

CASE STUDY AND LESSONS LEARNT

Organization of access to primary health care for newly arrived refugees in Germany: a case study in the federal state of North Rhine-Westphalia

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ABSTRACT

Background: Access to health care for newly arrived refugees is organized differently among Germany's municipalities. In the federal state of North Rhine-Westphalia, municipalities choose between two different access models: the health care voucher (HCV) model and the electronic health card (EHC) model. The EHC model was developed to facilitate access to primary health care and reduce bureaucracy. Currently, only 22 out of 396 municipalities have implemented the EHC model.

Methods: We conducted semi-structured interviews with 23 local decision-makers in four municipalities. We used the public health action cycle to identify the challenges of introducing the EHC model and to illustrate this case study on organizing access to primary health care for refugees in Germany.

Results: There is substantial diversity in the local organization of access to health care for refugees. Reasons were identified at the local and structural levels for the refusal of many municipalities to implement the EHC model. Reports from municipalities that have implemented the EHC model suggest that it improves access to primary health care. However, local actors stress that important factors for facilitating access to primary health care may be implemented irrespective of the formal access model used.

Conclusion: Neither of the access models addresses existing restrictions on the legal entitlement to health care faced by refugees in Germany.

Keywords: ACCESS TO HEALTH CARE, REFUGEE HEALTH, CASE STUDY, GERMANY

BACKGROUND

Public health professionals working in the field of refugee health are confronted with a surprising mismatch between the high vulnerability of refugees at arrival and a lack of willingness in destination countries to facilitate their entitlement and access to health care. Many European countries restrict entitlements to health care for newly arrived refugees (1). This is also the case in Germany (2). Especially during the first months after their arrival, refugees do not have the same entitlement and access to health care services as the host population. Even though refugee status has not been granted at arrival, we will refer to newly arriving people who claim asylum as refugees to avoid using the politically loaded term asylum seekers. The Asylum Seekers Benefits Act (sections 4 and 6) restrict the entitlement to health care for newly arrived refugees. Health care services only cover acute illness and pain, pregnancy and birth, and officially recommended vaccination and medically necessary

check-ups. Additional services are provided on a case-by-case basis. However, differences in access to health care services – especially to primary health care – are based on Germany's federal structure. Two main models have been implemented in communities: the health card voucher model (HCV model; Fig. 1) and electronic health care model (EHC model; Fig. 2) models. In communities using the HCV model, refugees collect (or receive via email) HCVs for accessing care from local welfare agencies on a quarterly basis. In communities using the EHC model, refugees receive an e-health card upon arrival which is valid for up to 15 months or until their refugee status has been legally assessed. The second model is comparatively new and has been developed (among others) to facilitate access to health care, reduce administrative barriers and improve the bureaucratic process. So far, little is known about implementation of the new EHC model and how it affects access to primary health care. This case study analysed (i) existing strategies to facilitate access to health care for newly arrived refugees; (ii) why many

of the municipalities that are free to choose between the models predominantly opt for the HCV model; and (iii) how this decision affects access to primary health care. The analysis was based on material compiled as part of the larger mixed-methods study Flight, Health and Social Participation, which was financed by the Ministry of Culture and Science of North Rhine-Westphalia and carried out at Bielefeld University (Department of Epidemiology & International Public Health, School of Public Health). The study considers the perspectives of decision-makers in local welfare offices, social workers, health care providers and health insurance companies, as well as of the refugees themselves. The federal state of North Rhine-Westphalia was chosen for the case study because both the EHC and HCV models are being used and sufficient municipalities for analysis have introduced the EHC model (more than 20).

