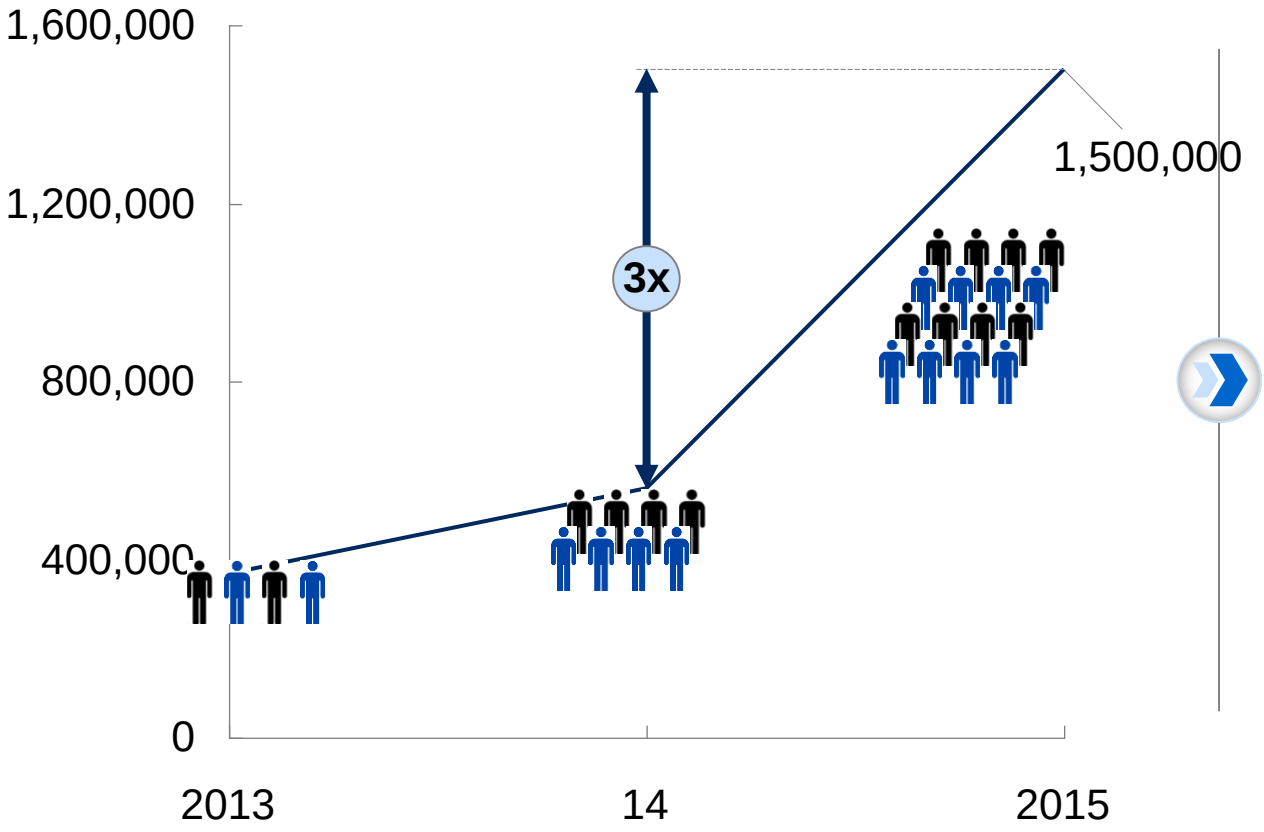
Refugee health – in light of the EU‘s current migration crisis

The number of asylum applicants has increased by factor 3 between 2014 and 2015 – claims based on family reunification not included

Number of asylum applicants in the EU[1]



In 2016, a similar number of applications can be expected – not including additional claims based on family reunification (est. factor 1,4 - 1,6)

