Task Force on Migration, Equity & Diversity

International workshop on the management of diversity in health care

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What can be learned from the MIPEX Health strand about responsiveness to diversity in health services?

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Outline of talk

1. What is the MIPEX Health strand?
2. Some results from the 2015 round
3. What do the results tell us about responsiveness to diversity in service delivery (scale C)?

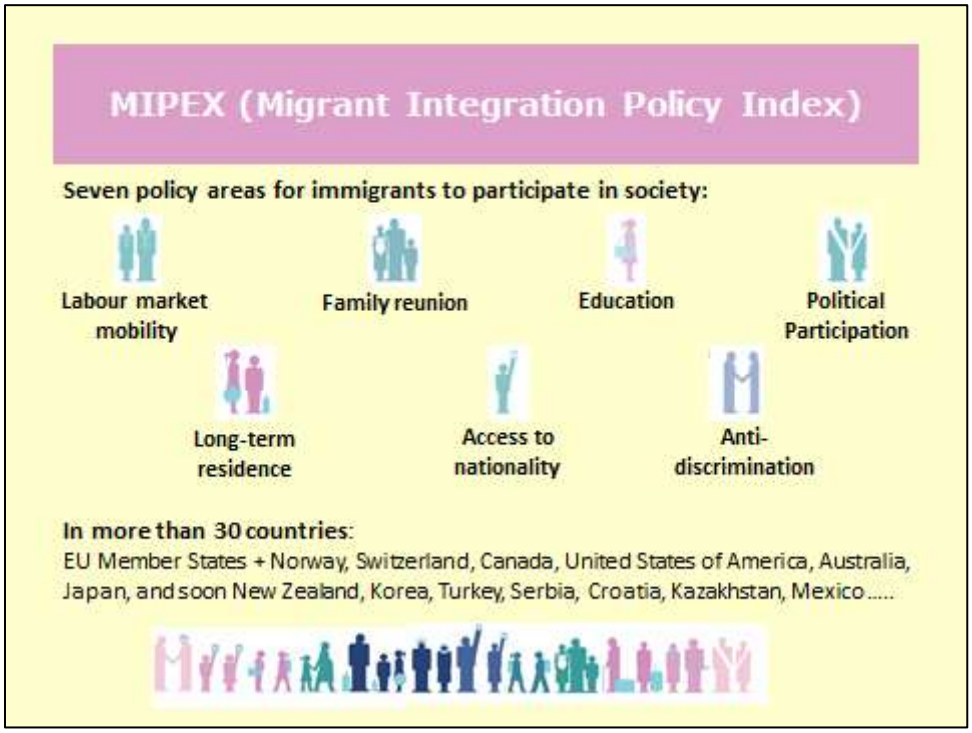
(Link to Summary Report: http://bit.ly/2Ms7ZUR . See also this article: http://bit.ly/2OCYyEK)

Equity is not the same as equality: it means having the same policies for people with the same needs, but different policies for people with different needs. So migrants' rights to health care should be the same, but the care they get should sometimes be different.

MIPEX doesn't only look at policies laid down by parliament at a national level, but also the policies of local authorities, service providers, health insurers, professional bodies and so on. The instrument was developed in order to carry out a survey in 2015 which covered 38 countries. The number of countries is increasing and there will be another round of the survey in 2020.

Why was a new instrument needed? In the past there have been many studies describing the extent to which migrants are included in different countries' health systems. Unfortunately, they all use different indicators, concepts and methods and it's very difficult to synthesize them. There was a great need for an instrument for measuring these inequities in a systematic way, so that scores could be compared with each other and over time.

The Migrant Integration Policy Index or MIPEX has been running since 2003. Before Health was added it had 7 "strands" or dimensions:



The way a strand on Health was added is a very long story. It began in 2008, when the Council of Europe started developing a set of recommendations for migrant health, based on consultations and research.

Council of Europe

Committee of Experts on Mobility, Migration and Access to Health Care (SP-MIG)

Mandate: July 2008 - June 2010
Task: to produce draft recommendations
(final version published 2011)

Based on these recommendations, a plan was hatched in the COST Action ADAPT, together with IOM Brussels, to persuade the MIPEX people to allow us to develop a new strand on Health for the 2015 round. So the instrument was a joint effort that brought together three projects:

MIPEX Health strand was a collaboration between:

