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The MIPEX Health strand: a longitudinal, mixed-methods survey of policies on migrant health in 38 countries

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Background: Within health systems, equity between migrants and native-born citizens is still a long way from being achieved. Benchmarking the equitability of policies on migrant health is essential for monitoring progress and identifying positive and negative aspects of national policies. For this purpose, the 2015 round of the Migrant Integration Policy Index (MIPEX) was expanded to include a strand on health, in a collaborative project carried out between 2013 and 2017 in 38 countries. **Methods:** Indicators of policies to promote equity were derived from the 2011 Recommendations of the Council of Europe on 'mobility, migration and access to health care' and used to construct a questionnaire compatible with MIPEX methodology. This yielded scores for Entitlement, Accessibility, Responsiveness and Measures to achieve change. **Results:** As a measuring instrument, the questionnaire has a high degree of internal consistency, while exploratory factor analysis showed a coherent relationship between its statistical structure and the four scales it comprises. Measures to achieve change were strongly associated with Responsiveness, but not at all with Entitlements and only slightly with Accessibility. Examining the results from the sub-sample of 34 'European' countries, wide variations in the equitability of policies were found: these were mainly associated with a country's wealth (GDP), but differences between EU13 and EU15 countries were too extreme to explain completely in such terms. **Conclusions:** The MIPEX Health strand is a robust measurement tool that has already yielded a number of important results and is providing a valuable resource for both researchers and policy-makers.

Introduction

In 2016, 11.0% of the combined population of the EU28 and European Free Trade Area (EFTA) were born in another country, 4.1% within the region and 6.8% outside it.[1] Health equity for this steadily growing group requires equal access to health services, responsiveness of services to migrants' needs and intersectoral attention to the social determinants of their health. Very few countries can claim to have achieved anything like equity between migrants and national citizens in all these respects. Benchmarking policies is therefore essential, in order to monitor progress towards equity and to highlight examples of fair and unfair policy.

However, although publications on migrant health policies have appeared with increasing frequency since the 1990s,[2,3] a systematic approach has been impossible up to now because each study has tended to focus on a different sample of countries and issues, as well as using different concepts and criteria. Coverage has also been uneven, with some countries surveyed repeatedly and others not at all. In order to study changes over time and to compare countries with each other, standardization and quantification are essential.

It is for precisely these kinds of reasons that instruments like the Migrant Integration Policy Index (MIPEX) have been developed. MIPEX has been benchmarking policies on various 'strands' of integration policy (such as Education, Labour market mobility or Family reunion) at four-yearly intervals since 2003. Starting from the premise that migrants' inclusion in the receiving country's health system is also a vital aspect of their integration,[4] we designed a questionnaire and used it to augment the 2015 round of MIPEX with an eighth strand on Health. For 34 of the 38 countries covered, detailed Country Reports were also written to provide background data and interpretation of the results.[5]

Four organizations worked together between 2012 and 2017 to carry out this survey: the International Organization for Migration (IOM, Brussels Office, EQUI-HEALTH project); COST Action IS1103 'ADAPT' (Adapting European Health Systems to Diversity), an EU research network with 130 members from 30 countries; the developers of MIPEX, the Migration Policy Group (MPG); and the Barcelona Centre for International Affairs (CIDOB), coordinator of the 2015 round of MIPEX. Altogether, some 155 experts from 40 countries collaborated in the project (see Supplementary data S1 for the full list). The data were published on the MIPEX website[6] in June 2015, followed in 2016 by a Summary Report[7] and in 2017 by the 34 Country Reports on the website of the EQUI-HEALTH project.[5]

Methods

Choice of items

For any measuring instrument, a selection has to be made of items to be used as indicators. As yet, little empirical evidence is available about the ability of different measures to improve health equity for migrants: in any case, these effects will vary depending on the nature of the migrant population in a given country, region or period. The importance of some policy goals is self-evident: for example

migrants must have equitable entitlements to access health services, as well as adequate information about what these are and how to exercise them. Likewise, health workers and migrant patients must be able to communicate adequately with each other in order for treatment to be safe and effective. Regarding the importance of some other policy goals, there is room for disagreement; however, a recent review of international standards[8] showed that a high degree of consensus has already been achieved regarding the most important ones.

