



Tozija F, Lizana T. Migrant Health Policy in European Union (EU) and non EU country: Current situation and future challenges for improvement (Original research). SEEJPH 2020, posted: 16 March 2020. DOI: 10.4119/seejph-3369

## ORIGINAL RESEARCH

# Migrant Health Policy in European Union (EU) and a non EU country: Current situation and future challenges for improvement

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### Abstract

**Aim:** The influx of refugees, asylum seekers and migrants in Europe is an ongoing reality and migrant health has become very important public health problem. The aim of this paper is to analyze and compare the health profile, migrant situation and migration integration health policy in Spain as a European Union (EU) country and Republic of North Macedonia as a country in process of European Union accession.

**Methods:** Migration Integration Policy Index (MIPEX) Health strand questionnaire (2015) was applied to compare health policies for migrant integration in both countries.

**Results:** There are differences between Spain and Macedonia in health care coverage and access to health services for migrants. Spain has health strand total score of 52 and is in the same group with Austria, Ireland, Belgium, Netherlands, Denmark and Sweden. Macedonia has lower health strand total score 38 and is in the same group with Turkey, Cyprus, Slovakia. Targeted migrant health policies are stronger and services more responsive in Spain compared to Macedonia which offers migrants legal entitlements to healthcare, but health services should be more culturally responsive to migrant health needs.

**Conclusion:** Health migration policy in both countries is closely tied to the general immigration policy.

**Keywords:** *health, integration policy, migrant, MIPEX.*

**Conflicts of interest:** None declared.

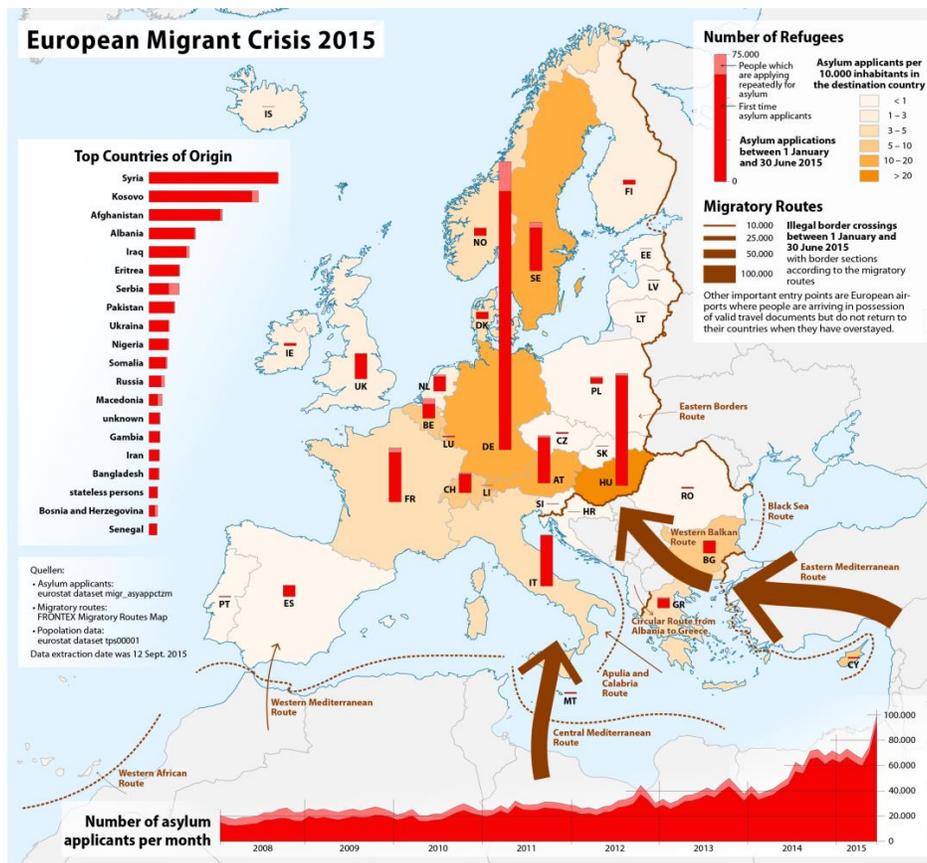
## Introduction

The influx of refugees, asylum seekers and migrants into the European Region is an ongoing reality that will affect European countries, with security, economic and health implication. The number of refugees and migrants entering European states is increasing, driven by the wars in Syria, Iraq, Afghanistan, Eritrea and elsewhere. It is estimated that 75 million international migrants live in the European Region, which is 8.4% of the total European population and one third of all international migrants worldwide. Over 1 million refugees and migrants entered the European Region in 2015. Since 2013, the numbers of refugees