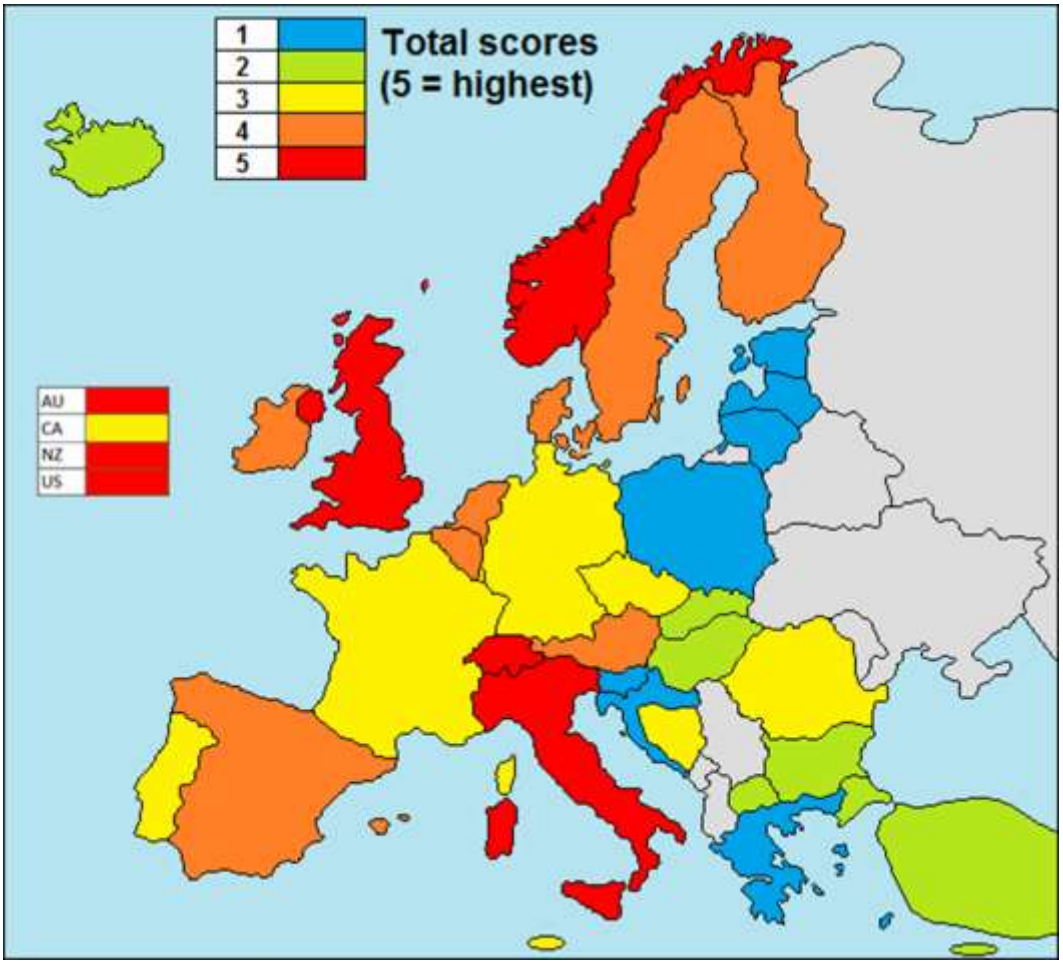
- **COST Action IS1103 ADAPT** (Adapting European Health Services to Diversity)
- International Organization for Migration, Brussels (**EQUI-HEALTH project**)
- Migration Policy Group (Brussels), developers of **MIPEX**, together with **CIDOB** (Barcelona)

Started in 2012 (IOM & ADAPT); MPG & CIDOB joined in 2013

Over 160 experts in 42 countries worked on the Health strand

Main funding from European Commission and IOM

Data were analysed from 38 countries, with the help of about 160 researchers. Let me fast forward to the end of the story and show you the map we made. This shows how 'migrant-friendly' different countries' health systems are:



To make this map we ranked countries' total scores into 5 groups (red stands for the highest score, blue for the lowest). There was a strong relationship with a country's wealth, which in turn is related to the percentage of migrants in a country. The highest scores tended to be found in the US, AU and NZ, Western Europe, IT and ES, and Scandinavia. Eastern Europe did less well.

