6 Health Care

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6.1 Introduction

Health is an essential part of human life and access to health care is a core need of every human being. Newly arrived migrants are no exception, some of them might have suffered traumatic experiences before or during migration, others may have acquired health problems already in the host country (and not necessarily as a result of their migration). Just like anyone else, migrants may have chronic and acute illnesses, or be need pregnancy check-ups and treatment at childbirth, or be at risk of infections such as Covid-19 or the flu. However, newly arrived migrants may face various legal, administrative, linguistic, and cultural barriers when accessing health care systems in receiving countries (Gil-González et al. 2015). When untreated, health problems can create obstacles to integration and participation in the labour market, as well as society at large, and even lead to premature death (Slootjes 2021). This chapter aims to synthesise research about integration of post-2014 immigrants into health care systems of European countries. We will draw on both academic and policy-oriented literature and research projects to provide a comprehensive overview of how

the health of newly arrived migrants is addressed through policy and practice. The review includes studies on the health status of immigrants, their use of health care services, and how their access to health care is regulated and facilitated. The first years after arrival are especially challenging in terms of access to health care, from both institutional and individual perspectives. On the one hand, there are institutional challenges related to formal incorporation of the newcomers into receiving structures, for instance, arrangement of all necessary documentation to access health care. On the individual or informal side, there could be a lack of knowledge regarding the health care system, an inability to communicate the health issue, cultural norms that may cause misunderstandings or even prevent migrants from seeking medical help, and many other issues.

Migrants' health and access to health care is a well-established area of research. Barriers to health care access for migrants generally, but particularly asylum seekers and irregular migrants, have been increasingly studied in the past decade. There is also a growing body of research evaluating interventions and programmes that attempt to facilitate access to health care for migrants, such as cultural competency interventions, the use of interpretation services in hospitals, or measures to improve health literacy among migrants.

This chapter begins by outlining recent research on the health and health care access of post-2014 migrants and the evidence gathered on their health status and barriers to health care. It discusses how the question of both facilitating and restricting health care access is discussed in public and policy debate, before providing an overview of instruments and tools employed to facilitate and regulate access. Finally, the scarce evidence on such policies and programmes is discussed, and the sustainability of such practices is commented on.

6.2 Research on health

A review carried out by the MigHealth care project in 2018 (co-funded by European Union's Health Programme), which was based on 71 papers published between 2011-2017, indicates that research on migrant health is usually country specific and focused on specific illnesses. Mental health remains an underexplored topic, studied mostly in relation to refugees, since those are groups fleeing

Figure 1: Key words from titles of the reviewed literature on migrants' health

Figure 6: Medical related issues in the reviewed literature. (Bigger words are more frequent).

Note 1: words inherent to the topic (i.e., health or health care) are filtered out. (Bigger words are more frequent).

conflicts and violence, as well as long processing times of asylum applications result in psychological traumas and disorders (Bogic, Njoku, and Priebe 2015; Fazel et al. 2012; Hodes, Anagnostopoulos, and Skokauskas 2018; Hollander et al. 2016; Leitner et al. 2019; Melamed et al. 2019; Mohamed and Thomas 2017; Niemi et al. 2019). Generally, a top-down evaluation approach is employed, and there are fewer investigations of migrants' own, self-defined health needs. Several studies investigate accessibility of health care for migrants, where the focus lies predominantly on undocumented migrants and refugees (Henry, Beruf, and Fischer 2020; Agudelo-Suárez et al. 2012; Kor Grit, Otter, and Spreij 2012; El-Gamal and Hanefeld 2020; Médicins du Monde 2016; Kohlenberger et al. 2019; Aniek Woodward, Howard, and Wolffers 2014; O'Donnell 2018; European Union Agency for Fundamental Rights 2013; Gil-González et al. 2015; Arora et al. 2018; Spencer and Hughes 2015; Razum and Bozorgmehr 2016; Cuadra 2012). Across the literature, there is a greater focus on communicable diseases rather than non-communicable diseases, preventative care, and equity in health (Lebano et al. 2020). In terms of scientific disciplines, most research can be found in specialised medical and health journals, journals dedicated to health policy, and journals focusing on the issues on the intersection of migration and health.