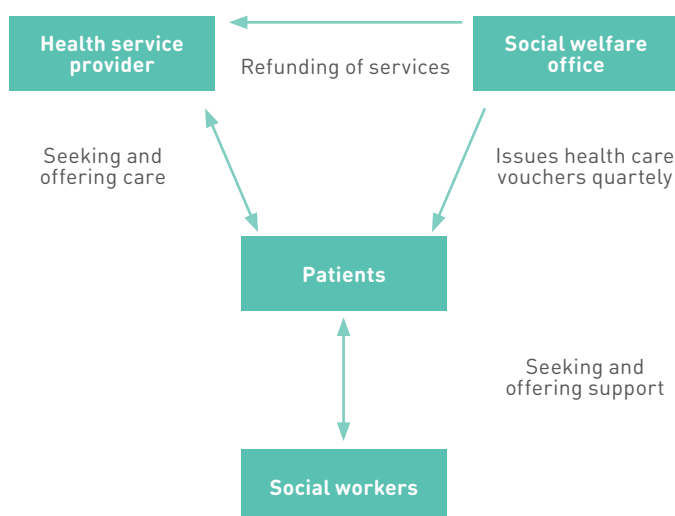
METHODS

Although the State Government of North Rhine-Westphalia has endorsed the new regulation, most of its municipalities still adhere to the HCV model and have refused to implement the EHC model. As part of this case study, we conducted semi-structured expert interviews with 23 local decision-makers between July 2017 and July 2018: in the municipalities using EHC model, six employees in social welfare offices and five social workers were interviewed; and in those using the HCV model, six social welfare office employees and six social workers were interviewed. The interviews included questions on the organization of health care for refugees and the use of health

care access models in communities, along with associated problems or opportunities. The questionnaire was pre-tested and modified. Interviews were transcribed in full and anonymized. A qualitative content analysis based on Mayring (3) was done using Atlas.ti software. Interviews with social welfare office employees (including heads of the social welfare offices, department heads and administrators) and social workers took place in four municipalities, of which two had implemented the EHC model and two had decided to continue using the HCV model. A range of interviewees with different roles were selected with the aim of obtaining as many different perspectives as possible.

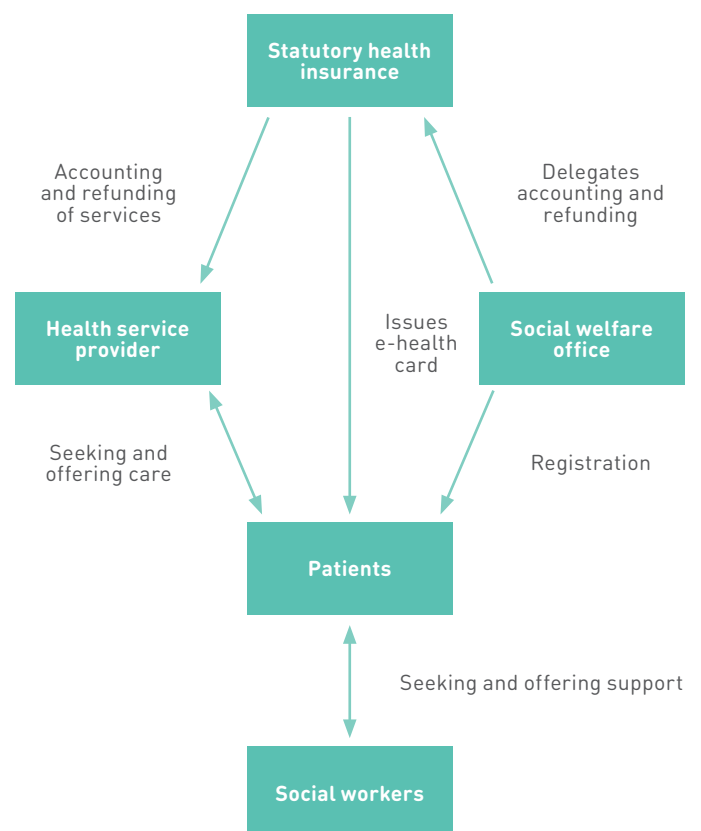
The public health action cycle is a method commonly used to first identify public health challenges and then work towards solving them. It is a structured approach to problem-solving through policy changes, interventions or public health programmes, usually consisting of four steps: defining the problem, developing the policy or strategy, implementation, and evaluation (4–6). We use this approach to illustrate the case study on different access models for newly arrived refugees in

FIG. 1. HCV MODEL: PLAYERS INVOLVED IN ORGANIZING PRIMARY HEALTH CARE SERVICES FOR NEWLY ARRIVED REFUGEES IN GERMAN MUNICIPALITIES



Source: authors' own design.