and migrants crossing the Mediterranean has increased significantly. More than 3,700 refugees drowned in the Mediterranean Sea (1). Increases in arrivals have also been recorded in Greece and Spain. UNHCR data shows that 63,311 migrants have risked their lives reaching Europe by sea in 2019 (1,028 drowned in the sea). There are 5,690 sea arrivals registered so far in 2020, including refugees and migrants arriving by sea to Italy, Greece, Spain, Cyprus and Malta and 1,152 land arrivals including refugees and migrants arriving by land to Greece and Spain (2). EU states without external borders need to accept far larger numbers of refugees who landed in the southern European member states (3).

**Figure 1. Immigration and European Migrant Crisis 2015**

(Source: [http://geoawesomeness.com/wp-content/uploads/2017/03/Map\\_of\\_the\\_European\\_Migrant\\_Crisis\\_2015.png](http://geoawesomeness.com/wp-content/uploads/2017/03/Map_of_the_European_Migrant_Crisis_2015.png))



The integration of the Schengen area and the recent conflicts in the Middle East increased the concentration of immigrants and refugees seeking better life chances in the European Union (EU), due to the ease movement between the countries. The European Union is home to around 1 million recognized refugees. The most attractive EU countries for asylum seekers that are hosting the most refugees are France, Germany, United Kingdom, Sweden and Italy. In 2008 EU member states signed the European Pact on Immigration and Asylum (4), which was intended to be the basis for European Union immigration and asylum policies in a spirit of mutual responsibility and solidarity between Member States and a renewed partnership with non-EU countries. Many asylum-seekers and refugees move and face difficulties in applying for asylum at borders, inadequate or insufficient reception conditions, or a lack of local integration prospects (1). Underlying causes of refugee movements need to be tackled and EU states need to implement their Global Health Strategies (5).

Spain, due to its geographical position, between the Atlantic Ocean, the Mediterranean Sea and its proximity to Africa, is a destination point for immigrants and refugees from Africa, to reach other countries in the northern part of Europe, mainly Germany. Since 2000 Spain has had one of the highest rates of immigration in the world, coinciding with a period of remarkable economic expansion. This influx began to decline rapidly after 2007 as the economy began to slow down. In 2015, 291,387 people immigrated to Spain, thus increasing foreign population to 4,454,353, coming mainly from Romania, Morocco, Italy, the United Kingdom and Venezuela

(6). According to UNHCR, in 2016, 59.5% of immigrants and refugees arrived by sea (2).

In Spain, the concentration of the immigrant population is in the Autonomous Communities of Madrid, Catalonia and Valencia. In Catalonia, 15.3% of the total population in 2016 was foreigners, mostly immigrants from Morocco, Romania and Ecuador, with a mean age of 32.2 years and 111 men per 100 women. In Catalonia there are 21% of the total number of foreigners in Spain and 27% of the total non-EU population in Spain (7).

The immigration process in the Republic of North Macedonia (Macedonia further in the text) is quite different than in Spain. Macedonia, largely a country of emigration, has become a country of transit and permanent immigration, experiencing several refugee crises. Migrant health became serious public health problem in Macedonia, as in other European countries with the migrant influx in 2015. There has been a notable growth of transit and illegal migration in Macedonia from Greece in 2015 mainly from Syria, Afghanistan, Pakistan and Iraq, and given the geographic position of the country, there is a high likelihood of further growth of such migratory developments. According to UNHCR 747,240 refugees left the country from July 1<sup>st</sup> 2015 (up to 10,000 refugees daily). Since September 2015, the proportion of women and children transiting the western Balkans route has progressively increased to more than 50% (2).