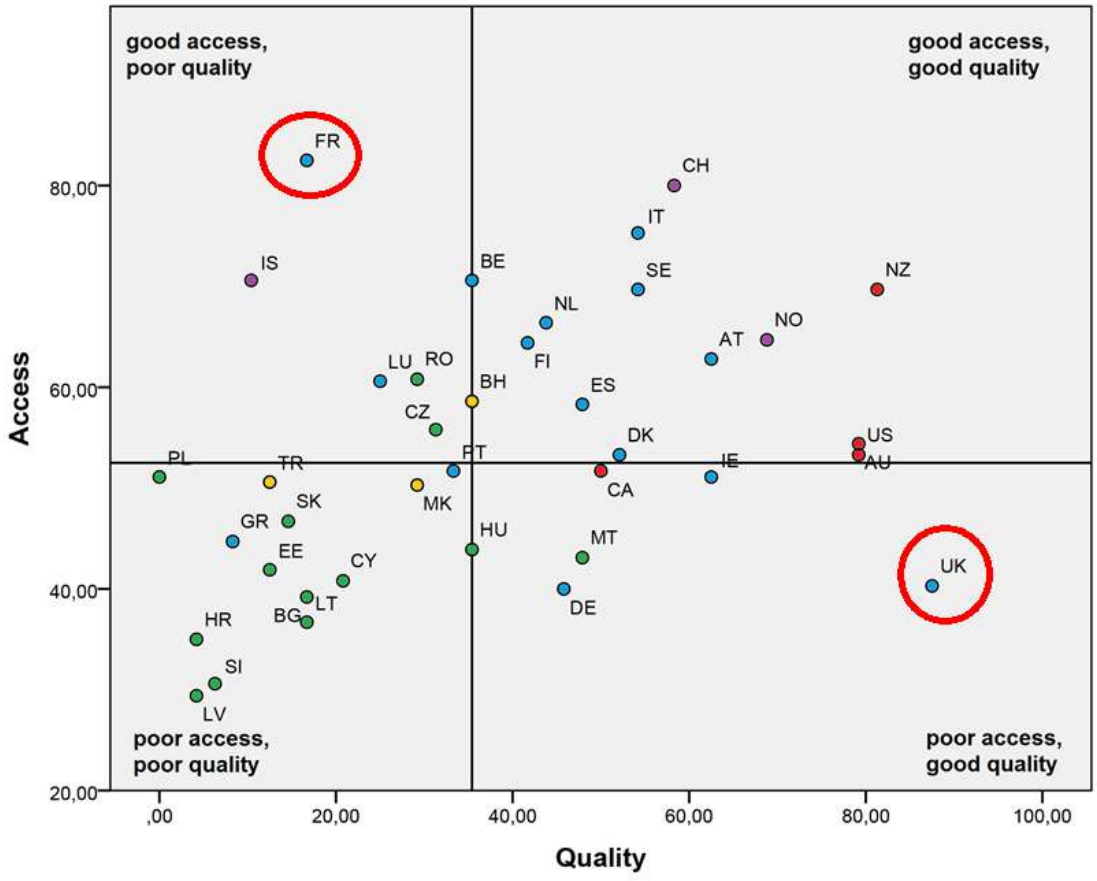
However, just looking at the total scores can be misleading, because health systems can be good or bad for migrants in different ways. You also need to look at the four scales:

A. Entitlement to health services
B. Removing barriers to access
C. Responsive health services
D. Measures to achieve change

The first two scales concern access, but we distinguish legal barriers to access (*Entitlement*) from more practical ones (*Accessibility).* *Responsiveness* describes whether the delivery of care is adapted to the needs of migrants – it's the most relevant scale to compare with the Equity standards, because it's about service delivery. The fourth scale *(Achieving change)* describes data collection, research and governance. Oddly enough, the fourth scale is strongly correlated with the third but not with the first two, so it seems that the latter activities are mainly focused on responsiveness.

2. Some results from the 2015 round

We can add together scales 1 and 2 and label them **access:** scales 3 and 4 can be combined and labelled **quality.** When we plot access against quality we see that they mostly resemble each other, but there are some interesting exceptions:



Key to colours:

Blue: EU15 countries Purple: EFTA countries

Green: Post-2000 accession countries Yellow: EUneighbour countries

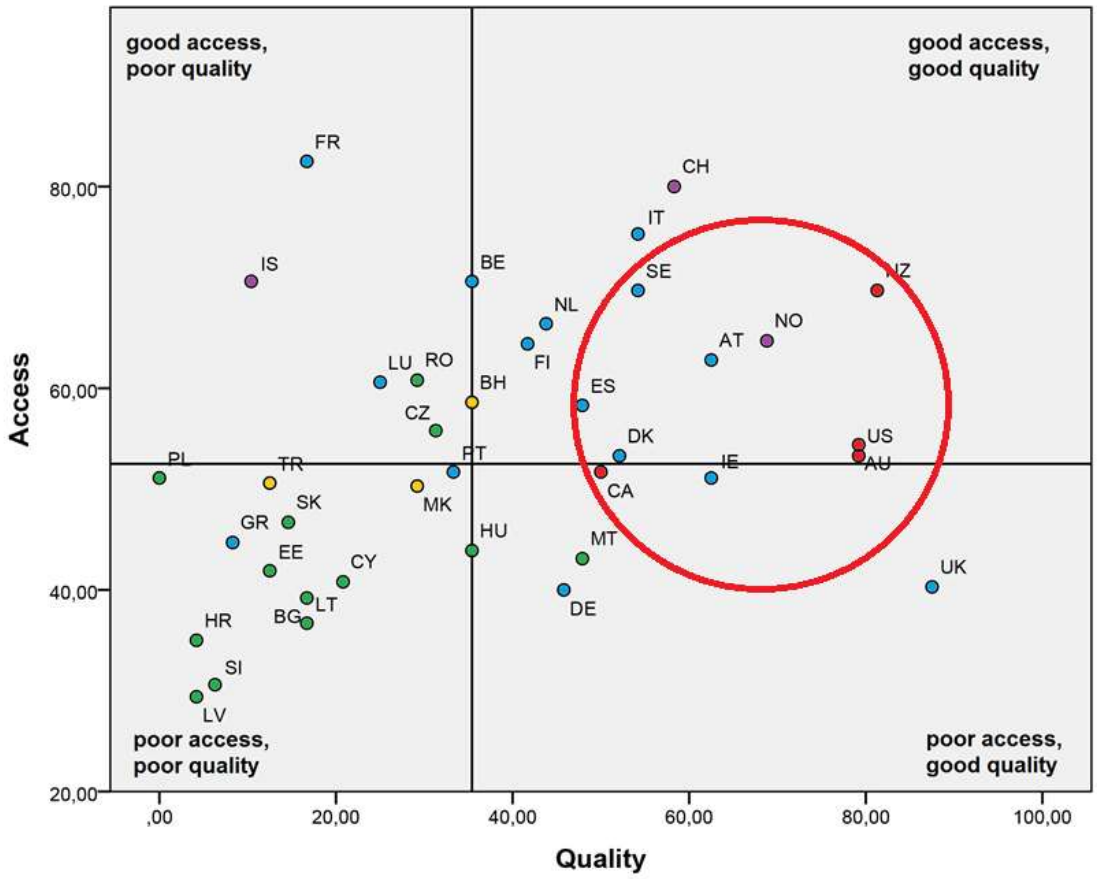
France and the UK are diametrically opposite:

- In France migrants can easily get into the health system, but once inside they are treated the same as everyone else. (Iceland is similar).

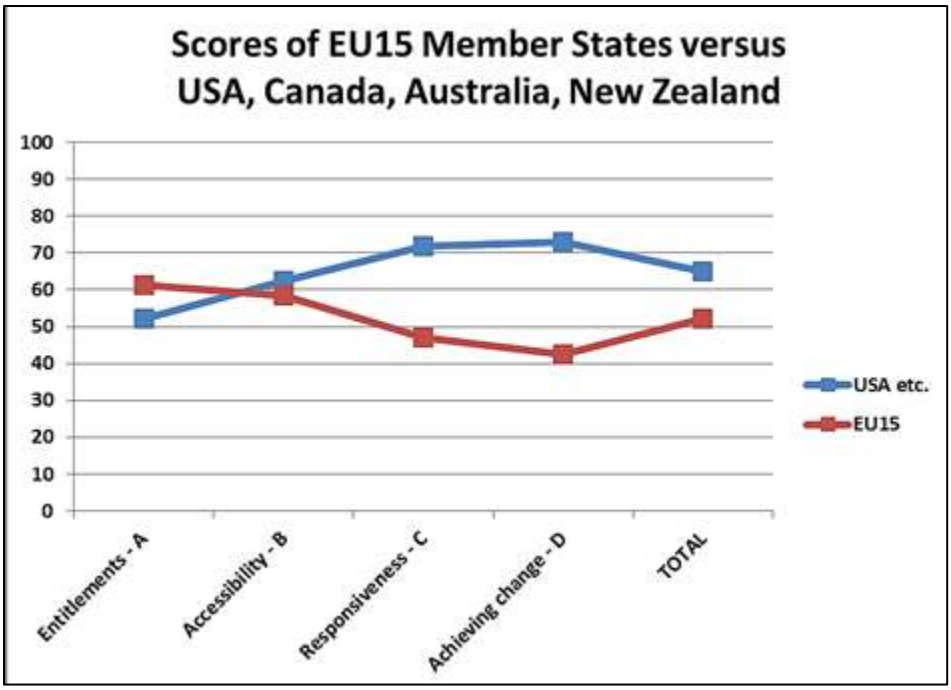
- In the UK, both access and quality were excellent until the Conservatives took over in 2010. They restricted access for migrants. However, for migrants who manage to get into care (or people with a migration background), a lot of attentionis paid to their special needs.

Belgium scores well on access but only average on quality.