Figure 7: Groups in focus of the reviewed literature on migrants' health (Bigger words are

According to an earlier review carried out by PHAME (Public Health Aspects of Migration in Europe) in 2015 on delivery of health care and health care policy for refugees and asylum seekers, research comes mostly from three European countries: the UK, the Netherlands, and Scandinavia. They also state that country-specific research makes a comparison in terms of health care difficult. They highlight a limited scope of evidence on health status of asylum seekers and refugees, where focus mostly lies on maternity care and mental illness. They argue that there is scant evidence on use of health care services by migrants compared with non-migrant populations (Bradby et al. 2015).

Figure 8:Countries from titles of reviewed literature on migrants' health. (Bigger words are more frequent)

The topic of self-determined or subjective perceptions of health and wellbeing by refugees has received more attention recently (Georges et al. 2021; Psoinos et al. 2017; Jaschke and Kosyakova 2021). Furthermore, the accessibility of health care services for migrants has also been increasingly studied. For example, a recent comparative study has examined differences in self-reported health of asylum seekers and refugees between Germany and Austria, in order to establish the effect of limited versus unrestricted access to health care (Georges et al. 2021). A similar study investigated whether early or improved access to the health care system has a positive effect on the mental and physical health of refugees in Germany (Jaschke and Kosyakova 2021). Both studies found that unrestricted access improved mental wellbeing, as well as the subjective health assessment of refugees.

Another recent research focus is on the perspectives of health care practitioners on providing services to migrants, examining the challenges they face in treating migrants, or their accounts of migrants' access (Harrison and Daker-White 2019; Dauvrin et al. 2012; Devillé et al. 2011; Lindenmeyer et al. 2016; Suphanchaimat et al. 2015; Balaam et al. 2016; Bradby et al. 2020). Two EU-funded projects have specifically focused on health care provision for migrants working together with health care professionals. EUGATE[19] (Dauvrin et al. 2012) project analysed legislation, policies, and perspectives of health care providers from 16 EU countries in the period from 2008 till 2012, to formulate recommendations of best practices of health care for migrants and minorities. Another project, Restore (2011- 2015), studied the implementation strategies for patients of different origins and language background in primary care settings[20] (Lionis et al. 2016). Together with health care professionals, Restore co-designed innovative solutions for adapting health care for immigrants and evaluated them from the perspective of participants.

[19] http://www.eugate.org.uk/index.html
[20] https://www.fp7restore.eu/index.php/en/project-details

6.3 Integration situation (inequalities) in terms of migrant's health and health care access

(1) Health situation and inequalities[21]

Research commonly refers to the 'healthy migrant' effect, as in Europe immigrants are, on average, younger and healthier relative to native population. This may be true initially, since good health and younger age are important personal determinants of migration in the first place. This leads to 'natural' selection, especially among voluntary labour and family migrants both within the EU and from third countries. However, for forced migrants, multiple factors before and during migration process might engender ill health. Self-reported health of refugees falls below that of resident population (Kohlenberger et al. 2019). War, social unrest, and extreme poverty in the countries of origin prone people to leave and in the process cause a detrimental impact on their health. Many refugees have not only seen the horrors of violence, but some experienced them: bombings, killings, loss of loved ones, abuse, torture, and rape. Moreover, harsh conditions of perilous journeys that refugees make in order to reach Europe contribute to both mental and physical health problems. Furthermore, upon their arrival, precarity and uncertainty related to long processes of recognitions, overcrowded living conditions, or a lack of resources may continue to contribute to ill health (O'Donnell 2018). There is clear evidence of a higher prevalence of mental distress in refugees and migrants (Lebano et al. 2020; Bogic, Njoku, and Priebe 2015; Fazel et al. 2012; Hodes, Anagnostopoulos, and Skokauskas 2018; Hollander et al. 2016; Leitner et al. 2019; Li, Liddell, and Nickerson 2016). For example, a cohort study in Sweden found that refugees are at increased risk of schizophrenia and nonaffective psychotic disorders compared to native-born Swedes and non-refugee migrants. Migration trajectory, racism, discrimination, and poverty are named among possible reasons (Hollander et al. 2016). Literature further discusses unmet mental health needs of migrant children, particularly unaccompanied minors (Bradby et al. 2015). Poor living conditions among various vulnerable migrant groups are linked to their poor physical and mental health (Lebano et al. 2020). This can occur not only among refugees, as mentioned above, but also irregular immigrants, low-skilled migrant workers, and family migrants joining spouses with low earnings, who may experience poor living conditions more often than others.