In 2011, the Council of Europe (CoE) published a set of recommendations to its 47 member states on 'mobility, migration and access to health care'.[9] These were based on a two-year consultation process involving an international expert committee, many intergovernmental and non-governmental organizations and a wide range of researchers and practitioners specializing in migrants' health and access issues. The results of this consultation were summarized in 14 recommendations, 31 guidelines and an 8000-word Explanatory Memorandum. These documents served as the foundation of the MIPEX Health strand.

Construction of the questionnaire

To ensure consistency and comparability with the other strands in MIPEX, the Health strand had to use the same basic methodology.[10] Each strand contains four sections or 'dimensions' with about 6 questions each, using one or more indicators per question. The 23 questions in the Health strand use 38 indicators. Questions are scored on a three-point Likert scale with the following levels: 0 (no policies to avoid inequities), 50 (a defined intermediate position) and 100 (equitable or near-equitable policies). Scores within each section are averaged, as are the means of all sections. The four sections (scales) were as follows:

(A) Entitlements to health services;
(B) Accessibility of services;
(C) Responsiveness to migrants' needs;
(D) Measures to achieve change.

The CoE recommendations have six topic areas; four of these correspond to the above sections, while the two additional topics ('Improving knowledge about migrants and their situation' and 'Migrants' state of health') were incorporated in Section D. The MIPEX Health strand refers to 'health services' rather than 'health care', to emphasize that preventive activities such as population screening and health promotion campaigns are included.

Entitlements (A) refers to coverage in the national system of risk-sharing, which may be predominately tax-based or insurance-based. This is scored separately for three types of non-EU/EFTA migrants (i.e. third country nationals or TCNs): (i) 'legal migrants' (specifically, the largest category, i.e. those with a residence permit for work reasons), (ii) asylum seekers and (iii) undocumented migrants (UDMs, i.e. migrants in situations of irregularity). Questions 1–3 record the coverage that each group is entitled to by law (the basket of services, conditions for eligibility and exemptions applying to special groups or health problems), while questions 2–4 describe administrative barriers that may prevent migrants from accessing these entitlements (discretionary judgements or demands for documents that may be hard for migrants to produce). Scores on the remaining three scales are not disaggregated by the type of migrant.

Accessibility (B) examines policies to help migrants find their way to health services (e.g. provision of appropriate information, health education and promotion).

Responsiveness (C) examines the extent to which policies promote the adaptation of services to migrants' needs (e.g. issues of language and culture; migrant involvement; diversity in the health workforce and adaptation of diagnostic and treatment methods). All these are commonly referred to as 'diversity sensitivity' or (especially in English-speaking countries) as 'cultural competence'.

Measures to achieve change (D) Examines 'flanking measures' that support the improvement of policies affecting health equity for migrants, such as data collection, research, leadership and governance structures. Intersectoral application of the 'Health in all Policies' (HiaP) principle, as well as mainstreaming of migrant health policies, is also included.

It should be noted that the Health strand measures equity in policies, not absolute standards. In some respects, equity means treating migrants and nationals identically; where needs are different, however, it means treating them differently. The methodology and procedures used for collecting data, including the concept of 'policy' adopted, are described in Supplementary data S1; together with the full questionnaire.

Regional policy variations are quite common ('multi-level governance'),[11] especially where migrants are concentrated in particular areas within a country. In such countries, the standard MIPEX procedure is to focus on two 'migrant-rich' areas and aggregate the results found. This method creates a potential bias towards higher scores for such countries. To counteract this, respondents in all countries were required to give more weight to results from 'migrant-rich' areas. Scores may thus misrepresent the overall level of policy development in a country; however, this increases rather than decreases their relevance, because it is in 'migrant-rich' areas that policies to promote migrants' health should have most effect.