FIG. 2. EHC MODEL: PLAYERS INVOLVED IN ORGANIZING PRIMARY HEALTH CARE SERVICES FOR NEWLY ARRIVED REFUGEES IN GERMAN MUNICIPALITIES



Source: authors' own design.

Germany and their access to primary health care. The four steps are discussed separately in the next section.

RESULTS

FIRST STEP: DEFINING THE PROBLEM

The first step depends equally on empirical findings or observations and on the normative idea of a good public health system. Public health problems usually arise when observations and ideals diverge. This is also the case for access of newly arrived refugees to health care in Germany.

A common ideal of a good (public) health system is developed in the Declaration of Alma-Ata on primary health care. Although primary health care provision needs a comprehensive approach, we only focused on the health system aspect, which emphasizes the importance of primary health care as “the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process” (7).

The HCV model was used in all municipalities until 2005 and is still used in most federal states and communities. However, it has been criticized as complicating access, especially to the first level of care, that is, to general practitioners working in the communities where refugees settle. HCVs are valid for only three months, are not well known by health professionals and immediately show that a person has no regular access to health care. Patients might delay use of or refrain from using primary health services to avoid applying for and showing the HCV. Without an HCV, only emergency care is accessible. Instead of accessing primary care, patients might delay treatment until hospitalization is necessary. As a result, the HCV model might contribute to a higher use of inpatient and emergency care, and to underprovision and higher costs for health care services (8–13). A recent study suggested that refugees living in municipalities using the EHC model visit general practitioners more frequently compared with those in municipalities using the HCV model (14). The finding that access to health care for newly arrived refugees might be complicated by use of the HCV model is contrary to the ideals of primary health care.

SECOND STEP: DEVELOPING THE POLICY OR STRATEGY

In the second step, possible strategies to overcome the identified problems were developed. Public health professionals, the statutory health insurance companies system and civil

society organizations, as well as stakeholders in some federal states and municipalities, were involved in developing these strategies. Introduction of the EHC model has been much discussed as a solution to the barriers caused by the use of HCVs. E-health cards are comparable to the health insurance cards distributed by the statutory health insurance company and are valid for up to 15 months or until refugee status has been secured. Once this status is achieved, refugees do not depend on HCVs, but may instead access health care directly like other members of the statutory health insurance system (around 90% of the population). A framework agreement was negotiated between the federal state of North Rhine-Westphalia and eight health insurance companies. Each municipality which joins the agreement cooperates with only one statutory health insurance company (15). The statutory health insurance company is then responsible for payments to health care providers and is refunded by the municipality for both the costs and additional administration expenses. Municipalities using the HCV model usually take the responsibility for the administrative work.