In the US, CA, AU and NZ (red dots) there is much more emphasis on quality than on access:

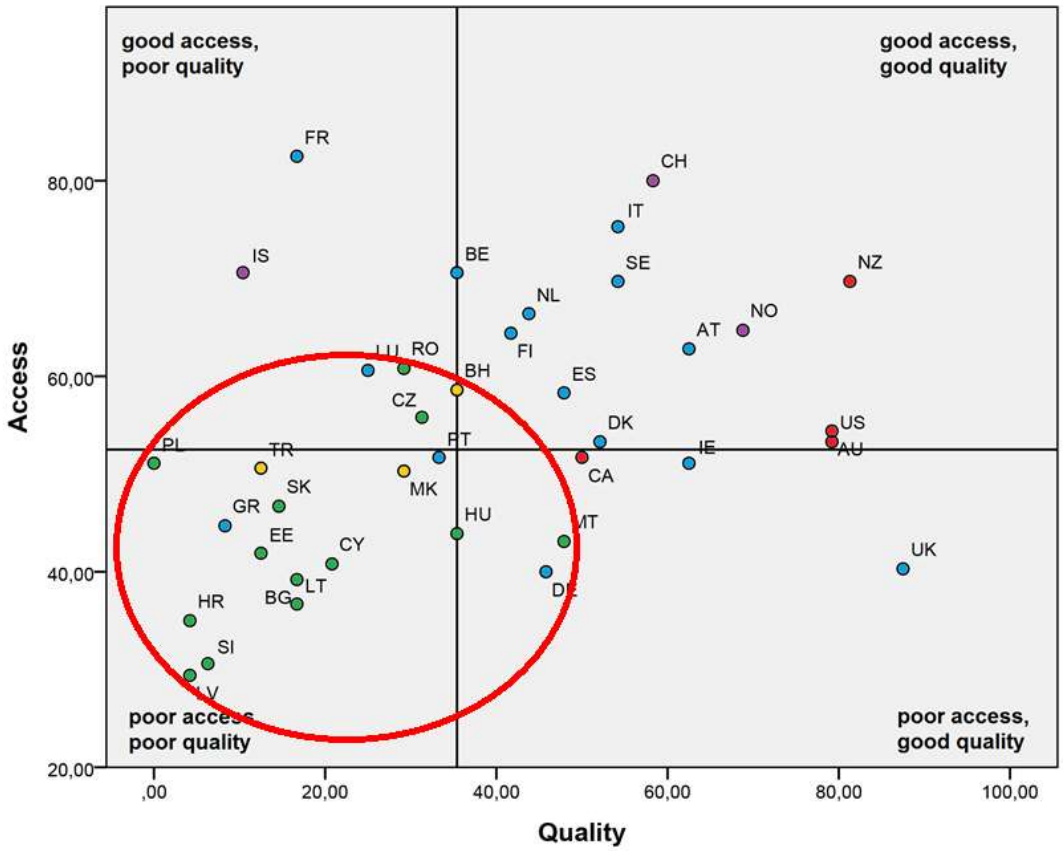


Another way of looking at this is shown in the next graph:



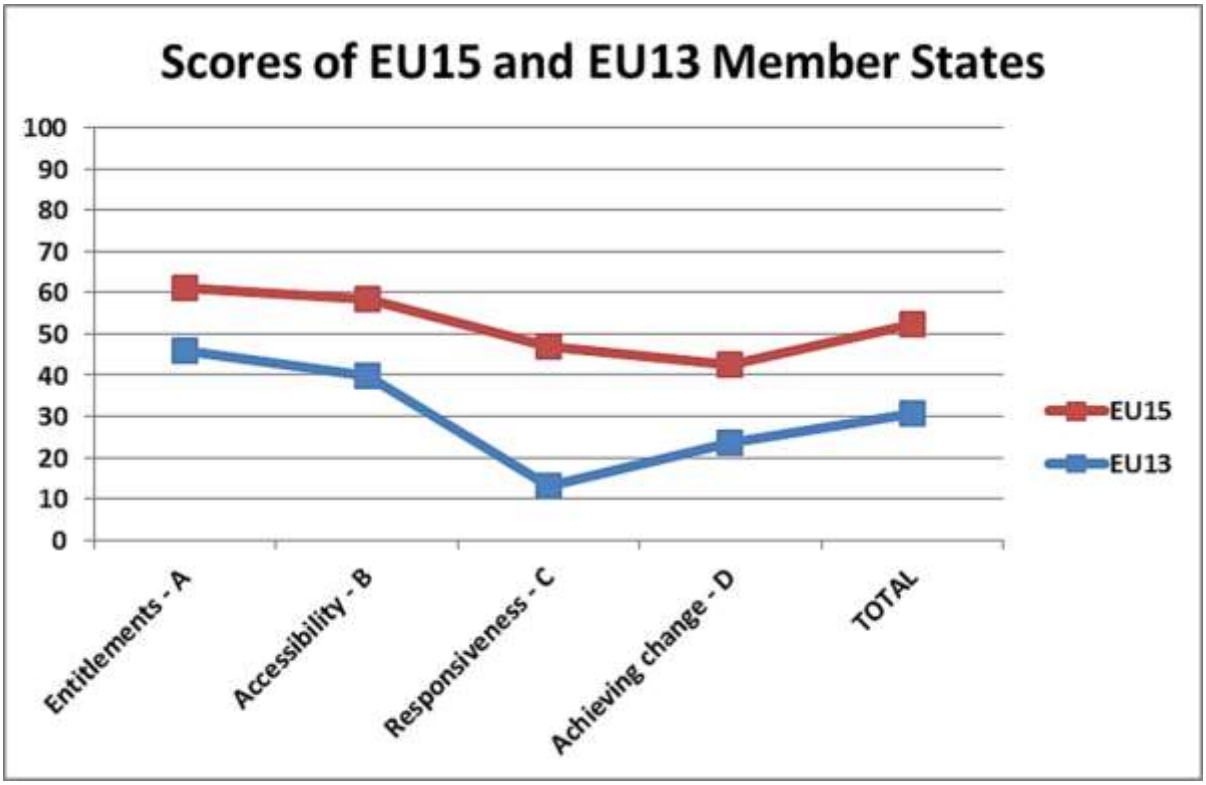
Like the UK, all these countries have a strong tradition of work on "cultural competence". This concept is mainly taken seriously in English-speaking countries. As we have seen, it's very unpopular in France, nor is it very popular in Scandinavian countries.

Both access and quality are generally worse in the EU13 (green dots):



Partly this is because EU13 countries are much poorer, but this is not the whole story. Attitudes and policies regarding migrants are more negative in the EU13 than one would expect on the basis of GDP alone. This can be seen in other MIPEX strands as well. As we all know, there are strong conflicts over migration between East European member states and the EU.

We can also look at the difference in this way:

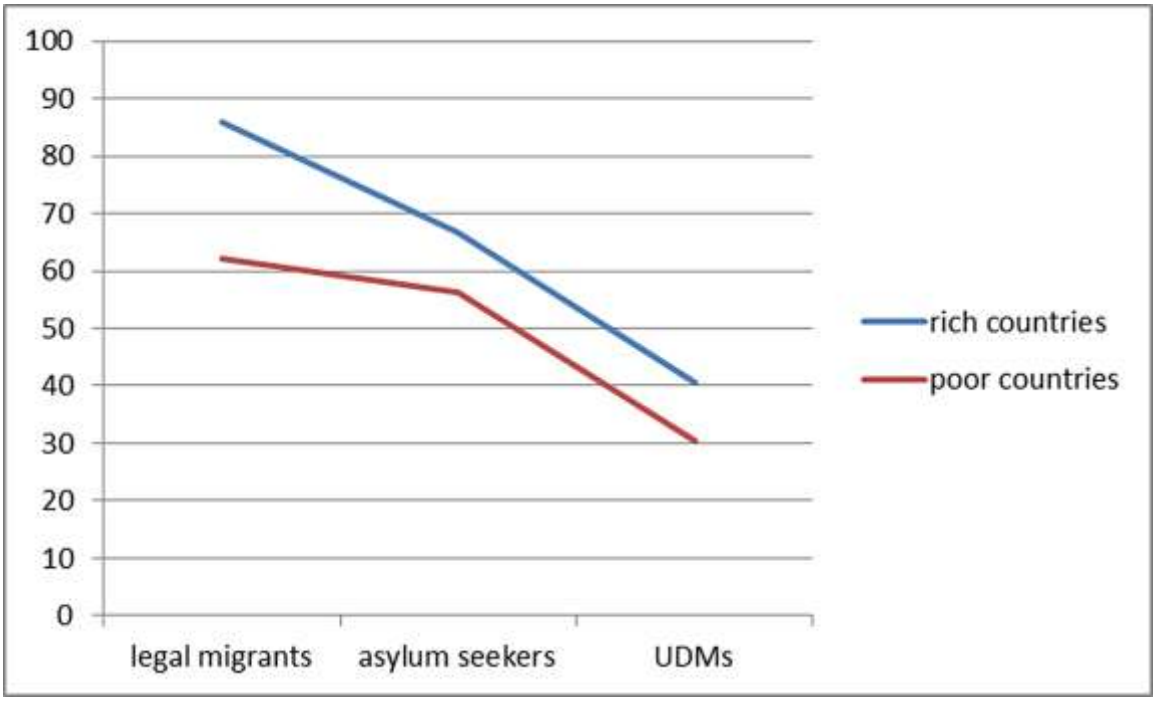


In the next graph we compare the entitlements for different categories of migrants in the EU, distinguishing at the same time between 'rich' and 'poor' countries (above or below average GDP).