Migrant mothers reportedly have poorer birth outcomes and perinatal health compared to native populations; asylum seekers and refugees are particularly at risk (Bradby et al. 2015; Anouk E.H. Verschuuren et al. 2020; Heslehurst et al. 2018; Kaufmann et al. 2021). A systematic literature review carried out in 2018 found that there was consistent evidence that perinatal outcomes were predominantly worse among migrant women, particularly in terms of mental health, maternal mortality, preterm birth, and congenital abnormalities (Heslehurst et al. 2018).

[21] (See Migration and Health programme 2018; Lebano et al. 2020; Bradby et al. 2015)

Evidence also indicated that health needs of migrants are less likely to be met, and the risk of not being treated is significantly higher among irregular migrants, since their access to health care is legally restricted in many countries (Busetta, Cetorelli, and Wilson 2018). For migrants in transit, the continuity of health care is also a big issue, since in order to gain access, many countries require registration (van Loenen et al. 2018).

The recent COVID-19 pandemic has revealed further inequalities of migrants' health. Migrants are at a disproportionately higher risk of infection compared to native populations, and their mortality rate is two to five times higher. These trends have been observed globally. These observed inequalities in health are linked to higher exposure of migrants to drivers of ill-health, such as low income and poor housing, as well as various barriers to accessing the health services in countries of residence (Slootjes 2021).

(2) Access to health care

Out of all migrants, undocumented ones have the most barriers to access health care. According to an overview published in 2015, in six EU member states, they are entitled only to emergency care. In a further 12 countries, irregular migrants are excluded from primary and secondary care but have entitlements to certain specialist services. In 10 Member States, irregular migrants have the right to access some primary and secondary care. Those countries are Belgium, Czech Republic, France, Germany, Ireland, Italy, Netherlands, Portugal, Sweden, and the UK. However, in four of these countries, they are required to pay full costs, which are often very high, and in Germany, public servants are required to inform immigration authorities if an undocumented migrant comes for treatment (Spencer and Hughes 2015). Such legal barriers restrict integration of irregular migrants into health care systems, creating unwelcoming circumstances for establishing their lives in the receiving countries and reconfirming the 'undesirability' of their stay. Even when undocumented migrants are entitled to care, fear of being reported to immigration authorities prevents them from approaching health care, even when in need. Moreover, the lack of knowledge of migrants' right for health care among health care providers creates an additional barrier (O'Donnell 2018).

Further administrative barriers for other migrants entitled to health care include lack of health insurance, which is necessary in many countries, and linked to this, high costs of treatments and medication (Müllerschön et al. 2019). Insufficient knowledge of a common language among both migrants and health professionals lead to further communication barriers (van den Muijsenbergh et al. 2014). Lack of trustworthy information available in foreign languages is one of the reasons behind lower health literacy among migrant groups and insufficient knowledge of health care systems. Absence or insufficient amount of interpretation services in the health centres exacerbates those communication problems and may lead to discriminatory practices based on perceived linguistic incompetence (Peled 2018). Customs of gender relations distinct from the mainstream receiving countries pose cultural barriers to migrants' health care access. For instance, lack of

female interpreters and possibilities to choose a treatment by a doctor of the same sex make it more difficult, especially for women, to seek specialised gynaecological care (Henry, Beruf, and Fischer 2020; Heslehurst et al. 2018). Remote locations of reception centres, asylum-seekers centres and detention centres lead to geographical barriers of access to health care for migrants living there (Bradby et al. 2015; Wahedi et al. 2020).