THIRD STEP: IMPLEMENTATION

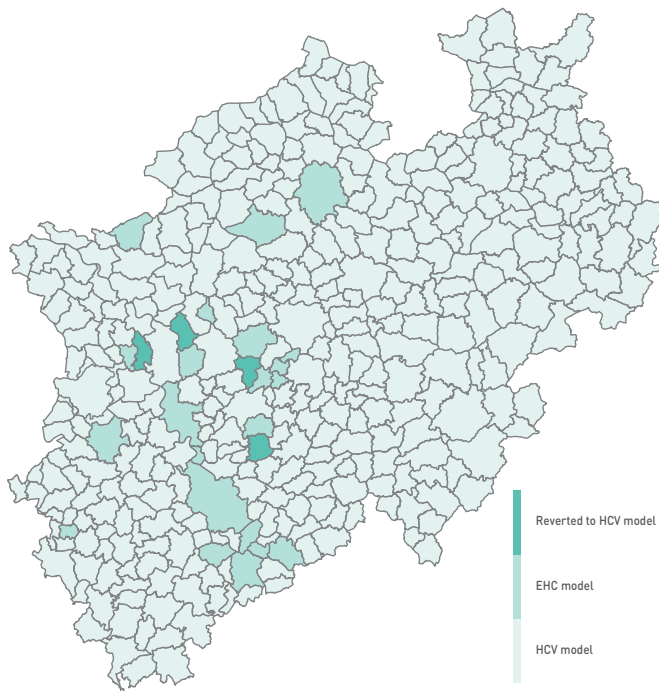
Once strategies such as the EHC model have been identified, they need to be implemented. In 2005, Bremen was the first German federal state to introduce the EHC model. Next, the city states of Berlin and Hamburg and the federal states of Brandenburg, Schleswig-Holstein and Thuringia replaced the HCV model. The federal states of Lower Saxony, North Rhine-Westphalia and Rhineland-Palatinate have only partially introduced the EHC model. These three federal states have concluded framework agreements with a number of health insurance companies, to which individual municipalities of the federal states can voluntarily accede. The municipalities are responsible for deciding whether to introduce the EHC model. Some municipalities in the three federal states are currently using the EHC model, with the remainder continuing to use the HCV model. Seven federal states (Baden-Württemberg, Bavaria, Hesse, Mecklenburg-Vorpommern, Saarland, Saxony, Saxony-Anhalt) have not yet decided or oppose the introduction of the EHC model (Table 1).

In North Rhine-Westphalia, municipalities are free to choose between the different models. Fig. 3 shows the status of introduction of the EHC model in North Rhine-Westphalia, where this case study is located. In total, only 26 of the 396 municipalities in North Rhine-Westphalia have introduced the EHC model. Of these, four had reverted to the HCV model after around a year. Thus, 22 municipalities have currently implemented the EHC model.

TABLE 1. IMPLEMENTATION OF THE EHC MODEL IN THE FEDERAL STATES IN GERMANY

EHC model introduced at a federal level	EHC model introduced at a municipality level	EHC model not introduced
Berlin	Lower Saxony	Baden-Württemberg
Brandenburg	North Rhine-Westphalia	Bavaria
Bremen	Rhineland-Palatinate	Hesse
Hamburg		Mecklenburg-Vorpommern
Schleswig-Holstein		Saarland
Thuringia		Saxony
		Saxony-Anhalt

FIG. 3. IMPLEMENTATION OF THE EHC AND HCV MODELS IN THE MUNICIPALITIES OF NORTH RHINE-WESTPHALIA, GERMANY, FEBRUARY 2018



Source: authors' illustration based on data from gadm.org

FORTH STEP: EVALUATION

Despite all local authorities facing similar challenges, there was great heterogeneity among municipalities in the practical implementation and organization of health care access for refugees. Analysis of the interview transcripts showed that the binary option for access models (EHC versus HCV) does not necessarily correspond to reality. Instead, the municipalities have established their own solutions to organizing health care

access for refugees beyond the models, which in many cases are unique. Such heterogeneity existed before development of the EHC model and has influenced whether the municipalities opted for the EHC model or retained the HCV model. The way in which the existing organizational structure for access to health care for refugees in each municipality determined the amount of effort needed to change to the EHC model.

The associated costs or cost-benefit considerations were given as the main arguments for or against, respectively, introducing the EHC model. In particular, the administrative costs to be paid to the statutory health insurance companies within the framework agreement of the EHC model were considered to be significantly higher than those of the HCV model. However, municipalities reported a considerable decrease in administrative work once they had successfully shifted from the HCV to the EHC model.

Municipalities which had implemented the EHC model reported a lot of extra work during the implementation phase. Records for newly arriving refugees and those who had been living in the community for some time (but no longer than 15 months) had to be included in the electronic data processing system. Commissioning an e-health card needed up-to-date passport photographs for each refugee, which could be difficult to obtain in some cases. Although this initially seemed a minor issue, it constituted a great challenge for the municipalities.

