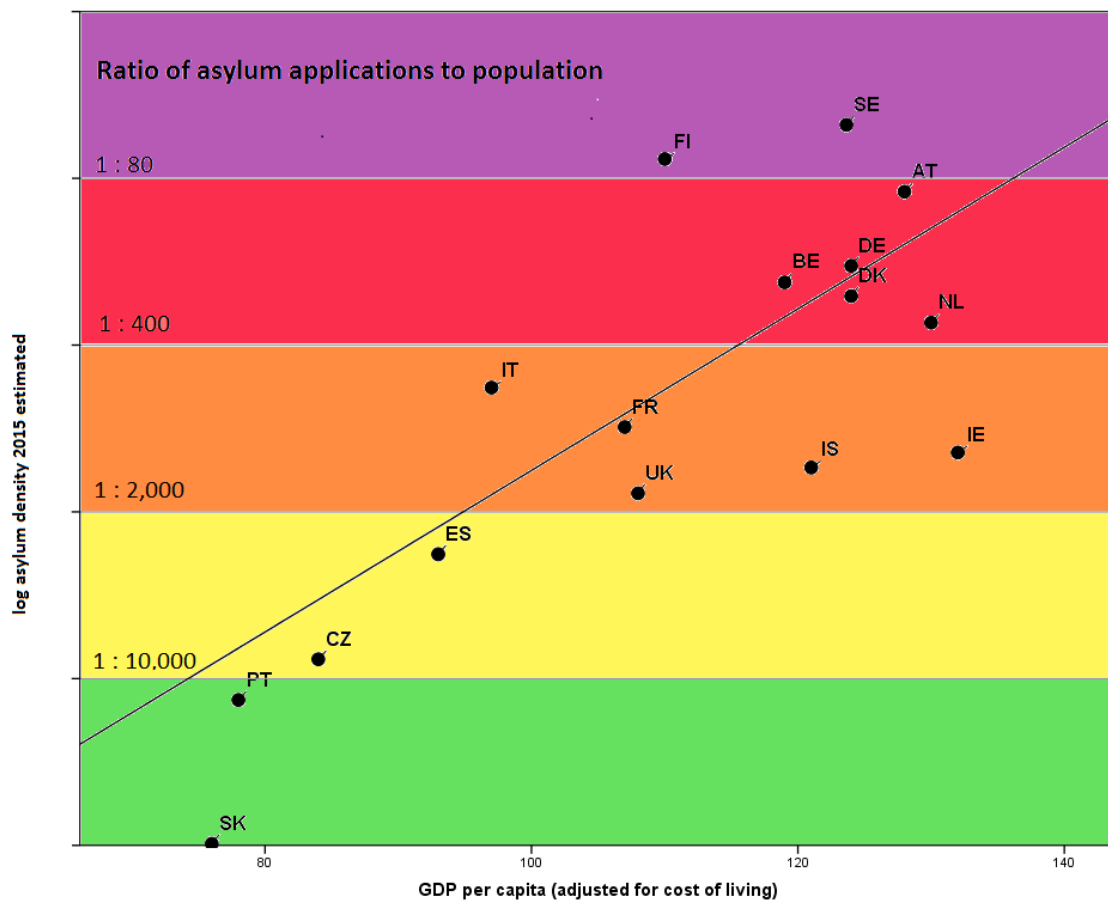


The green countries had extremely low asylum-seeker densities (one in 10,000 - 50,000). Yellow is higher (one in 10,000 - 2,000), orange is higher still (one in 2,000 - 400) and red is less than 400 inhabitants per asylum seeker. Transit countries tended to have higher figures, but in general we can see that it is the wealthier countries that receive most applications.

Why did more refugees start coming to Germany after August 2015? First of all, the popular idea that Angela Merkel “opened the borders” of Germany is grossly misleading. Ever since Germany ratified the Geneva Convention and its 1967 protocol, its borders have always been open for asylum seekers with a serious claim. The same is true for every other EU country – that is why “sealing the borders” is such an empty phrase.

What Merkel did was to partially suspend the 1990 Dublin agreement: **she said that Germany would not send Syrian asylum seekers back to Hungary or Greece.** In fact she had no choice. Hungary would not have taken them, and as early as December 2011 the EU Court of Justice had forbidden returns of asylum seekers to Greece. Therefore the statement simply confirmed existing policy – but it put an end to the humanitarian crisis caused by the arbitrary closing of borders by countries between Greece and Germany, and to the sickening pictures being sent to the rest of the world’s media from Europe. Unfortunately, it also gave Merkel’s political opponents a – spurious – pretext for blaming her for the increased flow.

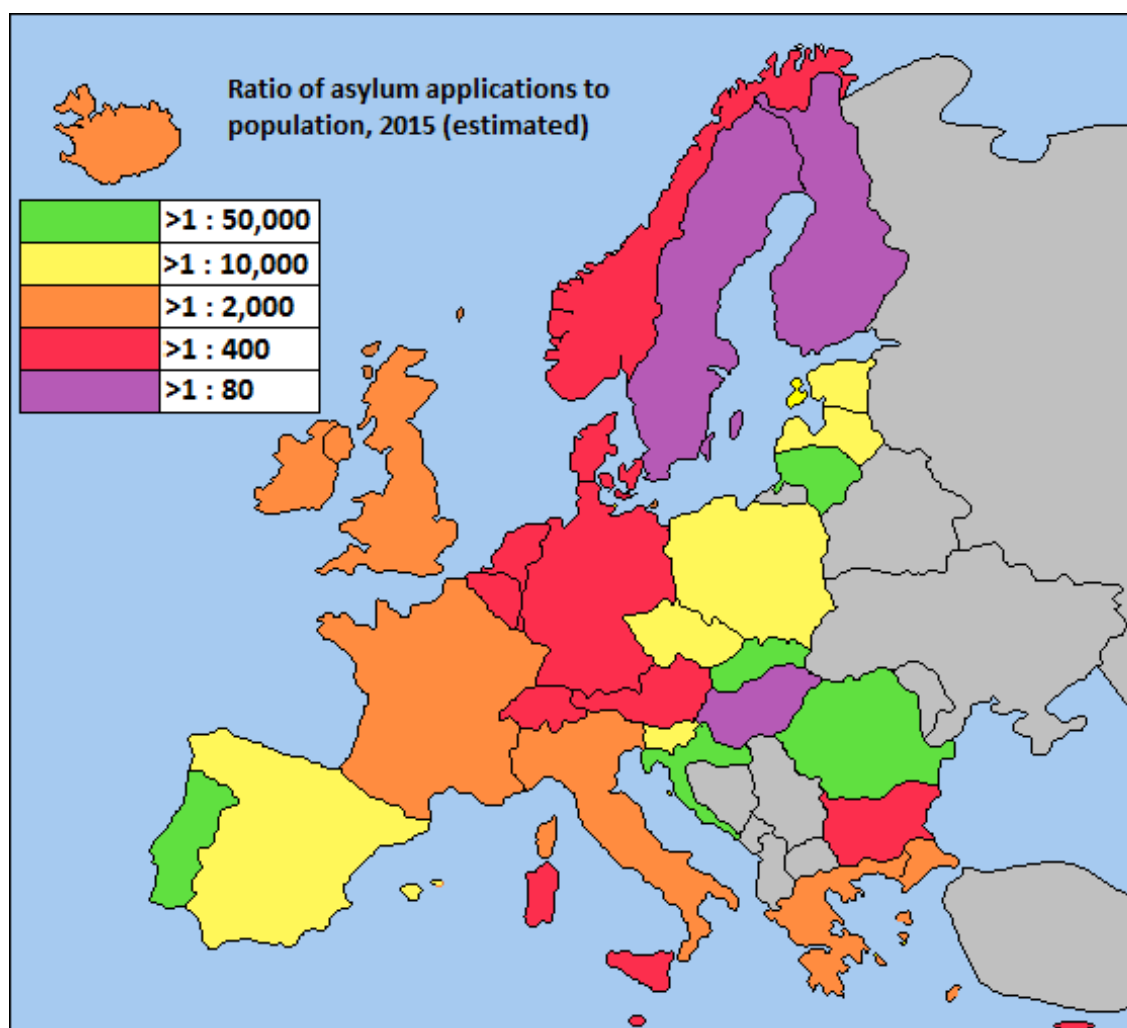
What has changed in 2015? Our figures for asylum applications are only estimates and they take no account of the backlogs, but it is nevertheless interesting to repeat the previous analysis for this year.