Structural aspects of health care provision differ across European countries. Access to health care is universal in some countries and insurance based in others. General practitioners or family doctors, community health services, and hospitals can fulfil different roles and functions in various countries. The organisation of health care systems has important impact on its accessibility for vulnerable groups. In a cross-European study analysing access to primary health care for marginalised migrants, it has been determined that national policies reducing the health care entitlement of these vulnerable groups have a negative impact on both the migrants' access to health care and the caregiver's capacity to provide such care. This can be illustrated when looking at the Netherlands, which, in 2012, withdrew its provision of interpreting services. Policy changes like this increases the systemic barriers to health care. Barriers on a structural level include, for example, limited competencies in communicating due to linguistic differences at the level of the provider (Kringos et al. 2013; O'Donnell et al. 2016).

(3) Health care utilization

A systematic review of scientific literature between 2009 and 2017 analysed findings of the studies in terms of differences between migrants' and non-migrants' utilization of health care services in Europe. Even though the evidence was limited for making a comprehensive comparison between the countries, a tentative conclusion was that no difference was found in the use of general practitioner services. However, most evidence point at the higher use of accident and emergency services by migrants (Graetz et al. 2017). Literature points to various reasons for this discrepancy, among which are: lower-social economic status, poorer diet and living conditions, free and easier access to accident and emergency services compared to GPs and specialists, lack of health literacy, and poor understanding of the system itself.

Another literature review focused specifically on undocumented migrants' use of health care services. Most of the studies confirm that these migrants are less likely to seek medical assistance than other migrants and non-migrants. This is usually the case even when legally the access to primary or emergency care is permitted for this group. Lack of knowledge about their rights and fear of being reported are the main reasons for this underutilization of health services. Both health care professionals and migrants themselves often do not know which medical help they are entitled to receive and under which conditions. As mentioned before, access to health care differs among European countries, and these findings come from the countries with more than minimum health care entitlements for these migrants. There is a lack of research on this topic in the countries with

'less than minimum health care rights' to undocumented migrants, where their exclusion from health care systems is most severe (Winters et al. 2018).

6.4 Framing interventions and policy objectives of integration into health care systems

In the area of health care system there are two polar framings of the integration issue. The first and dominant framing focuses on disadvantages of migrants' access for the receiving country, while the second focuses on the needs or human rights of migrants and problematizes the fact that some groups of migrants are insufficiently included in the health care systems.

(1) Restricting access to health care for (irregular) migrants

Cost considerations is a widely spread argument used to justify exclusion from health care of some groups of migrants, for instance, undocumented ones. This argument is based on the perceived threat to resources of the receiving state. The assumption is that providing health care for undocumented migrants poses a financial burden to the health system, leading to unavailability of health care for the receiving state's own citizens. This argument has been disproved, as timely treatment of diseases in primary health care is actually cost saving for the receiving state as a whole (European Union Agency for Fundamental Rights 2015; Trummer and Krasnik 2017). The evidence presented in the section 6 of this chapter provides as explanation into why this happens. Another related framing problematizes excessive and unwanted immigration flows and uses exclusion from health care as a tool to deter new arrivals (Razum and Bozorgmehr 2016; Slootjes 2021). This 'health care-as-magnet' hypothesis is based on the same rationale as 'welfare-magnet' hypothesis. For example, in Germany, access to full health care for asylum seekers was legally restricted in 1993 with the aim of reducing budget spent on asylum seekers and to deter asylum seekers from coming to the country (Bozorgmehr, Wenner, and Razum 2017; Razum and Bozorgmehr 2016). This legislation created a natural experiment and based on the comparative study it was found that, in the long term, such a measure actually resulted in higher costs for the receiving state (Bozorgmehr and Razum 2015).

Another example is the creation of 'Hostile Environment' in the UK, where the National Health Service (NHS) was directed to enforce immigration controls by requiring health officials to inform the authorities of people whom they suspected of being in the country illegally. The measure was originally justified as it assisted with controlling irregular immigration and also reduced the financial and resource strain on the NHS. The policy was criticised for various reasons. These included the loss of confidentiality in health care and how it ignored the growing discussions that resource issues in the public health care sector largely results from austerity and the subsequent funding cuts,

rather than its usage by irregular immigrants. This measure has since been withdrawn due to the unforeseen negative implication for public health as a whole (Hiam, Steele, and McKee 2018).