Fine-tuning and piloting the questionnaire

Development of the questionnaire was carried out in a series of six international meetings organized by ADAPT between September 2012 and December 2014. First, a draft version of the questionnaire was constructed, which was tried out in two countries to uncover the problems it presented for users. This stage mainly concerned the precise formulation of questions. The revised version was then piloted in 19 countries; at this stage, further adjustments to the wording and category boundaries were made to improve the discriminatory power of items. Modifications continued to be made on the basis of experience gained during data collection.

Data for the project were collected in the countries of the EU28 and EFTA (Norway, Iceland and Switzerland), FYR Macedonia, Bosnia & Herzegovina and Turkey, as well as in the 'traditional countries of migration' (USA, Canada, Australia and New Zealand). The SPSS statistical package (Version 24) was used to carry out analyses.

Results

Validity, reliability and structure of the instrument

The fact that over two years were required to develop the questionnaire reflects the care that had to be taken to ensure that from the start, the meaning of each question was as precise and unambiguous as possible. In a longitudinal survey, too much modification of the original instrument in later rounds would make comparisons over time impossible. As with all MIPEX strands, respondents were required to have expert knowledge of the topic, to be independent, to document the sources of their information, and to submit their work to cross-checking by one or more peer reviewers and the project leaders. Nevertheless, the answers to some questions were easier to substantiate than others.

The internal consistency of the instrument is high (Cronbach's alpha = 0.86), even though the four scales were intended to measure different aspects of equitability. Scale A was designed to have two distinct components: (i) national laws and (ii) freedom from the administrative barriers that often impede the effective implementation of these laws. Putting both components in the same scale ensured that countries that confront migrants with serious administrative barriers to claiming entitlement could not receive high scores. Table 1 gives summary information on each scale as well as the results of the factor analysis.

Table 1 Topics of questions, mean scores, item-total correlations (*r*) and factor loadings for the 23 questions in the MIPEX Health strand questionnaire, with values of Cronbach's alpha for each (sub)scale (based on 34 'European' countries)

Scale	Question number	Topic of question LM: Legal migrants AS: Asylum seekers UDM: Undocumented migrants	Mean score ($N = 34$)	Item-total correlation	Loadings on the first 3 factors (above 0.40 marked bold)		
					1	2	3
(A) Entitlement	1	LM: conditions and extent of coverage, special exemptions	79	0.63	−18	0.10	**0.77**
	2	AS: conditions and extent of coverage, special exemptions	73	0.67	0.00	0.00	**0.83**
	3	UDM: conditions and extent of coverage, special exemptions	47	0.60	−08	−0.14	**0.87**
		Scale A (1–3): mean score = 66, alpha = 0.79					
	4	LM: lack of administrative discretion, documentation problems	65	0.50	−0.07	**0.68**	−0.37
	5	AS: lack of administrative discretion, documentation problems	47	0.47	−0.33	**0.58**	−0.08
	6	UDM: lack of administrative discretion, documentation problems	22	0.36	−0.15	**0.61**	0.01
		Scale A (4–6): mean score = 45, alpha = 0.62					
(B) Accessibility	7	Information for service providers about migrants' entitlements	35	−0.09	0.15	−0.19	0.24
	8	Information for migrants on entitlements and use of services	71	0.39	−0.10	**0.49**	0.16
	9	Health education and health promotion for migrants	58	0.53	**0.47**	**0.50**	0.04
	11	Provision of 'cultural mediators' to facilitate access for migrants	27	0.36	0.03	**0.75**	−0.06
	12	No obligation to report undocumented migrants	67	0.45	−0.03	**0.41**	0.05
		Scale B: mean score = 52, alpha = 0.51 (0.68 without item 7)					
(C) Responsiveness	13	Availability of qualified interpretation services	52	0.80	**0.59**	0.35	0.23
	14	Requirement for 'cultural competence' or 'diversity sensitivity'	22	0.63	**0.73**	0.21	−0.26
	15	Training and education of health service staff	32	0.73	**0.67**	0.16	0.25
	16	Involvement of migrants (information provision, service delivery)	28	0.79	**0.87**	0.01	−0.06
	17	Encouraging diversity in the health service workforce	16	0.43	**0.56**	−0.20	0.06
	18	Development of capacity and methods for diagnosis and treatment	32	0.82	**0.76**	0.11	0.18
		Scale C: mean score =31, alpha = 0.88 (0.90 without item 17)					
(D) Achieving change	19	Collection of data on migrant health	54	0.56	**0.69**	−0.04	−0.06
	20	Support for research on migrant health	68	0.59	**0.67**	−0.09	0.19
	21	''Health in all policies'' approach	12	0.51	**0.77**	−0.11	−0.07
	22	Whole organization approach (mainstreaming)	25	0.78	**0.88**	−0.07	−0.06
	23	Leadership by government	28	0.48	**0.68**	−0.20	−0.22
	24	Involvement of stakeholders, especially migrant groups	27	0.54	**0.66**	−0.34	−0.16
		Scale D: mean score =36, alpha = 0.81					