The relation between GDP and asylum-seeker density in 2015 remains equally close ($r = .82$), but FI is now receiving far more applications than one would expect given the country's size and wealth, and SK far fewer. The number of applications in DE is still roughly what would be expected, but it is certain to exceed that level when the backlog has been processed.

From the next map we can see how widespread the increase in asylum seeker density has been.

- SE, HU and FI have reached a new level of density (purple), although the high figures for Hungary are subject to doubt (see below).
- In 2012-2014 there were 5 red countries, now there are 12.
- UK, IS and IE have changed from yellow to orange, while BG, NL, DK, CY, BE, DE, LU, and NO went from orange to red. FI changed two levels, from orange to purple.
- Previously there were 6 'green' countries with very low asylum-seeker densities, now there are 5. In LT and RO applications have actually fallen, but CZ, EE and ES have changed from green to yellow.
- Germany will have a high asylum-seeker density in 2015 (1 in 185), **but not as high as Sweden, Hungary and Finland** (1 in 49, 52 and 66). Hungary has a high figure because it forces migrants to apply for asylum, but they will probably leave again soon (if they haven't already done so). So **Sweden and Finland** are under even more strain than Germany, though Germany has still to register many applications.



When we talk about ‘strain’ we should always remember to put these figures in global perspective. Even in Sweden and Finland, the asylum seekers arriving in 2015 will only add one or two percent to the local population. In Germany the figure is half a percent. By contrast, the corresponding figure for Lebanon last year was 23% – nearly fifty times higher than for Germany. When we consider that people in Germany are also about three times better off than people in Lebanon, it’s clear that ‘strain’ is a very relative notion.

Is there a need for a compulsory reallocation scheme to ensure more burden-sharing between EU countries? Relocation from Greece is an obvious priority, but most of the countries which are currently refusing to take part in burden-sharing would not be expected to attract many asylum seekers anyway, given their small size and low GDP. The graph on p. 6 shows that IE, IS, NL, UK and SK are receiving lower numbers than expected at the moment; the same is true for LU, NO and CH, which were excluded from the analysis as ‘outliers’. However, forced (as opposed to voluntary) reallocation exerts compulsion on either the asylum seeker or the destination country, or both: in either case, conflicts may arise with international law. In fact, the present picture suggests that among the richer countries, demand is reasonably well matched to capacity, though some could do more – and should be encouraged to do so.

Finally, a very important point is that **the crisis concerns not simply a lot more asylum seekers, but also a lot more undocumented migrants**. Here is an estimate of the number of asylum seekers from this year’s applicants in Germany who are likely to be rejected:

Likely rejections Germany 2015
(based on January-October figures from BAMF)

- Acceptance rate war zones 99%
- Acceptance rate Balkans etc. 2%
- Percentage from Balkans etc. 42%

So overall acceptance rate is 58%

- Estimated applications all 2015 434.584
- **Estimated rejections all 2015 183.258**

*Some will appeal against their rejection, some will be deported or go home voluntarily, the rest will become **undocumented migrants**.*

This may be good news for the asylum system, but it is bad news for everyone else. We must also remember that a very large number of new entrants to Germany have not been registered, which could at least double the above figures. Something approaching half a million people who arrive in 2015 are likely to receive rejections, after which they will become undocumented and may go underground. Therefore, the challenge to the health system doesn’t only concern asylum seekers and refugees, but also **undocumented migrants**.

Global distribution of asylum applications

In this section³ we analyse the relative asylum burden experienced by four groups of countries, comparing applications in 2014 and 2015 (estimated). Average GDP's are given for each group⁴:

	GDP
• Poorest 15 EU/EFTA countries	71
• Richest 16 EU/EFTA countries ⁵	135
• Canada, USA and Australia	129
• Turkey, Lebanon, Iraq and Jordan	43

Figures on asylum applications should only be taken as indicative, since some of the data they are based on is unclear or missing.