Close cooperation and direct communication between the welfare agency and the responsible health insurance company were decisive factors for successful implementation. This required fixed contact persons and fast, efficient exchange on both sides.

Those municipalities with the EHC model and included in this case study report positive effects from introducing the EHC model: a smaller workload for social service employees and reduced costs. In addition, the decision of whether to grant health care services is taken over by the health insurance company, to the great relief of municipalities. In contrast, employees of those municipalities without the EHC model are skeptical about these results. Most do not expect the EHC model to lessen their work or reduce costs: instead, they anticipate losing control over the services granted to refugees and increased costs.

The interviewed social workers reported non-discriminatory access to health services – especially those in primary health care – as an advantage of the EHC model, as the appearance and function of the EHC are similar to the insurance cards held by all members of the statutory health insurance system

in Germany. At the same time, the interviewees stressed that direct access to the health system via the EHC without having to go to the local welfare office cannot reduce important barriers such as discriminatory practices in scheduling appointments and existing uncertainties on where to seek care. The language barrier to accessing to health care also persists in both models.

The social workers interviewed in the municipalities see themselves mainly as advocators of the refugees' needs and rights. If refugees need support with aspects of the health system, social workers are usually the first point of contact. The health system is new for all refugees and may differ somewhat from the one they are familiar with. The social workers reported observing a great deal of uncertainty among refugees about the available health services and their entitlements and access. From the perspective of social workers, receiving no guidance may lead to non-utilization of services, irrespective of the access model. Thus, the local support infrastructure in the municipality plays an important role in access to health care by refugees. Close communication between social services, social workers and doctors (or other service providers) is essential to ensure easy access to health care services. In particular, good cooperation between the welfare office and service providers can improve the quality of care for refugees.

The interviewees further stated that the financing and availability of interpreters is a major problem. Appointments for treatment often cannot be made if no interpreters are available. This barrier hampers access to necessary health care in communities with and without e-health cards. In addition, restrictions to the legal entitlement (in accordance with sections 4 and 6 of the Asylum Seekers Benefits Act) were also identified as causing of uncertainties on all sides – among doctors, social workers and refugees. Many interviewees thus advocated for equal entitlements and equal access to the health system, irrespective of how long somebody has already lived in Germany.

CONCLUSION

Access to primary health care depends not only on the local access model but also on the details of its implementation. The heterogeneity of both access models and local solutions thus goes beyond the binary option (EHC model versus HCV model). Worries about additional costs and uncertainty about the actual improvements in access to health care that can be achieved by the e-health card might partly explain the reluctance of municipalities to implement the EHC model. Given that the effects of the models on access to primary health

care for refugees have not been rigorously studied, different municipalities continue to stress the advantages of locally implemented EHC and HCV models. Further evaluation studies that include refugees' perspectives on how to best organize their access to primary health care, as well as analysis of claims data, are ongoing.

This case study has limitations. First, a qualitative explorative approach was used, with a small number of interviews; therefore, the study cannot claim to be representative. Secondly, selection bias cannot be ruled out since municipalities with a good opinion of their access model might have been more likely to participate in the study.

Lastly, none of the implemented access models can offset existing restrictions on legal entitlements to health care faced by refugees Germany. Advancing primary health care is a long-term aim, and reaching it necessitates the political will to change existing policies. Municipalities can only organize access to health care in accordance with federal and national legislation.

This case study revealed the implications of political interventions on access to health care for refugees. Firstly, municipalities primarily base their choice of access model on an analysis of accruing costs. Thus, national or federal policies should guarantee that health care expenditures do not overburden municipalities, irrespective of the model implemented. Secondly, close cooperation and direct communication between the welfare agency and respective health insurance company are key to successful implementation. Thirdly, the shared experiences of municipalities that have already introduced the EHC model can help in changing the access model in other municipalities. Finally, the interviewees called for restrictions within the Asylum Seeker Benefits Act to be abolished to improve access to primary health care for refugees.

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¹ All references were accessed on 6 December 2018.