Although the suitability of this dataset for factor analysis is far from ideal, an exploratory factor analysis was carried out to investigate its statistical structure, applying principal component extraction to the correlation matrix followed by Promax rotation. Bartlett's test of sphericity gave satisfactory results ($\chi^2 = 544$, df = 253 and $P = 0.000$), but the Kaiser-Meyer-Olkin measure of sampling adequacy was only 0.51. The main reasons for this low value were probably the low ratio of cases to variables (38 to 23), the non-optimal properties (skewness and kurtosis) of some of the scales on which correlations were based and the use of Pearson correlations with ordinal data. Nevertheless, the analysis yielded very useful information (see table 1). On the basis of the scree plot, only the first three factors are reported here.

Examining first the factor loadings, we see that all the items in scales C and D have high loadings on the first factor. This suggests that the 'flanking measures' described in D are mainly found in countries where health policies encourage services to be more responsive to diversity [r(C, D) = 0.75, $P < 0.01$]. By contrast, the correlation between scales D and A is zero and between D and B only 0.35 ($P < 0.05$). This implies that countries investing in 'flanking measures' do not score better on entitlement, and only slightly better on accessibility.

Legal entitlements (questions 1–3 in scale A) have high loadings on the third factor, while questions concerning freedom from other kinds of barriers (4–12) load on to the second factor, with the exception of question 7. Respondents evidently found it hard to assess the adequacy of policies to inform service providers and health workers about migrants' entitlements. However, these policies are nevertheless extremely important; although their determinants do not seem to be the same as the other policies in scale B, their effects almost certainly are. Entitlements are of little value if service providers and health workers are not told what they are.

Indeed, it is important to remember that the internal homogeneity of any scale only reflects similarity in determinants, not effects. The effects of the policies measured by the Health strand should be to increase the proportion of migrants who are able to access health services, are effectively helped by them, and are protected against threats to their health. However, we are still a long way from having systematic measures of these variables which could be used to validate the questionnaire.

Findings concerning average scores

Table 1 also shows the average scores on each question (based only on the 34 'European' countries in the EQUI-HEALTH study). To interpret these scores, it is necessary to know the precise wording of the questions; a detailed discussion is provided in the Summary Report.[7] The most striking findings were:

Entitlement (A)

- In tax-based health systems, even 'legal migrants' may be excluded from coverage if their stay is not long-term or permanent; in such cases, they have to pay taxes to help finance a system from which they are not allowed to benefit. In insurance-based systems, migrants who become unemployed may have to finance their own health care precisely when they are least able to.
- Asylum seekers are often confronted by restricted entitlements and barriers to claiming them.
- In most countries studied, health service coverage for undocumented migrants is well below the standards required by international law.[12] The main reasons are the widespread use of discretionary powers and the emphasis on emergency rather than primary care.