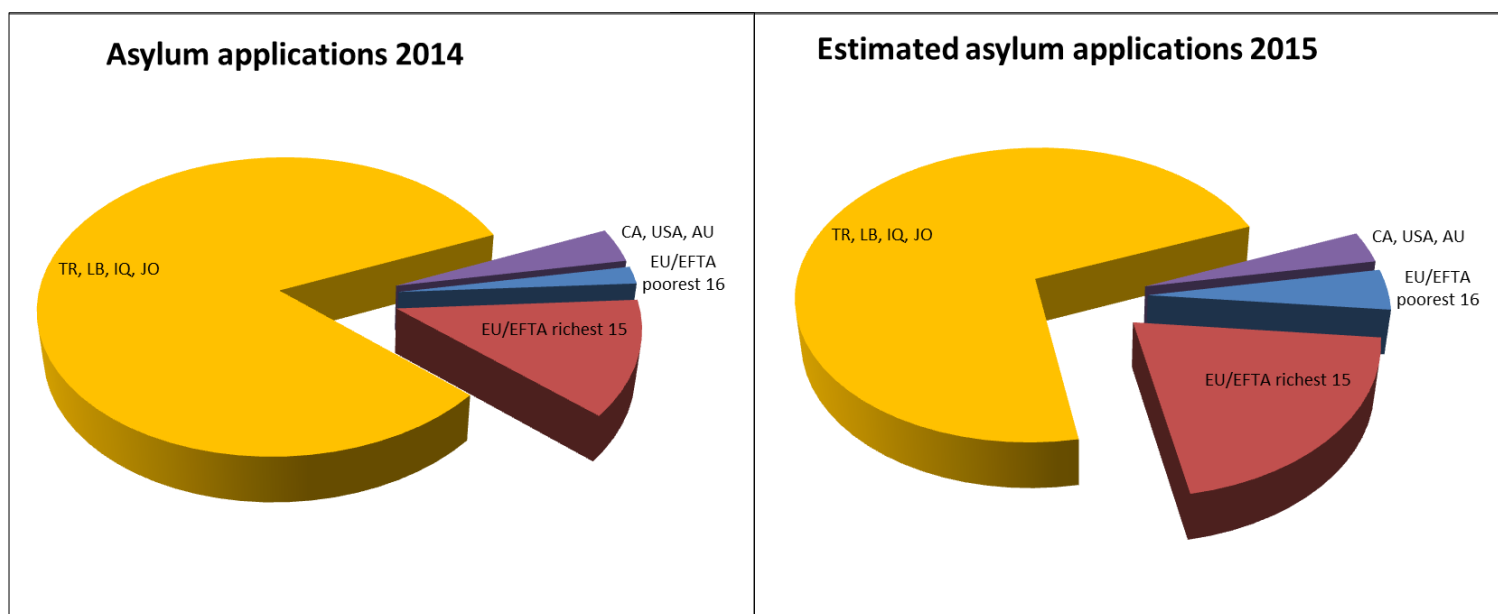
- More than half of the total for the poorest 15 EU/EFTA countries is contributed by Hungary, which (as already noted) has rather idiosyncratic asylum policies. These policies have been subject to sudden changes in 2015 and it is unlikely that figures have the same meaning as in other EU/EFTA countries.
- Figures for CA, USA and AU concern asylum seekers from a different range of countries from those in Europe and the Middle East. Moreover, figures in these countries concern not just asylum seekers applying on arrival, but also 'resettled refugees' who have been living in UNHCR camps and are selected on the basis of their vulnerability and special needs.⁶ Resettled refugees have already been given refugee status by UNHCR, but asylum seekers can be denied protection. There is some uncertainty about definitions and data from CA, USA and AU: in particular, it is not clear to what extent the resettlement quotas are filled by (successful) asylum seekers. No figures could be found for 2015: we have estimated a 20% increase from 2014 to 2015.
- Figures for Turkey, Lebanon, Iraq and Jordan mainly concern forced migration from Syria. The concepts of 'asylum seeking' and 'international protection' do not apply here as in other countries: shelter is provided temporarily, under the aegis of UNHCR.

³ Added since the original talk.

⁴ GDPs per capita at 2014, adjusted for cost of living, normalised to the EU27 average of 100.

⁵ excluding Liechtenstein

⁶ A few thousand of such resettlements are undertaken by European countries annually, but these numbers are not yet large enough to take into account.



Bearing in mind the above qualifications, the following provisional observations can be made:

- The total volume of asylum applications represented in these charts increased between 2014 and 2015 by 42% (from 4,4 million to 6 million).
- As usual, most people fleeing violence sought shelter in neighbouring countries. However, the proportion applying for asylum elsewhere has increased (from 18% to 28%). This is mainly due to increased applications in EU/EFTA countries.
- The richest 16 EU/EFTA countries receive far more applications than the poorest 15. In fact, more than half of the total for the poorest countries is contributed by Hungary. For most migrants Hungary is a transit rather than a destination country, but an unusually high proportion of them are apprehended and forced to register at a centre.⁷ Among the richest 16 countries, the *average* number of applications in 2015 was 76,860; if we exclude Hungary, this is more than the total for the poorest 14 countries put together (69,276). This shows how marginal the contribution of the poorest countries is and what little difference it would make to increase it.
- In recent years, policies in CA, USA and AU have been in flux. Following the October 2015 elections, the Canadian government immediately started to relax the hard-line policies of the previous administration. In the USA asylum seekers must now wait two years for an interview; the backlog of cases was 82,175 in March 2015.⁸ Despite an announced increase in the quotas for resettlement, concern about security is hampering efforts to resettle Syrian refugees in the USA. In Australia policies have hardened considerably since the September 2013 elections.

⁷ In September 2015, hundreds of migrants who had boarded a train in Budapest thinking it would take them to Germany were transported instead to a reception centre. See

<http://www.theguardian.com/world/2015/sep/03/hungary-train-diverts-refugees-back-to-camp>

⁸ <http://www.theguardian.com/commentisfree/2015/sep/09/backlogs-bureaucracy-no-excuse-us-fail-asylum-seekers>

2. The challenge to health systems

Obviously these increased numbers are going to put a lot more strain on health systems and that is the main topic of today's symposium. Let's look at **health services for asylum seekers and undocumented migrants**, in Europe in general and Germany in particular.

In fact this is a hot topic in the international health community at the moment. In the last few months countless guidelines, recommendations and policy briefs have been circulated (including the one from Leopoldina). But few of them follow the basic medical procedure of making a thorough diagnosis before prescribing a remedy. I think we first have to identify the problems, or the predictable problems, before we decide on the solutions.

Fortunately we now have detailed information on the deficiencies in health policies affecting migrants. This comes from a large survey on these policies covering the whole of Europe. The results I will show you now are hot from the press – they haven't been published yet.

This survey was a partnership set up by the COST Action ADAPT⁹, which I coordinate. We collaborated with the International Organisation for Migration (IOM) and the MPG, which produces the MIPEX (Migrant Integration Policy Index). Co-financing was provided mainly by the EC (DG SANCO). We surveyed all EU and EFTA member states plus a few neighbouring countries, as well as 6 OECD countries outside Europe. You can find the raw data at www.mipex.eu. Detailed reports on the results will be published by IOM next year in their project EQUI-HEALTH (<http://equi-health.eea.iom.int/>).

a. Access to health services

This is clearly the most basic issue, because high quality care is no use if people don't have access to it. Access has many components, so we first have to separate them from each other.