The internal misfunctioning of health care systems are also attempted to be solved by excluding migrants. The UK's NHS has been built around the principle that it should be free and not provided upon the ability to pay. In recent years, the emergency department of the NHS has faced increasing pressure, leading to underperformance in terms of waiting times. To address this, a 2016 act by the UK government set forward charges to non-British citizens in receiving secondary care, with a proposal for this to be extended for emergency care too, clearly working against the NHS's key foundation principles (Harrison and Daker-White 2019).
All in all, the exclusion of migrants from health care access can be understood as either an objective pursued to solve the perceived problem of their financial burden, or as a means to reach a further objective – the prevention of undesirable immigration.

(2) Enabling and facilitating health care access for migrants

The opposite kind of policy framing sees the lack of health care access for migrants as the violation of their human rights. Humanitarian or rights-based view states that anyone in need should be able to get medical assistance no matter their legal status. While the state organization is bounded by the national laws, charity and humanitarian organizations often step in to fill the gap. For instance, in Germany, where regular health care is provided on the basis of a patient having health insurance, many irregular migrants may be excluded from access, either due to legal or financial reasons. Response to this exclusion of health care access can be found since the 1990s in Germany, with humanitarian organisations such as 'Malteser Migranten Medizin', a Catholic Church funded charity run by both employees and volunteers, addressing the health care access gap. Similar humanitarian organisations providing health care access to irregular migrants have expanded across large cities in Germany ever since. Despite their efforts and growing professionalisation within these humanitarian organisations, their level of care simply is inferior to that of the insurance-based health care system in Germany (Huschke 2014).

Another related framing sees the problem in the risks posed by untreated diseases brought to the receiving population. Therefore, for the sake of public health, immigrants are given access to receiving country health care services. Such framing explains access to infectious disease care for migrants, although evidence suggests that migrants rarely bring infections that pose a threat to host population (Legido-Quigley et al. 2019).

Spenser and Hughes's analysis in 2015 notes that health care access for undocumented migrants has been generally liberalised across Europe, with some notable exceptions. At least from the legal perspective, in most countries health care entitlements have been extended rather than restricted (Spencer and Hughes 2015).

6.5 Overview of commonly used instruments and tools in health care system integration

Regulatory instruments are the base line of all health care provision or restriction for migrant groups. Access to health care is generally granted by law. Article 35 of the Charter of Fundamental Rights of the EU states that 'everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. However, social insurance-based systems are problematic for two reasons. Firstly, it is because complex bureaucratic registration processes make it more difficult for refugees and asylum seekers to access those services, even when they are legally entitled. And secondly, because the social insurance system requires documentation and financial means from migrants, which they may not have. This is especially true for unemployed and poorer refugees and asylum seekers (Bradby et al. 2015).

An example of an instrument from Germany, that facilitates access through an electronic card, resulted in improved mental health of refugees. One of the changes in 2015 regarding refugees and asylum seekers' access to health care involved the introduction of electronic health cards (eHCs). Municipalities and federal states in Germany had the option to form an agreement with their health insurance funds to organise almost full access of health care for the groups of immigrants previously excluded from such health care. This includes asylum seekers who are within their first 15 months of arrival and rejected asylum seekers who have yet to leave the country. Once granted an eHC, these people would have "immediate and unbureaucratic access to the health care system" (para. 1). Seven of the 16 states in Germany decided to introduce this agreement (Jaschke and Kosyakova 2021).

For unwanted irregular migrants, states employ instruments legally restricting their access. For instance, German legislation in 1993 decided to legally restrict access to health care as means of deterrence policy, based on the argument that it would reduce numbers of asylum seekers (Bozorgmehr and Razum 2015). Another measure against irregular migrants is a formal obligation of doctors to share information with immigration authorities of the country. For example, a Memorandum of Understanding between the NHS (in the UK) and the Home Office introduced in 2017, required doctors to share information about their patients justified to be "in the public interest to support effective immigration enforcement" (Hiam, Steele, and McKee 2018).