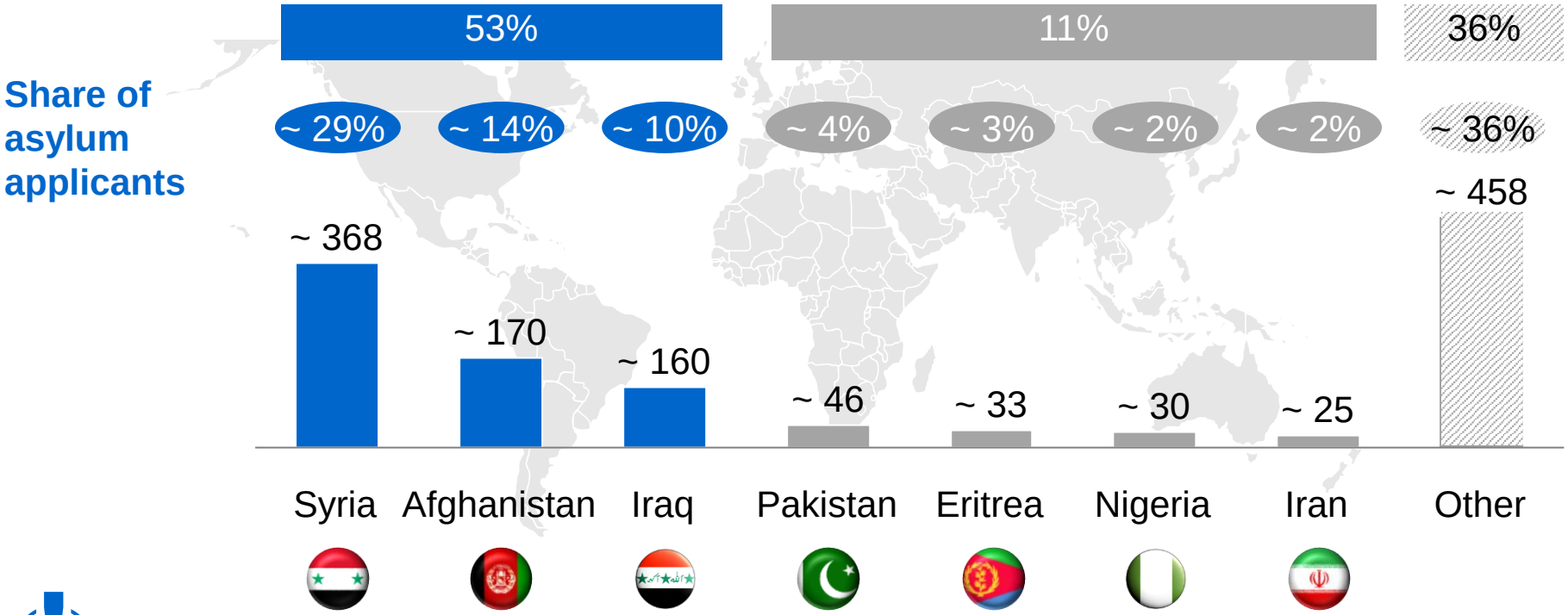
1 First time asylum applicants, annual aggregated data (rounded)
2 Estimates ~500,000 newly arriving refugees and ~350,000 who have had not applied for registered refugees asylum until 1/1/2016

SOURCE: Eurostat; German Federal Office for Migration and Refugees (BAMF)

More than 50% of the asylum applicants in the EU in 2015 came from only three countries of origin: Syria, Afghanistan and Iraq

Asylum applicants in the EU, 2015

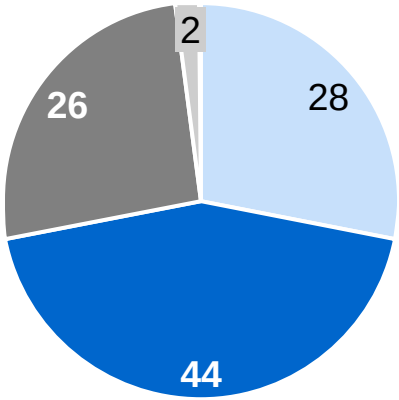
In thousands



Given the high proportion of the asylum applicants from Syria, Afghanistan, and Iraq **specific policies to meet the needs of refugees** from those countries should be considered

SOURCE: Eurostat

Demographics show that more than 65% of asylum seekers are under 30 and male, and over 80% without a formal education degree



- < 16 years
- 17 - 29 years
- 30 - 54 years
- >= 55 years

Academic degree **8%**

High school diploma/ formal vocational training **10%**

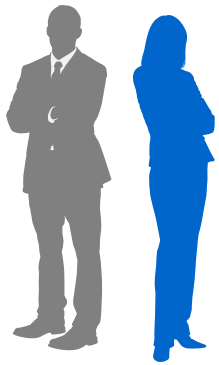
82%

No diploma, degree of formal vocational training

Age[1], share in %

Gender[1]