The aim of this paper is to analyze and compare the health profile, migrant situation and migration integration health policy in Spain as a European Union (EU) country and Republic of North Macedonia as a country in process of European Union accession.

## Methods

Migration integration health policy was compared in EU and non EU country, applying Migration Integration Policy Index (MIPEX) health strand as the most comprehensive and reliable tool. MIPEX was first published in 2004 as the European Civic Citizenship and Inclusion Index. There are 167 policy indicators on migrant integration in the MIPEX designed to benchmark current laws and policies against the highest standards in 8 policy areas, with 4 dimension scores for each area per country (8).

Health strand is a questionnaire designed to supplement the existing seven strands of MIPEX, which in its edition (2015) (9) monitors policies affecting migrant integration in 38 different countries. The Health strand questionnaire is based on the Recommendations on Mobility, migration and access to health care adopted by the Council of Europe in 2011, which were based on a consultation process that lasted two years and involved researchers, intergovernmental organizations, non-governmental organizations and a wide range of specialists in health care for migrants. The questionnaire measures the equitability of policies relating to four issues: migrants' entitlements to health services; accessibility of health services for migrants; responsiveness to migrants' needs; and measures to achieve change. MIPEX health strand survey was part of the EQUI-HEALTH project carried out by the International Organization for Migration (IOM) from 2013 to 2016, in collaboration with the Migration Policy Group (MPG) and COST Action IS1103, Adapting European Health Services to Diversity (ADAPT).

MIPEX Health strand study was conducted in all 38 countries, as well as Bosnia and Herzegovina and Macedonia. Data collection was organized by the IOM, while experts and peer reviewers responsible for completing the

Health strand questionnaire were members of ADAPT. Results from MIPEX 2015 Health strand were analyzed. Desk review was done on strategic documents, legislation, reports and studies for both countries.

## Results

### *Health profiles*

The political and economic processes have brought new lifestyles to the society influencing the health of the population as well; new disease patterns emerged, with the non-communicable and chronic diseases taking over the lead in morbidity and mortality trends. When compared the basic health indicators for both countries it is obvious that the health of population in Spain is much better than in Macedonia, with 6 years longer life expectancy, lower rate of infant mortality, lower SDR of diseases of circulatory system, lower rate of TB incidence etc (10). This is directly correlated with the economic situation in the countries, Spain is high income country with more than twice higher gross national income per capita (11) than Macedonia an upper middle income country and higher total health expenditure 9% of GDP in Spain compared to 6.5% in Macedonia, despite the impact of the 2008 economic crisis. In Macedonia non-communicable diseases and injuries are generally on the rise, while communicable, maternal, neonatal, and nutritional causes of DALYs are generally on the decline. Cerebrovascular disease, ischemic heart disease and lung cancer were the three leading causes of premature death in 2015, followed by cardiomyopathy and diabetes (12).

### *Migration Integration Health Policy*

Migration in Spain is regulated by the Organic Law 4/2000 on the Rights and Freedoms of Foreigners in Spain and its

Social Integration (13). Royal Decree 240/2007 (14) makes the Schengen Treaty effective by containing freedom of movement for community citizens. In order to respond to the Common European Asylum System, Law 12/2009 on the Right of Asylum and Subsidiarity is created (15).

Spain is a member of the European Union, so the right to health is protected with the Charter of Fundamental Rights of the EU (16) and the Universal Declaration of Human Rights (1948) (17). At the national level, the right to health is regulated by Act 14/1986 (18), with which all Spanish and foreign citizens in the Spanish territory have the right to health with the following characteristics: universal coverage, free services, public financing, high quality and comprehensive care.

The reforms of the Spanish Constitution gave the Autonomous Communities some competences such as health planning, public health and health care. Autonomous Communities have the ability to manage public services and special programs for asylum seekers and foreigners (reform of the Organic Law of 2/2009) (19). Since 2000, Catalonia has been supporting and formalizing its migration competencies with the creation of the Secretariat for Immigration. The National Pact for Immigration integrated the efforts of the different Catalan sectors that work on public policies of social integration (20). Law 10/2010 (21) stipulates an annual report on the state of integration of immigration while the Citizenship and Migration Plan 2016, considers the implementation of programs (22). From its establishment in 1981, the pillars of the Catalan health system have been universal coverage, comprehensive health service basket and gate keeping model. It is funded by taxes and offers almost universal access to health services, free at the point of

delivery, based on Act 15/1990 or Health Ordinance of Catalonia (23).