The most basic component is **entitlement to care**. In every country the law regulates this for different categories of migrants. Entitlement doesn't necessarily mean that care is free – but it has to be **affordable**. If you have to pay the full cost of treatments, or take out a private (i.e. not state-regulated) insurance policy, this doesn't count as entitlement. In the MIPEX survey we measure the restrictiveness of conditions for entitlement, the range of services covered and the exemptions that exist for vulnerable groups, or conditions regarded as a public health risk.

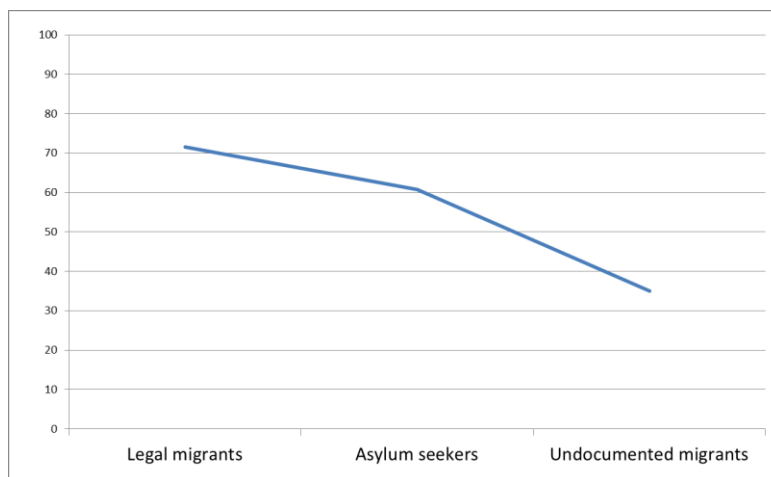
At the same time, MIPEX measures the **barriers to obtaining entitlement**: difficult procedures for getting access to treatment, or unclear rules which are subject to administrative or clinical discretion. This gives us the first two components of access:

1. Legal entitlements to health care
2. Administrative barriers to obtaining entitlement
3. Lack of information about the health system
4. [For UDMs] The threat of being reported
5. Linguistic and cultural barriers
6. Practical barriers

⁹ http://www.cost.eu/COST_Actions/isch/IS1103

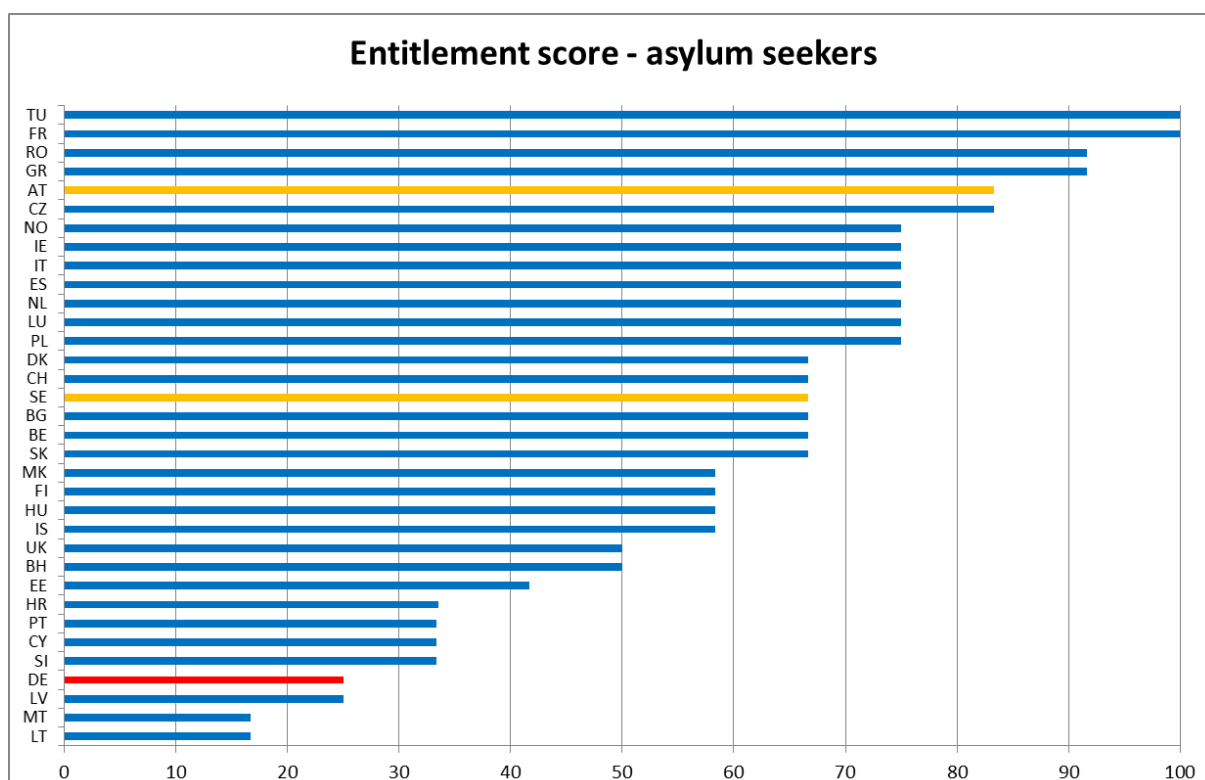
In MIPEX, the first two scores are combined to give a more realistic measure of entitlement. On average, the resulting entitlements for asylum seekers are halfway between those for legal migrants and UDMs.

Entitlements to healthcare for different categories of migrants (EU/EFTA countries)



The scores represent the extent to which provisions approach the ideal (i.e. equal rights for migrants and nationals). ‘Legal migrants’ are those from **outside** the EU/EFTA. The entitlements of asylum seekers are disappointing – only 61% of full equality. In 2003 the EU issued a Minimum Standards Directive on this topic, but we can see that the standards imposed were very low. (In fact, many countries have still not implemented them fully.)

How does Germany score regarding the entitlements for asylum seekers and undocumented migrants? Unfortunately, very badly.



Concerning care for asylum seekers, DE (red) is close to the bottom of the list, with the same score as Latvia and just above Malta and Lithuania. (Malta doesn't in fact restrict entitlements – it simply fails to define them.) The main reason for Germany's low score are the restrictions during the first 15 months (until 2014 this was 4 years). Care is limited to emergency treatment, attention to acute and painful conditions, pregnancy and childbirth, vaccinations and other 'indicated preventive measures' (*Asylbewerberleistungsgesetz* [AsylbLG, Asylum Seekers Benefits Act], §§ 4, 6). Additional measures can be taken only if they are 'essential' and they require a complicated administrative procedure. *Treatment for chronic and non-communicable illnesses, including mental health problems, is not covered.*

On 24th October 2015 the *Asylverfahrensbeschleunigungsgesetzes* (Asylum Procedures Acceleration Act) came into force. This attempted to solve some administrative problems related to health, but said nothing about basic entitlements except to emphasize an active vaccination programme for asylum seekers. Concerning asylum seekers with special needs, the law is still out of line with the EC Directive issued 12 years ago. The EC gave Germany a final deadline to transpose the Directive by July 2015, but this has apparently not been met.