Accessibility (B)

- Health information for migrants is often meagre, inaccurate and/or poorly targeted. Six countries require UDMs who receive treatment to be reported to immigration authorities, while four may in principle apply sanctions to health workers providing treatment.

Responsiveness (C)

- Eight countries (24%) score zero on this scale.
- In 14 countries (41%), no policies providing for medical interpretation seem to exist.
- Only about half of all countries studied have standards or guidelines for 'culturally competent' or 'diversity-sensitive' care, or training programmes to enhance such skills.
- Most countries do not involve migrants in any way in service delivery.
- Three-quarters of countries do not encourage diversity in the health workforce.
- In 40% of countries, policies are exclusively focused on standardizing diagnostic procedures and treatment methods.

Measures to achieve change (D)

- In only 20% of countries is a 'Health in All Policies' approach to migrant health ever applied.
- Only in four countries is attention to migrant health mainstreamed in the health system.
- Only in half the countries studied does national government offer any kind of leadership on migrant health.
- In 13 countries there are no stakeholder organizations concerned with migrant health, and only in 12 countries are migrant organizations consulted.

Relation of scores to other variables

Again, only the 34 'European' countries are studied here. Analyses of the relation between Health strand scores and background variables can shed light on the factors encouraging equitable policies. Significant correlations are not hard to find: in the Summary Report, experiments were reported using multiple regression to try and identify which of these correlations were artefactual, i.e. the result of confounding by another factor influencing both variables. However, such techniques require data that conform to rather stringent requirements, which may not have been met in this dataset, so only nonparametric statistics are used here.

The following background variables were related to total scores:

- Gross Domestic Product (GDP) per capita (Spearman's rho = 0.69, $P = 0.000$).
- Average score on other MIPEX strands (rho = 0.60, $P = 0.000$).
- Percentage of non-EU/EFTA migrants (rho = 0.44, $P = 0.009$).

Among EU countries, membership of the EU15 vs. the EU13 (i.e. accession before or after 2004) had strikingly large effects: average scores for the two groups were 52 and 31, respectively ($P = 0.000$ by the Mann–Whitney *U*-test). Scale C (responsiveness) showed even larger differences between means (47 vs. 13).

Using non-parametric partial correlation (rho) instead of multiple regression, we find that the effect of GDP is not removed by controlling for any of the other variables mentioned above, whereas the effects of the average scores on other MIPEX strands and the percentage of TCNs in a country are removed by controlling for GDP. The difference between EU15 and EU13 countries remains slightly significant ($P < 0.05$, one-tailed) when GDP is controlled for. This finding suggests that in addition to the major differences in wealth between the EU15 and EU13 (average GDP 121 vs. 71), other differences in the policy climate also affect Health strand scores.

Although the level of out-of-pocket (OOP) payments was not scored in the questionnaire, WHO data on the percentage of total health expenditure covered by such payments in 2013 were used as a background variable to see if this was related to the mean of legal entitlements (questions 1–3). There was indeed a strong negative correlation (rho = −0.54, $P < 0.001$), which was not entirely removed by partialling out the influence of GDP (rho = −0.40, $P < 0.02$). There is thus a non-artefactual relationship between imposing high OOP payments on the general population and granting inferior legal entitlements to migrants.

Another interesting finding was that tax-based health systems were associated with higher scores on scales C and D than insurance-based systems ($P = 0.024$ for both scales by Mann–Whitney *U*-test, two-tailed). This may have to do with the more centralized, top-down governance that tends to characterize tax-based systems, or with the egalitarian ideology that underlies them: further research is needed to clarify this link.