Macedonia has ratified the main United Nations conventions, contributed to establishing integration policies with respect for cultural and social differences, human rights and dignity. With the overall MIPLEX score of 44/100 (8) the country's policies for societal integration is just below the European average and slightly better than other countries in the region, such as Serbia, Bosnia and Herzegovina, Croatia and Bulgaria (24). The Macedonian Government adopted the first National strategy on integration of refugees and foreigners 2008-2015 (25) and the National Plan of Action (26), providing a national policy framework across sectors relevant to support the refugee integration.

Health care is a guaranteed universal right for citizens in Macedonia (27, 28), and is financed by the compulsory health insurance and from the central budget through the Ministry of Health vertical programs. Compulsory health insurance is based on solidarity, equity and equality providing universal coverage with basic benefit package to all insured persons and is defined by the Health Insurance Law (29). Foreigners (or legal migrants) in Macedonia are covered by the same risk-sharing system for health care, but are subject to additional requirements such as permission to stay and paid employment. Entitlement to health services including right to health insurance is regulated with Law on Foreigners (30) and with the Health Insurance Law (29). Migrants with access to compulsory health insurance are obliged to pay co-payments at the same level as nationals.

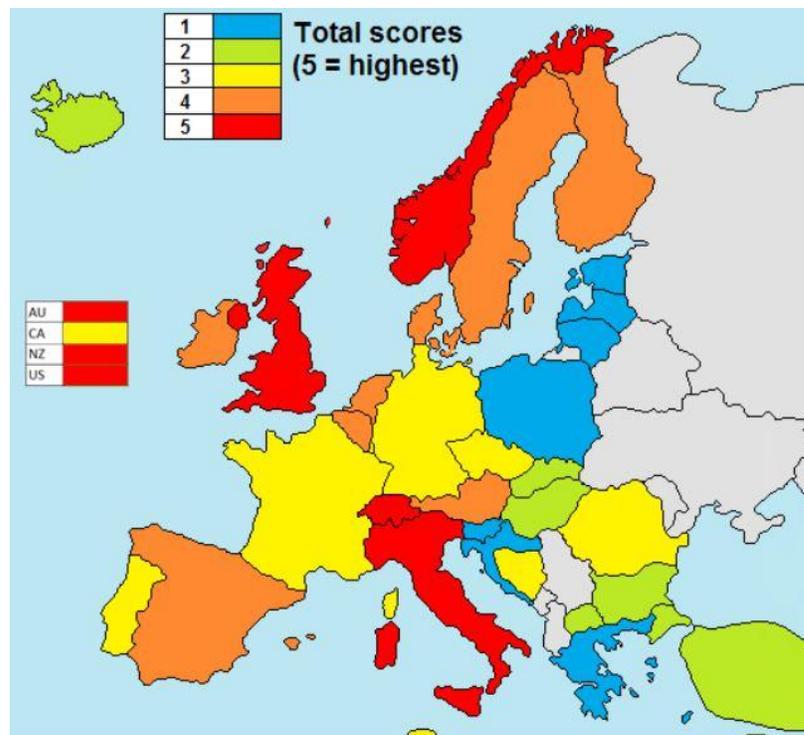
Asylum seekers are covered by the same system as nationals, with no additional requirements and no forms of care excluded. Health care of asylum seekers is regulated

with Law on Asylum and Temporary Protection (31), Law on international and temporary protection (32) and Health Insurance Law, and costs for the health insurance are covered by the Ministry of Labour and Social Policy. Undocumented migrants have no access to the same system as nationals: private insurance or payment of full costs of the services is required. Emergency care in life threatening situations should be delivered (documentation should be provided later). Migrants that entered the country illegally are transferred to the Transition Centre of the Ministry of Interior and the costs for health services are paid by the Government. If they seek asylum they become asylum seekers and are being transferred to asylum Reception Centre and

have the same entitlements to health care as asylum seekers. Although the law may grant migrants certain entitlements to healthcare coverage, administrative procedures often prevent them from exercising this right in Macedonia.