I imagine that health workers often try to bend these restrictive rules, but I don't see how it will be legally possible in Germany to offer adequate health care to the hundreds of thousands of asylum seekers now arriving. The paradox is that Germany has the largest numbers of asylum seekers, but almost the worst legal provisions for healthcare. If you look at the scores of Austria and Sweden (above, yellow lines), you will see that the law enables health workers there to do a much better job.

There is only one consolation: this paradox demonstrates that restrictive health care entitlements have little or no effect on the choice of destination countries – contrary to the widespread belief among certain politicians. If they did make a difference, most asylum seekers would have gone to France – where they have 100% entitlement!

The other argument which is used to justify restrictive measures is that they save money. In fact there is more and more evidence that the opposite is the case. If conditions are left untreated until they become an emergency, the ultimate costs can be much higher. This year a very sophisticated paper was published by two researchers in Heidelberg and Bielefeld. They calculated that the restrictive policies increased the cost of health care by €376 a year for each asylum seeker¹⁰.

Restrictive policies waste money:

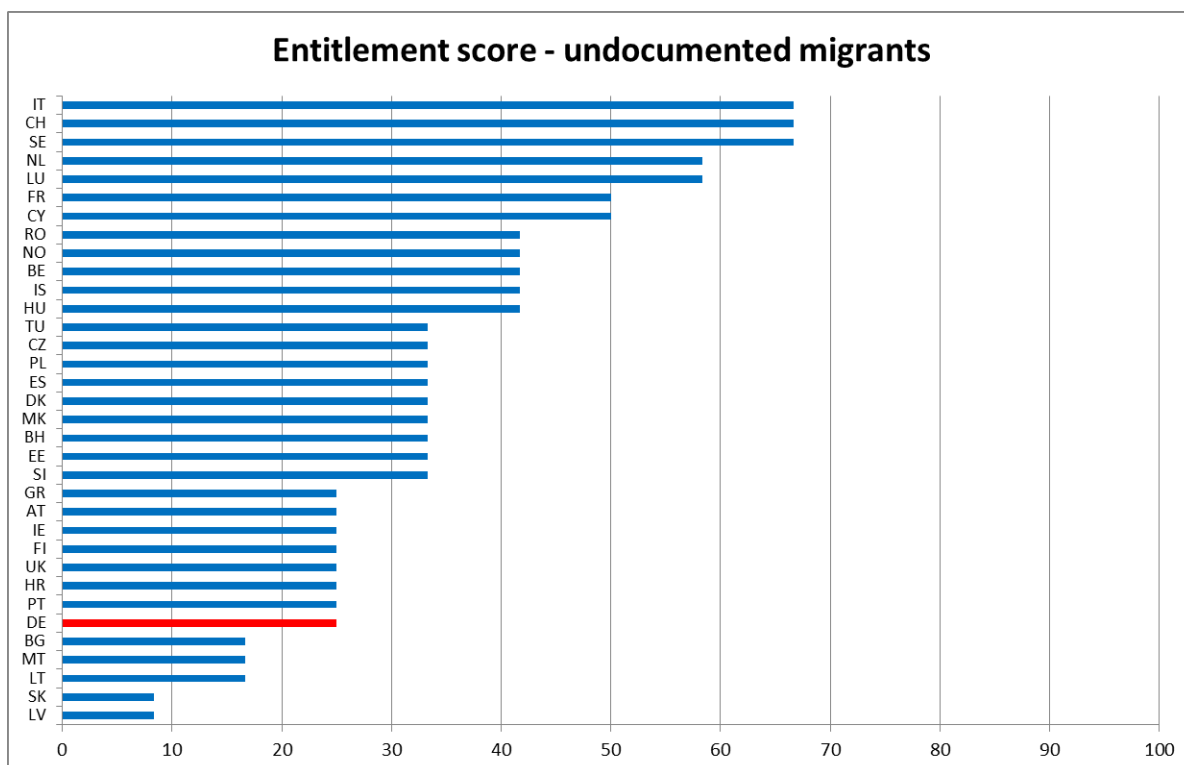
Bozorgmehr K, Razum O (2015)

Effect of Restricting Access to Health Care on Health Expenditures among Asylum-Seekers and Refugees: A Quasi-Experimental Study in Germany, 1994–2013. *PLoS ONE*, 10(7)

Estimate of extra costs over 20 years due to restrictive policies: **€1.56 billion**

¹⁰ <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0131483>

What about the many rejected asylum seekers who are likely to stay in Germany illegally?