~ 67%

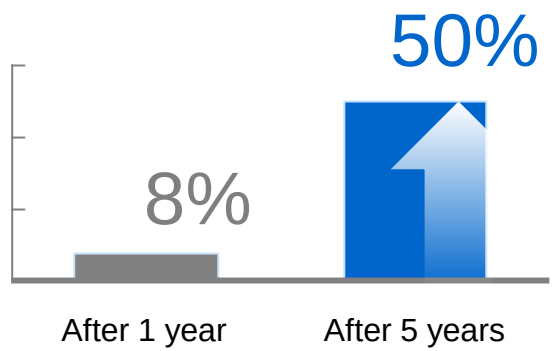


~ 33%

Demo-graphics of asylum seekers

Qualifications[2], share in %

Employment rate, in %



1 Age and gender based on asylum applications Jan – March 2016
2 Qualifications of asylum seekers when they obtained formal unemployment status (December 2015)

SOURCE: German Federal Office for Migration and Refugees (BAMF), German Federal Statistical Office (Destatis)

EU Member States have to consider refugee's health care needs - entitlements differ significantly

SAMPLE COUNTRIES

Same benefits as local citizen

Emergency care and those that cannot be postponed[2]

Emergency care

	Germany	Hungary	Sweden	Austria	Italy3	Greece
Access for refugees[1]						
Access for asylum seekers	First 15 months / After 15 months	Children under 18 years / Adults				
Access for unregis-tered migrants		Children under 18 years / Adults				

- Access **differ significantly across** Member States
- Other factors such as **capacity and ease of accessibility** influence access to benefits as well

1 Persons granted asylum (refugees) as well as beneficiaries of temporary protection temporary protection
2 Such as maternal health, psychiatric care, disability aids
3 Health care services for unregistered migrants includes essential care for diseases which aren't dangerous in the immediate, but may cause damage to health in the mid- to long-term.

SOURCE: Asylum Information Network, Ministries of Health, press research, national laws, Doctors of the World, National Migration Agencies

Disease patterns differ significantly between top countries of origin and EU host countries

DETAILED DATS WITH AGE AND GENDER SPLIT AVAILABLE

x% Difference to DAILY/inhabitant in Italy xx Share of total number of asylum seekers in Italy, 2015[1] **Bold** Also in top 10 disease in Italy

Top 10 diseases in DALYs/inhabitant[2] of top 3 countries of origin of asylum seekers in Italy[1]

Nigeria

Lower respiratory infections	0.11	+436%
Malaria	0.10	+644%
HIV/AIDS	0.08	+491%
Diarrhoeal diseases	0.06	+396%
Preterm birth complications	0.05	+370%
Birth asphyxia and birth trauma	0.05	+338%
Meningitis	0.03	+222%
Protein-energy malnutrition	0.02	+159%
Other infectious diseases	0.02	+140%
Neonatal sepsis and infections	0.02	+178%

21%

Pakistian

Lower respiratory infections	0.04	+95%
Preterm birth complications	0.04	+200%
Birth asphyxia and birth trauma	0.03	+116%
Diarrhoeal diseases	0.03	+115%
Neonatal sepsis and infections	0.02	+83%
Ischaemic heart disease	0.02	+37%
Chronic obstructive pulmonary disease	0.01	+34%
Tuberculosis	0.01	+48%
Other infectious diseases	0.01	+36%
Unipolar depressive disorders	0.01	+44%

12%

Gambia

Malaria	0.07	+232%
Lower respiratory infections	0.06	+335%
Birth asphyxia and birth trauma	0.04	+190%
Preterm birth complications	0.03	+173%
Diarrhoeal diseases	0.03	+168%
Tuberculosis	0.03	+133%
Neonatal sepsis and infections	0.02	+101%
Meningitis	0.02	+103%
Iron-deficiency anaemia	0.02	+97%
HIV/AIDS	0.02	+110%

10%

- **Top disease types differ significantly between countries of origin and EU host countries**
- For example, of Italy's top 10 disease in terms of Daily/inhabitant only 3 are also in the top 10 of one of the top 3 countries of origin
- Thus healthcare **delivery models** should take these disease patterns into account

1 First time asylum applicants in 2015

2 Excluding DALYs from injuries

SOURCE: Eurostat, WHO

In addition, diseases caused through refugees' escape via overland or sea routes to be addressed by host countries