There are differences in migration integration policy between countries in Europe in health as in other strands (9). The lowest total MIPEX health strand score in Europe is in Latvia 17, while the highest is in Switzerland 70. Spain has health strand total score of 52 and is in the same group with Austria, Ireland, Belgium, Netherlands, Denmark and Sweden. Macedonia has lower health strand total score 38 and is in the same group with Turkey, Cyprus, Slovakia (Figure 2) (33).

**Figure 2. MIPEX 2015 Health strand total scores in Europe**  
 (Source: Summary Report on the MIPEX Health Strand and Country Reports) (33)



In Spain there are Immigrant Shelter Centres responsible for providing social services and temporary shelter to immigrants and asylum seekers. The beneficiaries have access to health services, psychological support, legal services, training and recreation activities. However, they are only found in the two most important entry points, Ceuta and Melilla. In Spain, Act 16/2012 (34) denies the right to health of irregular migrants. Irregular immigrants are only entitled to receive emergency health care, assistance in pregnancy and childbirth, health care for children under 18 years.

The Government of Macedonia as a response to the migrant crisis in 2015 changed the legislation on June 19<sup>th</sup> 2015 providing free health services for all registered migrants, National Coordination Body was formed, technical expert group established, Migrant Action Plan adopted and two Transit Centers opened at the borders with Greece and Serbia. The following problems were faced in Macedonia during migrant crisis: huge number of undocumented migrants particularly upon arrival at entry points, no resources such as interpreters, intercultural mediators, communication problems between migrants and health care personnel and administrative staff (24).

### **Discussion**

Migration exposes people to vulnerable situations and their health is related to different determinants: individual (behaviour, genetic factors, age, and gender), environmental factors (physical, economical, social and cultural) and health services (availability, accessibility and quality). Migrant children and mothers are the most vulnerable and they require access to special protection and care (24).

Migrant health is very important and long-overdue issue in EU member states and of special concern is potential widening of the

health gap between migrant and host populations. Variation of national migration integration policies for entitlements to health services in European countries is a barrier to health care for refugees, asylum seekers and especially for un-documented migrants (35). Health systems need to be responsive to the migrant health needs and cultural differences such as concept of health and disease, felt and expressed health needs, language barriers, etc. Migrants arriving on European Union territory should be treated in a responsible and dignified manner and the need for accessible health services is more than obvious (36).

There are differences between Spain and Macedonia in health care coverage and access to health services for migrants. Spain has relevant regulations for immigrants, refugees and international protection, but also regulations that guarantee basic human rights, such as the right to health. Targeted migrant health policies are stronger and services more responsive in Spain as a country with greater wealth (GDP), compared to Macedonia which offers migrants legal entitlements to healthcare, but still more efforts should be undertaken to adapt services to their needs.

Effective health care delivery to migrant and minority groups is compromised by the absence of culturally sensitive health services in Macedonia. No resources such as interpreters, cultural mediators (there are only Roma mediators), health and social care professionals trained on multicultural approaches are available in Macedonia.

Strategies and policies are relatively new in Macedonia, along with the fact that such strategies are also subject to constant upgrade to the level of EU requirements (1) due to their wide socioeconomic impact and replaced migration developments. Although Government has taken commendable action to establish the necessary services, the

country has limited resources and requires support. There is a need to invest more, and sooner, in the health care to address migrants' specific health needs.

The integration of migrants into their host societies promotes equal opportunities for migrants and nationals (37), thereby fostering economic development in countries of origin and destination (38).

### **Limitations**

Migrant integration health policy has been analyzed only in two countries, Spain member of the European Union and accession country Republic of North Macedonia, both facing with the migrant influx and responding to the needs of the migrants.

### **Conclusions**

The Government of Macedonia adopted national legal framework and strategic documents on integration and established institutional framework and measures regarding immigrants' healthcare and broader welfare issues remain closely tied to the general framework of immigration policy. There is a need to create appropriate structures in health system accessible to refugees, responsive to different cultures, based on universal human rights. Meanwhile, the Government of Spain has responded to international and European Union conventions regarding the elaboration of regulatory mechanisms on international protection, immigration and health.

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