Examples of economic or market-based instruments have been presented in the literature review on the cultural competency of health workforces. They describe funding of cultural competency trainings for health care staff, the aims of which were referred to as achieving cultural awareness, cultural respect, cultural safety, or cultural understanding. Those trainings were provided not only to physicians or nurses but to a diverse range of health care professionals. Most common are the

trainings of two different types: categorical – the ones teaching about the cultural peculiarities of specific groups, and a cross-cultural training approach – aiming to enhance intercultural competences suitable for interactions with any different cultures (Jongen, McCalman, and Bainbridge 2018).

Subsidizing projects by civil society organisations that step in to 'fill the gap', or that provide care to irregular migrants without the threat of reporting them to immigration authorities. For instance, in Frankfurt 'Humanitäre Sprechstunde' was organized by a non-governmental organization, however, funded through the municipality. This instrument provided anonymous, primary health care consultations for irregular migrants, in order to prevent epidemiological risks to larger populations that can happen if the health issues of migrants are untreated. Regular health care was not available for these migrants because of bureaucratic requirements that irregular migrants could not meet. Regular job and health insurance are needed to register with doctors (Delvino and Spencer 2019). Another common financial instrument is to subsidise the costs of those unable to access health insurance. Some cities in the Netherlands, including Eindhoven, Amsterdam, Nijmegen, and Utrecht all fund NGOs that sponsor health care (ibid.).

Informational or communication-based and participatory measures commonly include information campaigns in order to increase health literacy of migrants. Particularly during the Covid-19 pandemic, the translation of public health information became a more wide-spread practice (Slootjes 2021). For instance, in Austria, the state issued an 'Impfbroschüre', providing information on vaccines in multiple languages (Gruber 2013). Another example of such type of measures is supplying courses on the workings of the health care system in Denmark, where immigrants often experience low patient-doctor satisfaction as well as suboptimal health care utilisation. The teaching about the local health care system was integrated in the language and culture courses for immigrants (Smith Jervelund et al. 2017). Besides that, the access to health care is facilitated through provision of translators and interpreters, as well as use of intercultural mediators. Good communication is so crucial in a doctor-patient relationship, and various measures have been undertaken in countries across the EU to address this communication gap. Intercultural mediators are found to play a significant role in immigrant patient and doctor relations. These people facilitate and improve communication and reduce the barriers caused by linguistic and socio-cultural differences. There are both formal and informal intercultural mediators and interpreters involved in the health care context (Lionis et al. 2016; O'Reilly-de Brún et al. 2015; Verrept 2019). The 'Refugees Health Unit' in Greece offers opportunity of health care providers working with translators, in the context where health care provision for migrants suffers from limited finances and insufficient coordination of actors (Lebano et al. 2020). NGOs and voluntary organisations play a large role in performing outreach tasks, for instance identifying the needs of refugees in terms of health care, providing them with relevant information, and directing refugees to the services they need (Berchet, Colombo, and Dumont 2018). Migrants, especially those with irregular status, tend to mistrust state service provisions, therefore NGOs are often better suited for such outreach tasks (Stefan Priebe, Giacco, and El-Nagib 2016). One of the ways to involve refugees themselves in health

care provision is to train them in providing mental-health counselling, for instance, the International and Psychological Organisation (IPSO) provides outreach mental health support, offered in a variety of languages, and trains refugees to become counsellors that are both culturally and linguistically more sensitive to the refugee-clients (IPSO 2020).

6.6 Effectiveness and Outcomes of instruments and tools in health care system integration

In this section we synthesise evidence from literature regarding the effectiveness of policies and instruments to reach their objectives. The objectives are set on the ground of the problem framing and, thus, their outcomes need to be analysed using this link.