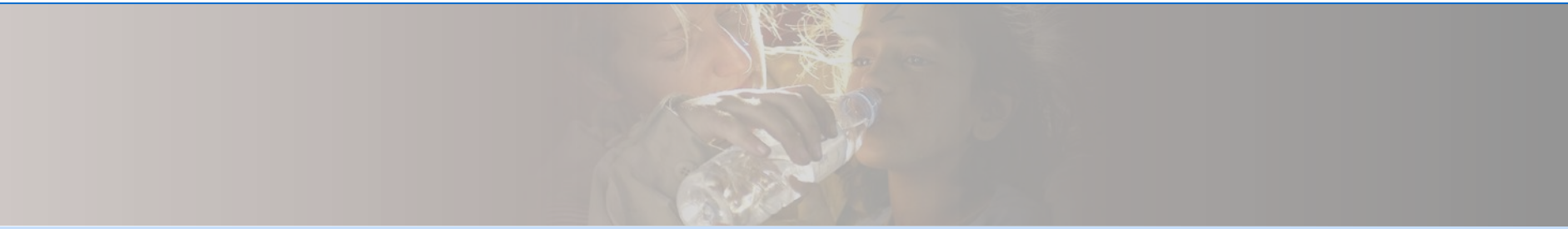
NOT EXHAUSTIVE

Conditions during refugees' journey

- Lengthy and unsafe trip
- Overcrowded refugee hubs
- Inadequate hygiene and water conditions
- Inadequate individual space
- Specific disease patterns in transit countries

Resulting disease types

- Dehydration and nutritional disorders
- Hypertonia
- Infectious diseases, e.g., Infectious respiratory
- Acute (post-traumatic) stress disorders
- Gastrointestinal disorders
- Skin diseases, e.g., scabies



SOURCE: WHO

Upon arrival, initial medical screening, provision of standard vaccinations as well as treatment of communicable diseases to be delivered

Refugees require immediate health care when they arrive in the EU

- **Provide initial medical screening** in order to
  - Identify and treat **communicable diseases**
  - Provide **emergency support for mental diseases**
  - Provide required treatment for known **chronic disease**
- Promote **measures to avoid spread of communicable diseases**
  - Provide of **standard vaccinations**
  - Offer **health education** and promotion regarding hygiene and vaccinations
- **Pay special attention to vulnerable groups**, such as children, pregnant women and older people

- Provision of initial medical care is centred in **main refugee reception hubs**
- **A European public health follow-up system** (documentation and communication) is required to allow follow-ups for moving refugees

!

SOURCE: European Journal of Public Health, PLOS One

In the long-term, health care systems need to ensure integration of refugees and migrants into the existing national health systems

In the long-term, refugees and other migrants need integrated and holistic health care provision

Scope of benefits	▪ Allow **access** to national health systems for – Primary care, including acute diseases – Chronic diseases – Mental diseases
Capacity	▪ Allow enough capacity to ensure **adequate maximum waiting times** ▪ Provide capacity at the **refugees' residences**
Targeted outreach	▪ Provide **refugee-specific programmes** – Immunization – Communicable diseases – Mental diseases, e.g.. posttraumatic stress disorder – Prevention of chronic diseases – Health promotion and education – Vulnerable groups
Communication and documentation	▪ Provide **information an access to health system** and **benefits** in comprehensive and multi-language formats ▪ Ensure **comprehensive communication,** e.g., through translator ▪ Reduce administrative process to **allow easy access** ▪ Adjust **documentation to volatility of** residence of refugees
Cultural competency	▪ Minimize cultural barriers **pre, during and post-appointment and treatments**, e.g. through staff training and health education

SOURCE: WHO, PLOS One

Initial assessments suggests that there are significant gaps along a key dimension in EU Member States' refugee delivery models

NOT EXHAUSTIVE

Dimensions	Examples of gaps in delivery models
Leadership and governance	▪ **Delayed implementation of measures** due to non-proactive governance
Scope of benefits	▪ **Limited scope of benefits** for migrants groups, e.g., unregistered migrants resulting in poor health outcomes
Capacity	▪ **Shortcomings in specialists**, especially for mental disorders
Data intelligence	▪ **Lack of transparency**, e.g., regarding migrant data (inflow, demographics), capacity planning and efficient management of resources
Target outreach	▪ **Lack of large-scale initiatives** targeting refugee and migrant health, e.g., for vulnerable groups
Communication and documentation	▪ **Shortcomings in translators** in terms of total number as well as geographical spread ▪ **Missing cross-border flow** of patient documentation
Cultural competency	▪ **Lack of information materials and trainings** for health workforce
Administration and coordination	▪ **Complex processes** to obtain benefits
Funding	▪ **Funding not yet secured** in all Member States to provide health care services as legally defined

- Addressing the gaps is **critical** given the high number of incoming migrants as well as the direct and indirect **effects of poor health**
- Improving the provision of health care will create significant **social impact**
  - Improved direct **health outcomes**
  - Improved **quality of life**
  - **Macroeconomic benefits**

SOURCE: WHO, Asylum Information Network, European Psychiatric Association, Doctors of the World, expert interviews