- On average, entitlements for **asylum seekers** are halfway between those for legal migrants and UDMs. This is disappointing.

- Even **legal migrants** are a long way from enjoying 100% equity. E.g. in some countries they have to pay for their own health insurance, even though they are paying taxes to support the health system – so in effect they are being charged twice.

- **Undocumented or irregular migrants** have the worst entitlements – in most countries, only emergency care. In practice, this means "the doctor decides" (discretionary decisions). A lot depends on the sympathy or hostility of individual doctors or their organisations to undocumented migrants.



Finally, the results told us something about the difference between tax-based and social insurance-based health systems. There is no difference between them in terms of entitlements, but there is in terms of the last scale, measures to achieve change. Tax-based systems are more top-down and centrally controlled: they are more likely to implement plans for migrant health, though these tend to focus on responsiveness rather than access.

3. What do the results tell us about responsiveness to diversity in service delivery (scale C)?

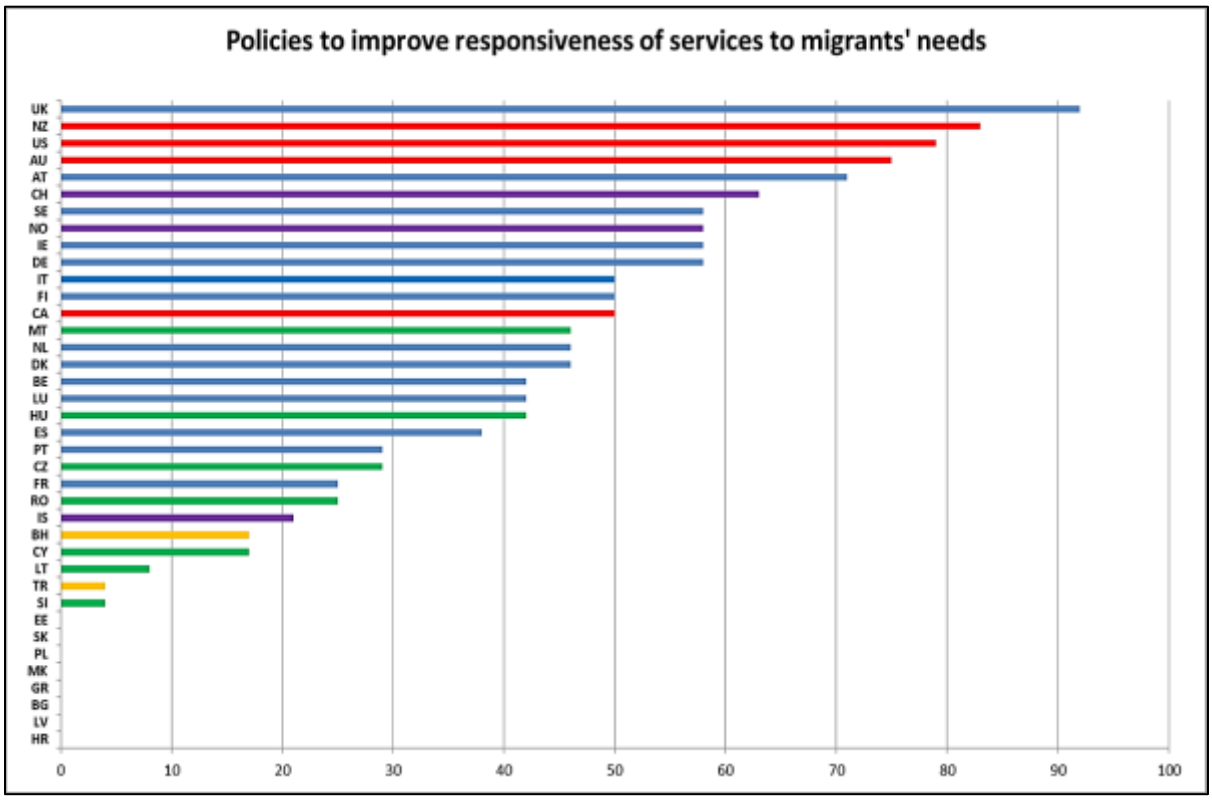
This is the most relevant scale for service providers – they don't have much influence on migrants' access to health services, which tends to be regulated at national level, or scale D.