With regards to the policy objectives restricting access to health care, we found mainly evidence of ineffectiveness of those policies. Migrants' access to regular health care was problematized due to a presumed financial burden on the receiving state. Several studies point that these considerations are fallacious. Costs of providing preventative health care are lower than the costs incurred when such care is not made accessible and migrants' health situations worsen (European Union Agency for Fundamental Rights 2015). A 2015 study examining the effects of restricting health care access for refugees and asylum seekers in Germany found that access restrictions are associated with higher expenditures and found no evidence for claims that providing asylum seekers with cards enabling them to access health care services would increase health care costs (Bozorgmehr and Razum 2015). The emergency health care places a greater financial burden than the preventive care. An example of this can be found in irregular migrants with propensity for strokes. Using data from countries across Europe, it was found that access to regular health care leads to cost savings of around 16% over a lifetime. A similar trend can be seen in the case of providing regular prenatal care for irregular migrants as opposed to just emergency care, with the former being more cost effective. This renders false the assumption that regular health care is more financially burdensome than emergency-only care (ibid.). The exclusion of irregular migrants from health care in order to enforce migration control has also been proven to have negative consequences. When the doctors were asked to report on the migrants' status, migrants aimed to minimise their interactions with health care providers, putting their lives and health at risk. As already established, putting off medical attention can lead to an eventual need for more expensive emergency treatment, ironically leading to greater public cost. Additionally, limited immunisations and undiagnosed illnesses are likely to cause a spread of infectious disease to wider populations (Hiam, Steele, and McKee 2018).

Regarding interventions aiming to facilitate access to health care for migrants, we have identified the evidence evaluating effectiveness and outcomes of various types of instruments. First of all, it was found that in the countries where *regulation* provides a more liberal access to health care, the self-reported health among refugees is better (Georges et al. 2021). This is supported by arguments

that access to regular health care minimises the implications of poor health for a person's ability to work and it prevents their need for emergency services later on (Bozorgmehr and Razum 2015). The study of Jaschke and Kosyakova's determined that the eHC for newly arrived asylum seekers and rejected asylum seekers in Germany positively affected the asylum seekers' health, psychological well-being, and satisfaction of the health care system as opposed to those who had to wait 15 months before full health care access (Jaschke and Kosyakova 2021).
Secondly, various communication instruments have been evaluated rather positively by the analysed studies. An evaluation study carried out in Ireland on the use of interpreters points at the benefits of employing both formal and informal interpreters. Formal interpreters promote greater trust and satisfaction as well as save time and money for the care providers. However, they can influence the patient-doctor dynamic and logistic could be challenging. Using informal interpreters was easier to organize, since it falls under the responsibility of the patient, also there was a greater relationship of trust between the patient and the interpreter. However, doctors had serious concerns about the involvement of informal interpreters too, such as a lack of competence and the presence of the interpreter's own interests when interpreting for a family member. Moreover, they saw the involvement of children as interpreters as problematic (O'Reilly-de Brún et al. 2015). The policy in Denmark that introduced paid interpreter services was evaluated as negatively affecting more vulnerable groups of immigrants, including those with small incomes, poor health, unemployed or inactive in the labour market, and thus contributing to social inequalities in health care access (Harpelund, Nielsen, and Krasnik 2012). Evaluation of intercultural mediators carried out by the World Health Organisation in 2019 points at the generally positive impact on the quality health care services for migrants. However, this positive effect can be hindered by a lack of professionalization, insufficient training of such mediators, as well as inconsistent and non-systematic implementation of intercultural mediation programmes (Verrept 2019).

Another type of instrument that was positively evaluated is the cross-cultural training programmes.

A systematic review of evaluations carried out in 2018 showed generally positive effects of workforce cultural competence interventions among health care professionals. However, the study noted that most evaluation studies focus on building awareness and changes in attitude of the health care professionals, however behavioural outcomes are not as consistently measured (Jongen, McCalman, and Bainbridge 2018). Evidence points at two main ways to provide cultural trainings - cross-cultural and categorical approach, as described in the section 4 of this chapter. Research shows that both types of approaches were proven effective, because the positive outcomes of practitioner knowledge and beliefs were reported. However, there were no clear evidence on the effect it had on culturally diverse patients (ibid.).

Another positively evaluated instrument are the interventions to improve health and health care literacy of migrants (Fox et al. 2021). The studies report significant improvements in clinical outcomes, attitudes of patients towards health care system and self-efficacy. Knowledge of the

health care system reportedly improves health care-seeking behaviour and migrants' contact with health care systems (Smith Jervelund et al. 2017).