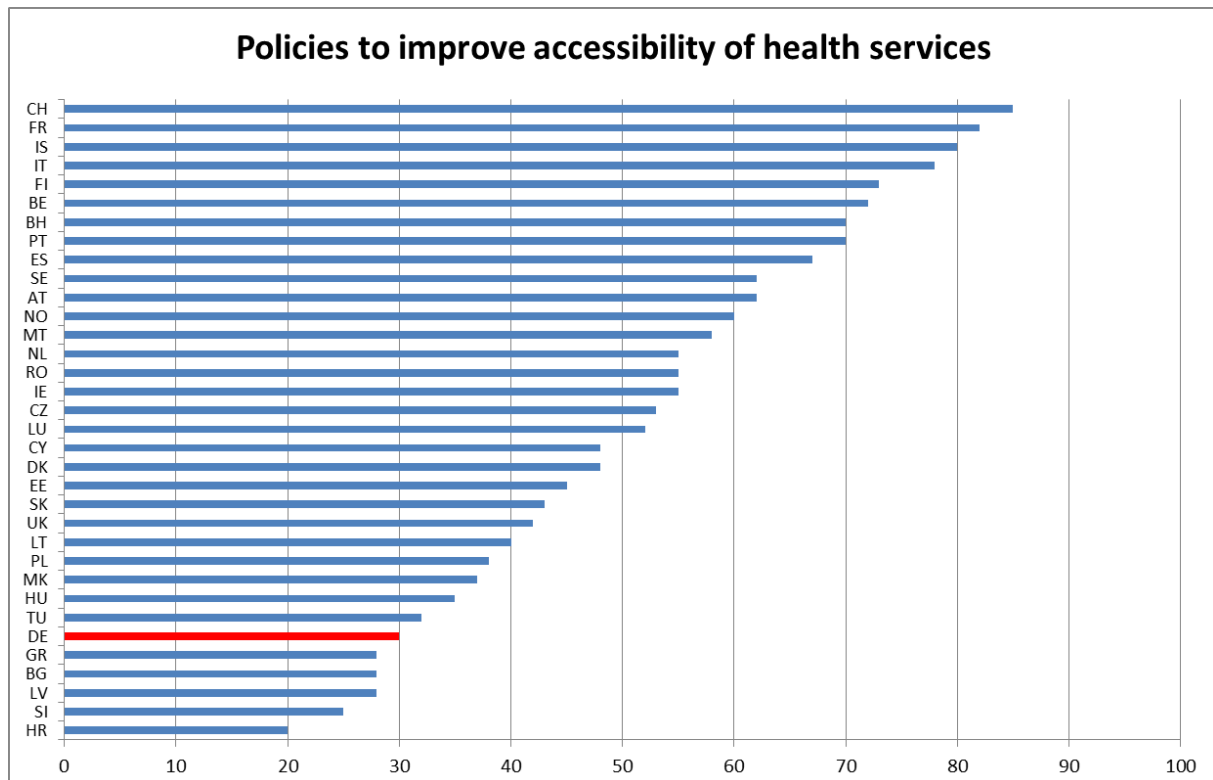


For this group the situation is even worse. This time Germany is a little further from the bottom of the table, because very restrictive policies for undocumented migrants are the rule in Europe. In Germany they have the same entitlements as asylum seekers do in the first 15 months – but public institutions have a legal obligation to contact immigration authorities if they discover that a person is residing illegally. There is an exception for medical staff in the case of an emergency, but an undocumented migrant still has to fill in forms at a municipal social assistance office to get entitlement. So again, there are many legal and administrative obstacles to providing good care for this group, and again the limitation to emergency care probably costs more money than it saves.

Now for the other components of access:

Policies to facilitate accessibility of health services

- Information for service providers about migrants' entitlements
- Information for migrants concerning entitlements and use of health services
- Health education and health promotion for migrants
- Provision of 'cultural mediators' or 'patient navigators' to facilitate access for migrants
- Is there an obligation to report undocumented migrants?



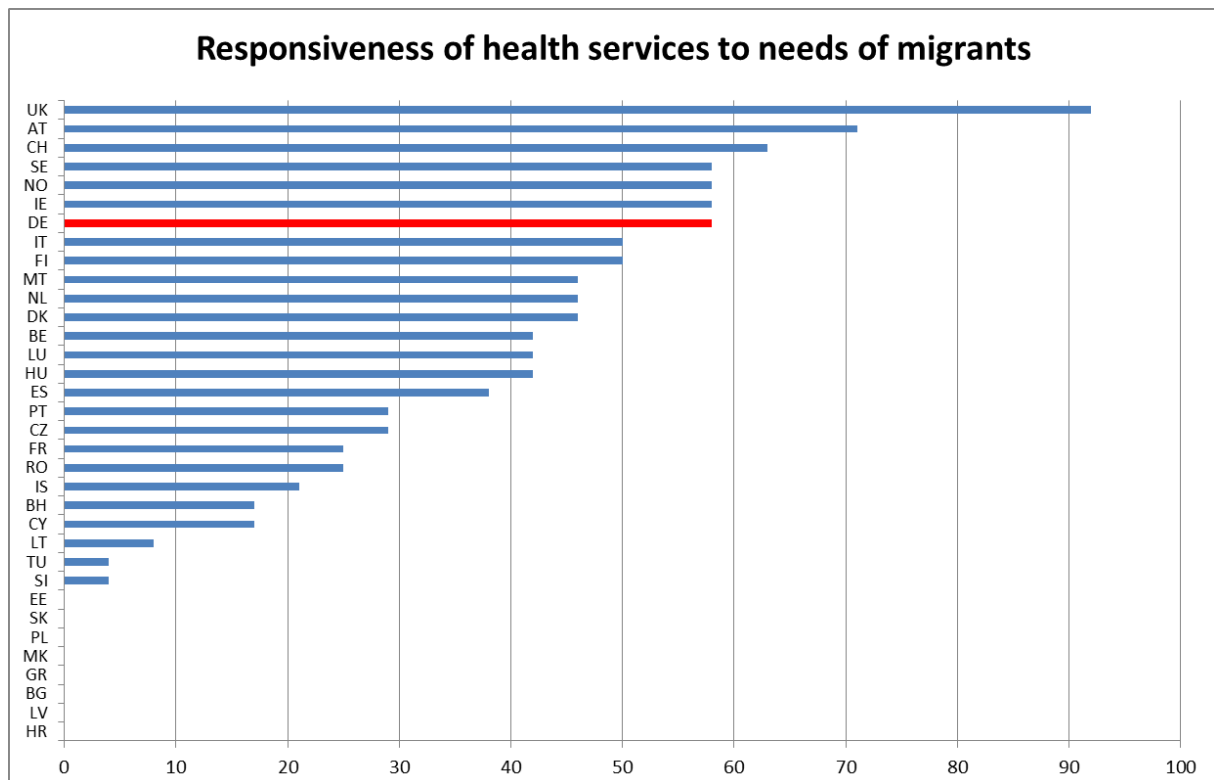
On this scale MIPEX makes a single score for all categories of migrants, so these data are not quite so specific. For asylum seekers the real situation is probably better in most countries than for other migrant groups, because they tend to receive more information: they are mostly housed in large centres, where interpreters and/or translated materials may be available. They also don't have to worry about being reported to the authorities. For undocumented migrants, on the other hand, the picture is probably worse, because they are not easy to reach and may have very little information about their rights and the health system. The threat of being reported to the authorities accounts for some of the low score for Germany.

b. Responsiveness of services

The next scale in the MIPEX instrument concerns quality, in particular the responsiveness of health services to the special needs of migrants.