The topics dealt with in this strand were as follows:

Topics in scale C (Responsiveness)

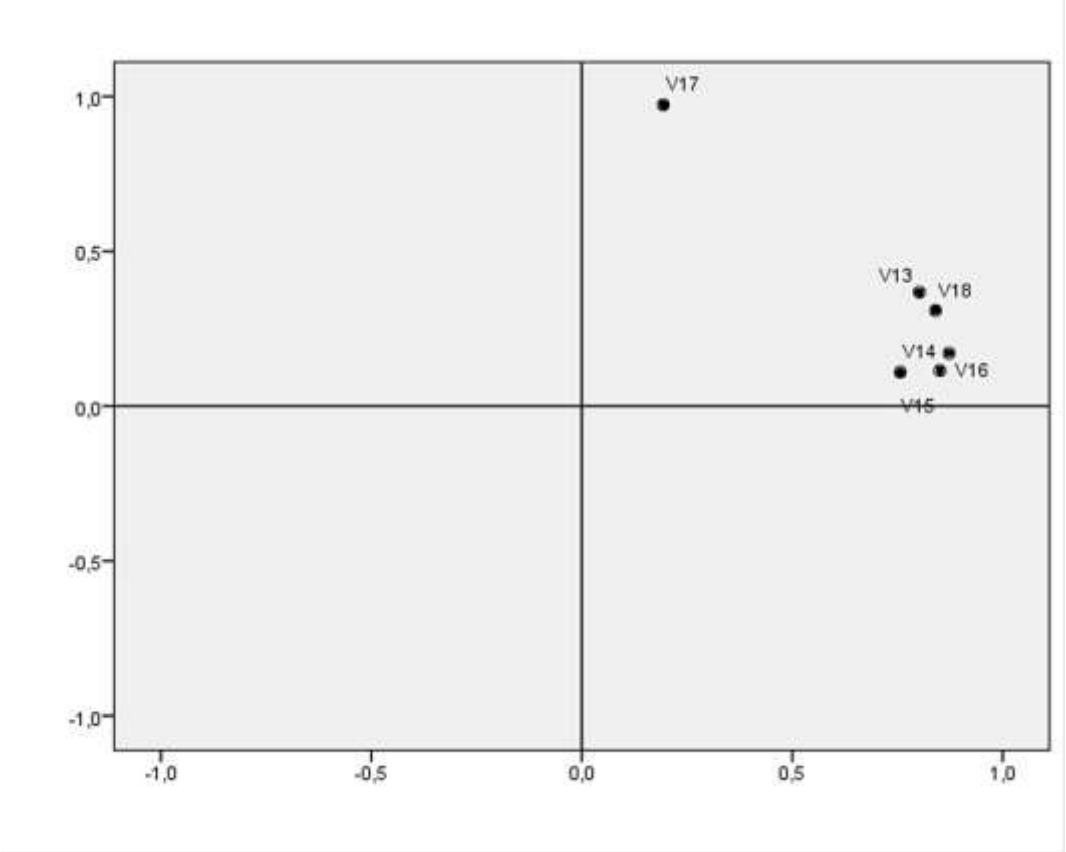
13. Availability and cost of qualified interpretation services
14. Requirement for "culturally competent" or "diversity-sensitive" services
15. Training and education of health service staff
16. Involvement of migrants in information provision, service design and delivery
17. Encouraging diversity in the health service workforce
18. Development of capacity and methods

We have already discussed the performance of different countries in relation to 'quality', which combines scales C and D. The same differences are found when we look at scale C by itself:



- Note the wide range of these scores. The highest is 93%, but there are 8 countries (EE, SK, PL, MK, GR, BG, LV and HR) that score zero.
- The highest scores are obtained by the English-speaking countries UK, NZ, US and AU.
- EU15 member states (blue) score better than the newer EU13 member states (green)
- Among the EFTA countries (purple), Iceland scores much lower than Norway and Switzerland.

The structure of the scale is also very interesting. A factor analysis shows the following picture:



You can see that five items are clustered together, but item 17 (Encouraging diversity in the health service workforce) is the odd man out. This is confirmed by the reliability analysis: question 17 has the lowest item-total correlation. The full scale has a homogeneity of .88 (as measured by Cronbach's alpha), but this rises to .90 when item 17 is removed.

The conclusion is that diversity in the workforce is not as highly regarded as an indicator of responsiveness as the other items. It used to be thought that staff should reflect the diversity of the population of users, but this doesn't seem to be regarded as very important.

I hope this has shown you that the MIPEX Health strand has many useful lessons for improving health equity for migrants. Scales B, C and D can also be relevant to other groups, such as native-born people with a migration background and members of indigenous minorities.