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A public health perspective on refugee migration and access to healthcare

60 million people are forcedly displaced worldwide (UNHCR, 2016). Being displaced constitutes a major life-event with far-reaching consequences for the individual's life and health. It is however, also a challenge for the communities they leave behind and those where they arrive. Some of these challenges touch upon the field of public health.

A common method to identify public health challenges and subsequently working towards their solution is the Public Health Action Cycle (PHAC). It is a structured approach to problem solutions through policy changes, interventions or public health programs. It usually consists of four steps: the assessment or the problem definition, the policy or strategy development, the implementation or assurance and the evaluation (Institute of Medicine 1988; Kolip 2006; Rosenbrock 1995).

We use the approach of the PHAC to illustrate the problem of, summarize evidence on and discuss potential solutions for entitlement restrictions and access barriers to health care for refugees in Germany.

First step: Assessment and problem definition

The definition of the problem constitutes the first step of the PHAC. It depends equally on the empirical findings or observations and on the normative idea of a good public health system. Usually public health problems arise when the observations and ideals diverge. This is also the case in the field of refugee migration and health care.

A common ideal of a good public health system is described in the WHO concept of universal health coverage (UHC) laid down in its 2010 World Health Report on *Health systems financing: the path to universal coverage.* It has been embraced by the UN General Assembly in December 2012 (United Nations General Assembly, 2013) and also by Germany. A public health system in accordance with the idea of "*universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the promotive, preventive, curative and rehabilitative basic health services needed and essential, safe,*

affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population" (United Nations General Assembly 2013: 10). It basically translates the ideal of equity in health (care) into practice. The WHO concept mentions three dimensions in which UHC should be advanced: all groups of the population should be covered (dimension 1), all important services should be included for all people (dimension 2) and the share of direct costs for the patient should be reduced (dimension 3) (World Health Organisation, 2010). However, what we observe in Germany does not comply with this ideal of UHC with regard to the health care of refugees.

(1) *Population covered*: During their first months after arrival refugees do not have the same entitlement and access to health care services compared to non-refugees. The Asylum Seekers Benefits Acts (AsylbLG) restricts the entitlement to health care (in §§ 4 and 6). Additional bureaucratic regulations complicate their actual access to necessary services in many parts of Germany through the system of health care vouchers that have to be collected from the local welfare agencies before accessing care. As such they differ from other migrants in Germany who usually have full access due to employment, education program, their family etc.

(2) *Services covered*: There are services necessary for refugees that are generally not covered within the public health system (neither by the statutory health insurance nor by (all) local welfare agencies). This applies for example to the financing of interpretation during consultation and therapy. This policy does not specifically aim at regulating the health care of refugees, but ultimately affects them most of all.

(3) *Proportion of the costs covered*: Given the restrictions and services not covered, refugees have to rely on alternative services financed by humanitarian/voluntary organizations (e.g. humanitarian consultation hours based on voluntary work, donations and external funding) or bear the costs themselves.

This assessment, namely, that observations and ideals (UHC) diverge, constitutes the starting point of a new PHAC. From a public health perspective, the following problem exists: Newly arrived refugees face specific barriers when accessing health care, namely the entitlement restrictions according to the AsylbLG and the obligation to apply for health care vouchers before accessing care. These barriers result in the exclusion of newly arrived refugees from certain public health services which runs against the ideal of UHC.

Second step: Strategy or policy development

Subsequent to the problem definition, possible strategies for the solution of the problem have been developed. Public health professionals, the statutory health insurances, social society organizations as well as stakeholders in some federal states and communities were involved in the development of these strategies.