Responsiveness of services

- Availability of interpretation services
- Requirement for 'culturally competent' or 'diversity-sensitive' services
- Training and education of health service staff
- Involvement of migrants
- Encouraging diversity in the health service workforce
- Development of capacity and methods



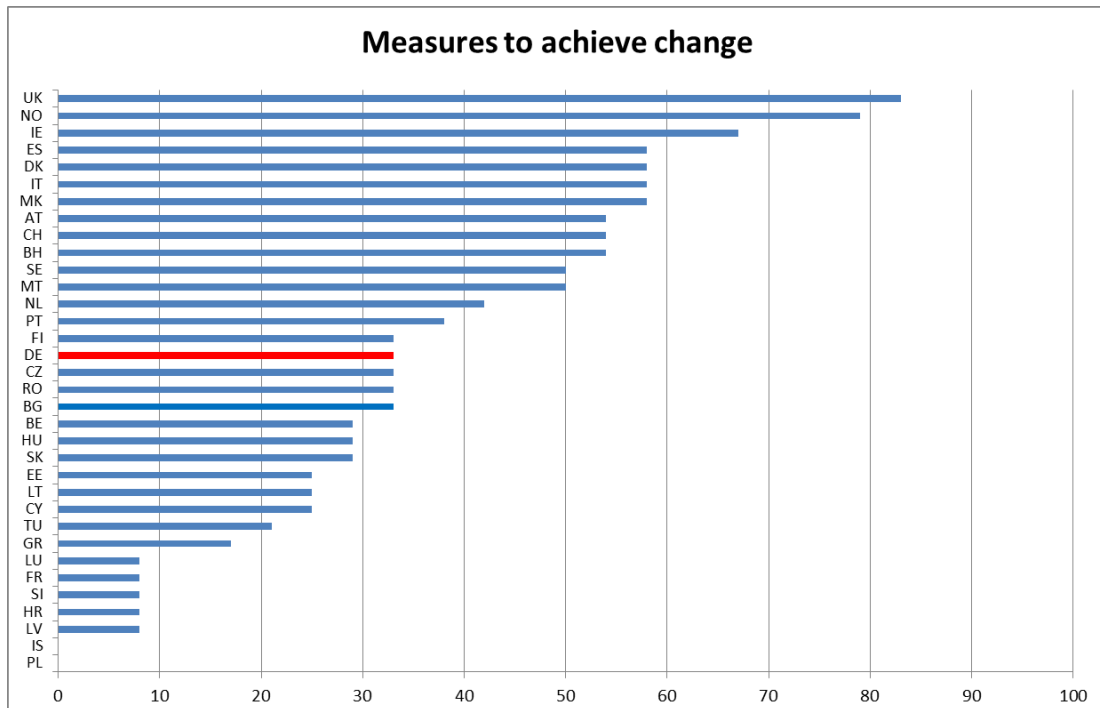
Here Germany does better. Eight countries score zero because they make absolutely no concessions to the idea that migrants have special needs in any sense. Germany has a well-established tradition of intercultural competence and attention for cultural differences, especially in the mental health sector. However, there are few system-wide measures.

Finally, the fourth MIPEX scale:

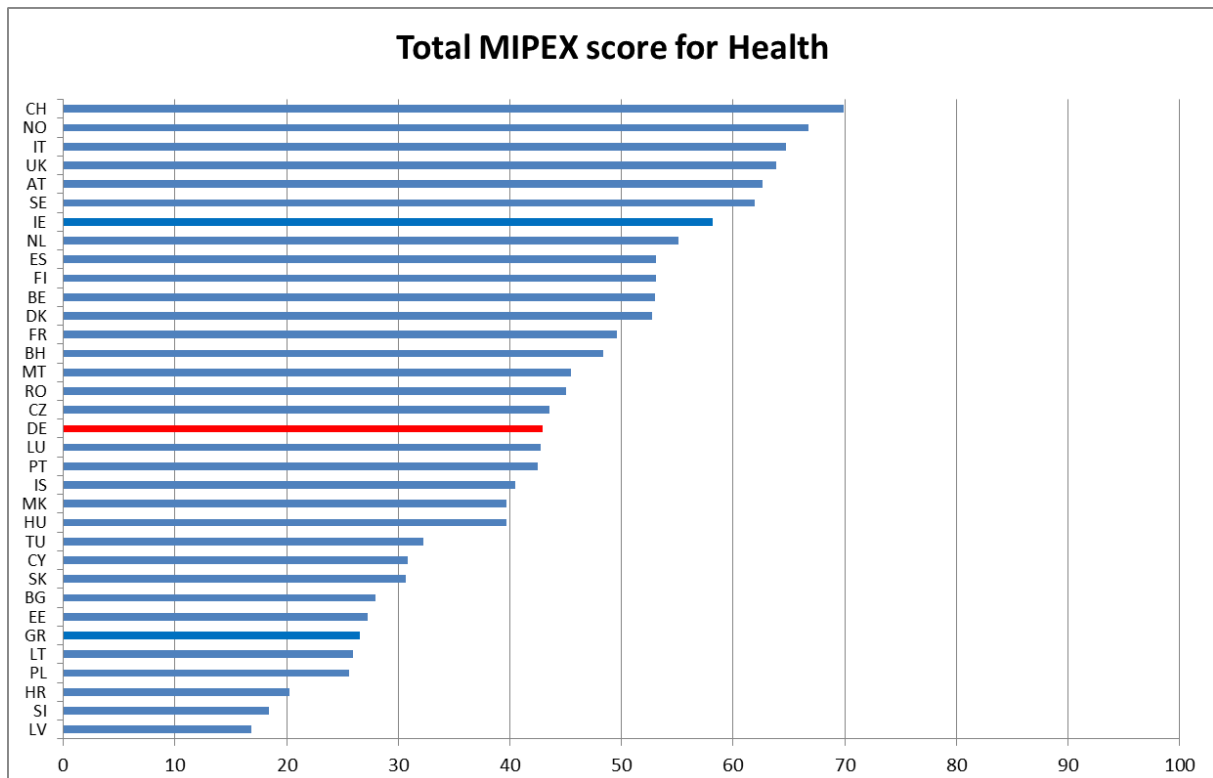
Measures to achieve change

- Data collection
- Support for research
- "Health in all policies" approach
- Whole organisation approach
- Leadership by government
- Involvement of stakeholders
- Migrants' contribution to health policymaking