Thirdly, studies have evaluated positively the involvement of NGOs in health care provision for migrants, however they also noted a number of problems that hinder the impact of their services. In the context of the COVID-19 pandemic, the evidence points at the importance of civil society organizations 'filling the gaps' of public sector. The examples include the provision of culturally sensitive health services or hotlines for refugees with insufficient health care access. However, it is also suggested that such solutions may not be sustainable due to limited funds for the NGOs and limited geographical coverage of such services, since they usually are located in the cities, leaving migrants in rural or remote areas without health care access (Slootjes 2021). The RESTORE project highlighted the benefits of **engaging with multiple stakeholders** and using participatory approaches to identify best practices in their evaluation of guideline and training initiatives on cross-cultural consultation (Lionis et al. 2016). However, such multistakeholder engagement has to be properly coordinated. Studies found that poor coordination among actors continues to hinder health care services for migrants. This problem is especially severe in transit countries, for instance Greece, Italy and Slovenia, where poor internal and external coordination of health care services seem to be a cause of insufficient service provision for the vulnerable migrant groups (Lebano et al. 2020). Evidence from a literature review on mental health provision, identified promoting social integration, developing outreach services, coordinating health care, providing information on entitlements and available services, and training professionals to work with these groups help to develop good practice of migrant health care. These actions require resources and organizational flexibility (Stefan Priebe, Giacco, and El-Nagib 2016). Another issue pointed by literature are the power imbalances that have been observed in voluntary health care practices driven by humanitarian considerations. The study of Huschke observed such power imbalanced between the service users and service providers in the form of expectation of gratitude from the patients that is shared among the health care professionals engaging in voluntary health services. On the other hand, patients of such good-will service often felt that they were not in the position to complain, speak up for themselves, or discuss an insufficient treatment with the health care providers (Huschke 2014).

Last but not least, the studies also point at the importance of other interlinked factors that influence good health of migrants. For instance, better living and working conditions are essential to good health of migrant groups, while poor living conditions attributed to higher cases of unmet health needs. Irregular immigrants are disproportionately affected by poor living and work conditions, thus interventions in those areas are needed to improve their health (Busetta, Cetorelli, and Wilson 2018).

6.7 Conclusion

This review focused on practices to promote the integration of newly arrived (non-EU) migrants in health care systems. It shows that there is much literature on this topic, ranging from studies of access to and use of health care, health care provision, and to specific health needs of groups such as refugees. One the one hand, migrants are often perceived as relatively healthy, as they are often younger on average. On the other hand, there is a broad recognition of specific health concerns in relation to mental health due to migration journeys, but also due to vulnerabilities related to their often weak and uncertain position (manifested clearly by the COVID pandemic). Such vulnerabilities seem to be most pronounced amongst undocumented migrants, who often face an accumulation of vulnerabilities (legal, social, economic, health).

In terms of policy practices, there are numerous examples of efforts to restrict (degrees of) access to health care. This is also fed by a 'health care-as-magnet' hypothesis, assuming that health care is a factor for immigration. Financial considerations sometimes played a role here as well. In several states there were examples where accessing health care was connected to immigration enforcement. Research suggests that such practices can be counterproductive, for instance because they can lead to higher health costs if someone's condition aggravates.

However, there are numerous examples as well of efforts to enable and facilitate access to health care. Such practices are fed by international human rights, but also by concerns about the impact of diseases on the larger population and by a recognition of the need for at least some basic services. This includes the decoupling of health services and immigration studies, but also, for instance, trainings in intercultural skills and the subsidizing of NGO's who 'fill the gap' in health care provision. NGOs seem generally very well capable of reaching otherwise difficult to reach target groups. And the training of intercultural competencies is seen as very welcome to challenge cultural biases in the field of health care. Also, many examples were found targeted at information provision, enabling access to health care (and enabling prevention). Communication instruments are generally assessed as rather successful.

In sum, our review of evidence learns that to develop a more sustainable approach to health care integration, it is recommendable to put effort and resources not only in the regulation of access to health care but also in intercultural competencies and in information provision. Such investments can also be seen as sustainable in terms of preventing longer-term health issues that weigh in on the health care system, but primarily on the migrants involved.

6.8 Bibliography

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