There were different approaches to the problem of restricted entitlement and bureaucratic access barriers. Legal changes constituted one possible approach. With regard to the

entitlement restrictions, the abolishment of the AsylbLG constitutes an obvious strategy. Its abolishment would mean a return to the situation before 1993 and a progress towards the ideal of the UHC (dimension: population covered). Whereas this would necessitate policy changes on federal level, the opening clause (§6 AsylbLG) enables federal states *de facto* to circumvent the restrictions on the state level. §6 allows for the granting of many additional services on a case-by-case basis. In federal states where the case-by-case review is loosened, refugees have access to services nearly equivalent to the benefits catalogue of the statutory health insurances. With regard to the health care vouchers, the ehealth card constitutes a much discussed solution. While the entitlement restrictions stay in place, refugees receive ehealth cards comparable to the health insurance cards distributed by the statutory health insurances. Hereby, refugees do not need to apply for health care vouchers, but may access health care directly.

Other approaches that do not need legal changes are also feasible. The number of voluntary and/or local projects and solutions for the problem of limited access to health care for newly arrived refugees is impressive. Many of them were in place even before the rise in numbers in 2015 and 2016. Several projects have been added during the last years. They all try to circumvent the entitlement restrictions and access barriers for newly arrived refugees. Additional consultation hours in the communal accommodation facilities have been organized and refugee clinics have been established at hospitals. There is also a growing (but still limited) number of specialized psychosocial and psychotherapeutic clinics, offering care for traumatized refugees free of charge. In some communities, health care vouchers are sent by mail directly to the refugees' homes with the effect that refugees do not need to collect their health care vouchers at the local welfare agencies. These services and changes are valuable (and needed as long as legal changes are pending). However, some of them are not part of the standard care system, but constitute a parallel system built on donations, third party-funding and voluntary work. Project-based solutions do not sustainably advance universal health coverage and equity in health (care).

Third step: implementation

Once strategies have been developed and selected, they are to be implemented accordingly.

The AsylbLG has not been abolished. The entitlement restrictions thus stay in place for refugees during the first 15 months – an advancement compared to 48 months before 2015. In addition, federal states interpret the restrictions differently. Bremen for example, has "de facto" abolished the restrictions even during the 15 months by loosening the case-by-case review and establishing additional services for psychiatric care. Some restrictions stay in place even in these states (e.g. long-term psychotherapy)(Classen, no date).

In the course of the introduction of an ehealth card for refugees, many federal states have entered into agreements with the statutory health insurances. While these agreements primarily enable refugees to seek health care directly without applying for or using health care vouchers, they also affect the entitlement restrictions. They basically have rendered the local

case-by-case reviews redundant with regard to many services and thereby reduced the number of services that are difficult to access for refugees.

As of today, four federal states have introduced the ehealth card completely and region-wide. There are additional five federal states that have legally introduced the ehealth card, but it is not (or not yet) fully implemented in all communities. The remaining seven states are either still discussing or oppose the introduction (Medizinische Flüchtlingshilfe Göttingen, no date; Wächter-Raquet, 2016).

Forth step: Evaluation

The problem that hampers the actual evaluation of the impact of these policy changes on access to health care for refugees is the incomplete health monitoring system. It does not yet cover information on health care needs and use of health care services among refugees in Germany (Razum *et al.*, 2016). Currently, there are plans to advance the monitoring system in this regard (Frank *et al.*, 2017). However, so far, evaluation is difficult as the analysis in Bremen and Hamburg show (Jung, 2011; Behörde für Arbeit Soziales Familie und Integration der Freien und Hansestadt Hamburg, 2014).

The focus of existing evaluations has been mainly on the cost development – albeit with meaningful results. In a study based on health expenditure data from the federal level, Bozorgmehr and Razum (2015) ascertained that the health care expenditure for refugees with restricted entitlements was higher than the expenditure for refugees without these restrictions (Bozorgmehr and Razum, 2015).

The evaluation is still ongoing. Financed by the Ministry of research in North Rhine-Westphalia, we currently evaluate the introduction of the ehealth card with regard to the actual differences in perception, organization and use of health care services of refugees using ehealth cards or health care vouchers.

Advancing UHC is a long-term aim. Reaching it necessitates primarily the political will to change existing policies. Public health research may facilitate these changes, develop new solutions and evaluate their impact.

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