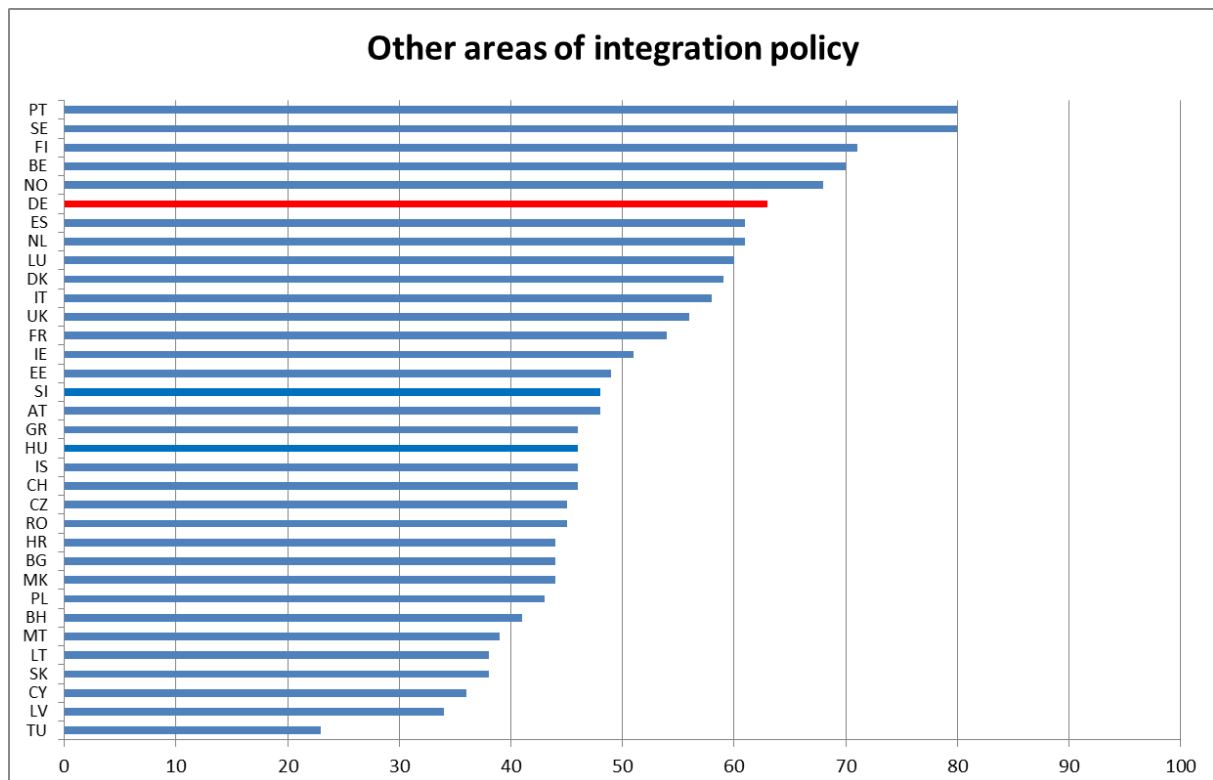
Here, Germany is about average: there not much central coordination and leadership. One can point to two main reasons. Firstly, the health system is Bismarckian rather than tax-based, so that governance is less 'top-down'. This may allow freedom for innovation (e.g. the MiMi project) – but more hierarchical tax-based systems tend to score better on this dimension. The second problem is the great degree of regional variation in Germany.



Total scores:



Again, Germany is about average. This might seem surprising given several low scores, but I didn't show you the scores for the entitlement of legal migrants, which are very good. I mentioned earlier that Germany's other policies concerning migrant integration are much better: unfortunately, few improvements in health policy have yet been undertaken.



That was the diagnosis – what should be the treatment? Clearly, an emergency action plan to improve migrant health care policies in Germany is needed. As just noted, in other areas of migrant integration there have been many changes for the better – but health policies seem to have been overlooked.

Unfortunately this may be a bad time to push for changes (due to the politically negative climate). Many politicians are deeply attached to restrictive policies for migrants – they think they have a deterrent function. In Germany, improvements to migrant health policies are apparently being considered, but changes in the political climate are very unpredictable at present. The recent ‘accelerated procedures law’ abolished or curtailed many rights of asylum seekers, which has led to a lot of protest from human rights agencies.

c. Health problems

When we say that migrants have special needs, this can mean two things. In terms of service delivery, it means one has to reduce the distance between the services and the migrants by taking away access barriers and improving communication. But it can also mean paying attention to the special health problems some migrants might have.

I mentioned before that Europe already experienced a large influx of asylum seekers in the 1990’s, and much was learned during that period about the health problems they may have. However, views have changed a lot since the earliest days.

Changing views on refugee health

How different are the health problems of refugees? Are the differences big enough to warrant separate treatment facilities?

When people first started to get interested in the health of migrants, there was a tendency to regard them as almost a different species: many thought that we needed a new medical speciality ('migrantology', perhaps?) because the illnesses they had were supposed to be quite different from those of the majority population. Many specialists in tropical medicine came to work with migrants. For refugees, other specialist knowledge was required to deal with the effects of traumatic experiences: here, the specialists came from working with survivors of World War 2 and (later) the Vietnam War.

So around 1990 there seemed to be strong arguments for offering migrants and refugees segregated health care – nevertheless, these groups became incorporated in mainstream health services. In fact, during the last 25 years there has been a change in views on migration, based on shifts in migration itself, summed up by the word 'superdiversity'. Many more different groups are migrating and there are often large differences within each group. Epidemiologists nowadays hesitate to make any kind of generalisations about migrants or refugees: there are no main effects, because everything depends on which group and sub-group you are talking about (and on age, sex and socioeconomic status).

When there is a group with a concentration of certain kinds of health issues and communication problems, there may be some point in separating care facilities. In any case, concerning primary care, when there are large numbers of asylum seekers living in a centre, the principle of "bringing care close to the community" dictates that the point of access to the health system should be located in the centre. However, it is doubtful whether a policlinic for specialist care in an asylum-seeker centre, with specialist services, would be viable. **The vast majority of the health problems refugees and other migrants have are the everyday ones shared by all human beings, depending on their age and sex.** Specialist care units require a large catchment area: their staff and equipment are expensive, and to offer a full range of expertise they have to be very large. That is why there are no village hospitals any more. The best resources for specialist care are therefore facilities *outside* the asylum-seeker centres, serving a much wider area. The drawback is of course that they are less accessible for asylum seekers and less likely to foster intercultural skills – so special measures have to be taken to counter these problems.¹¹

What else has changed in views on migration and health?

I will just list a few themes briefly.

- **"Health in all policies" approach.** There is more emphasis on social determinants of health, in particular the effect of post-arrival factors on well-being and mental health. This is largely a task for other ministries than Health (e.g. for asylum seekers: avoiding maddening legal procedures, unsatisfactory conditions of accommodation,

¹¹¹ See also *How health systems can address health inequities linked to migration and ethnicity*. Copenhagen, WHO Regional Office for Europe, 2010. <http://bit.ly/hKAe3T>

frustration of basic human needs such as work, study and recreation. Frequent relocations are disastrous for well-being.)

- **Integrated care** – health care linked up with other social services.
- **Continuity of care** – keeping medical records together, giving the asylum seeker a single ‘medical home’. Sporadic use of emergency facilities due to restricted entitlement makes this impossible.
- **Holistic approach** – training should not just be aimed at health workers, but at the whole organisation. Ultimately it is the health system itself which must become ‘diversity-proof’.

Finally, it is a very encouraging sign that the German Academy of Sciences has organised today’s meeting. and I hope it will produce some momentum in the right direction. In the present situation it will be extremely valuable for experts from all countries to come together and share their views on how to care for the health of refugees and other migrants.

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