Discussion

Measuring policies

Can the degree of equity in a country's migrant health policies be quantified? In political science and sociology, scales attempting to measure policies are becoming commonplace, but they rely on a far more pragmatic approach to measurement than that which characterizes (e.g.) epidemiology. Firstly, sample sizes are much smaller; secondly, it is difficult to move beyond nominal or ordinal levels of measurement to interval or ratio scales. Because of the lack of precision that inevitably results, we decided to present MIPEX scores in the Country Reports only on a five-point ranking scale (low - below average - average - above average - high).

A major problem concerns weighting the importance of different policy measures. Accurate weighting in a general instrument is not even theoretically possible, because policy priorities which are optimal for one migrant population will not be optimal for another. (E.g. a package of policies designed to respond to a sudden influx of mobile, irregular migrants may have little relevance to the needs of long-established sedentary legal migrants.) MIPEX responds to the weighting problem by using a 'grapeshot' approach – by treating all indicators as equally important and collecting large numbers of them (38 in the Health strand), in the expectation that errors of weighting will tend to cancel each other out. However, this common-sense solution runs up against the problem that most multivariate statistical techniques require datasets with far more cases than variables.

Nevertheless, the results reported here are encouraging. They make it possible to sketch the broad outlines of the European policy landscape and to pinpoint the most serious inequities. They show that GDP has an overwhelming influence on policies, but not an exclusive one; to uncover the other influences, further studies will need to focus on groups of countries that are reasonably similar in terms of GDP.

Examining the internal structure of the instrument showed—unexpectedly—that efforts to achieve change currently focus on responsive service delivery rather than improving migrants' entitlements to coverage. In a sizeable group of European countries (overlapping largely with membership of the EU13), notions of 'cultural competence' or 'diversity sensitivity' seem to be virtually unheard of. The main struggle in these countries is probably to reduce inequalities in service provision between rich and poor; many health workers seem to identify equity with equality and to regard any deviation from the 'one size fits all' principle with suspicion. A wish to promote cultural homogeneity may also play a role. More research into policy determinants in these countries is urgently needed.

Limitations of the study

A major limitation of this survey is that as with the rest of MIPEX, there is no explicit focus on EU migrants (as opposed to TCNs) or on ethnic minorities (including the descendants of migrants). However, many items have clear relevance to these groups, and additional data could easily be collected.

Applications to date

The MIPEX Health strand is already proving to be a valuable resource for researchers and policy-makers. Its results informed the *Opinion on Benchmarking Access to Healthcare in the EU* by DG SANCO's Expert Panel on effective ways of investing in health (EXPH),[13] while it is one of two good practices included in the Global Migration Group's *Handbook for Improving the Production and Use of Migration Data for Development*.[14] It was also quoted in the *Proposed Health Component in the Global Compact for Safe, Orderly and Regular Migration*, jointly issued by the IOM and WHO.[15] The dataset analyzed in this article can be downloaded from the IOM's website on EQUI-HEALTH;[5] it is to be hoped that more researchers will take up the challenge of using these data to further our understanding of the determinants of equitable policies for migrants.

Supplementary data

Supplementary data are available at *EURPUB* online.

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Disclaimer

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Key points

- The equitability of national policies concerning migrant health can be measured by a robust quantitative instrument, the MIPEX Health Strand, enabling countries to be compared with each other as well as with themselves at different points in time.
- Results from the 2015 round of MIPEX revealed very large differences in policies on migrant health in the EU/EFTA and three neighbouring countries, with countries that have recently acceded to the EU (the EU13) gaining particularly low scores, which should be of concern to Public Health authorities in those countries.
- In the whole sample, scores on measures to achieve change were strongly correlated with policies to promote responsiveness, but not at all with legal entitlements; 'migrant-friendliness' seems to be regarded mainly as a matter of making health services responsive to migrants' needs, rather than improving coverage for them.

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