REFUGEES AND ASYLUM SEEKERS IN GERMANY’S HOSPITALS

By: Marc Schreiner

Summary: The influx of migrants to Germany is relevant to the health care and hospital systems and has developed strong dynamics since 2014. This article provides an overview on how German hospitals are incorporated into migrants’ health care, the problems that occur at the organisational and financing levels for hospitals dealing with the special health care regime for migrants, and which measures have been taken to address evolving needs by politicians and responsible authorities. Additionally, the article explores the invention of the migrants’ health card.

Keywords: German Hospitals; Health Care for Migrants; Default Risk for Helping Hospitals; Migrants Health Insurance Card; Extra-budgetary Accounting of Migrants

Introduction

The influx of refugees and asylum seekers (referred to herein as “migrants”) has been subject to extraordinary dynamics since 2014, but especially since the second half of 2015. Since Angela Merkel’s “Wir schaffen das”* policy stance this fact is extremely relevant for Germany. In 2014 and 2015, there was a net influx of 1,715,000 refugees (see Table 1) – a population comparable to the size of Hamburg. Asylum applications are also on the increase (see Table 1); however, these figures are incomplete. According to Federal police assumptions approximately 500,000 additional refugees are actually living in Germany in recent years, without being registered by the responsible authorities.

First health check

In principal, people arriving in Germany need to get registered, which for logistical reasons is often organised by the first admission centres. Migrants are obliged to have their health status checked within the first few days after they arrive at their final destination. Therefore, they have to present themselves to a doctor who reviews their general health status and their vaccination coverage. Additionally, a chest x-ray to detect infectious tuberculosis has to be performed as long as the migrant is neither pregnant nor a minor.

The Federal States (Bundesländer) are responsible for these “first health checks”. In general, the federal state governments (regional governments) use the capacities of their public health services. However, due to cost cuts over recent years, capacities have not been sufficient in most of the Federal States to cope with the large number of migrants in 2015 and 2016. In order to have access to an

* Chancellor Angela Merkel coined the expression “We’ll manage this!” during the annual summer press conference on 31 August 2015. This expression became a synonym for the so called “welcome culture” in Germany which represents an open door policy with respect to the European migration crises. See also: http://www.faz.net/aktuell/politik/angela-merkels-summerpresskonferenz-13778484.html
adequate number of doctors and medical equipment for the first health checks, the governments of the Federal States are contracting with third parties, e.g. hospitals or doctors in hospitals, using a number of different arrangements. In some Federal States, refugees are brought to hospitals and get checked there, whereas in other Federal States hospital doctors are asked to conduct the first health checks in premises belonging to public health services or in first health check centres that are in or near first admission centres where migrants are housed during the first weeks of their stay. In yet other Federal States, first health checks are organised at first admission centres and are conducted by hospital doctors. As in 2015 and at the beginning of 2016, the number of arriving migrants became overwhelmingly large and rose faster than the official structures available. This meant that a lot of hospitals and hospital doctors worked in a honorary capacity as a personal contribution, often without receiving pay for their services.

Reports from hospitals and the Robert-Koch-Institute showed that the vaccination status of arrivals was in many cases insufficient or non-existent, thus endangering themselves and other migrants at overcrowded first admission centres. At the same time, experts were concerned about a possible threat to the health of the resident population. Some cases of infectious tuberculosis were detected, as well as cases of some other diseases, e.g. scabies, which were non-existent in Germany.

The financing of these support services was also problematic, especially during the second half of 2015. Contracts with service providers were consequently negotiated by the responsible authorities, setting the somewhat spontaneous cooperation on a more reliable footing. Nonetheless, at least in some of the Federal States authorities were lagging behind in paying hospitals for their support.

Hospitals' role in migrants’ health care

Apart from their involvement in the first health check, hospitals also provide health care to migrants. As soon as migrants leave the first admission centres and are admitted by and housed in cities and municipalities, the provision of health care is organised by the latter. The legal basis for migrants’ claims to treatment is the “code on services for asylum seekers” (Asylbewerberleistungsgesetz), along with the relevant rules in the Federal States. The cities and municipalities in which the newly arrived migrants have their “usual domicile” are also charged with paying for medical care.

Only limited access to care for migrants

The scope of the health care basket for migrants is defined by the “code on services for asylum seekers”. For those who have been in Germany for at least fifteen months as official asylum seekers, no restrictions apply in comparison to the normal scope of the health care basket. For migrants who have not yet completed this waiting period and for foreigners who are officially bound to leave Germany, only a limited scope of health care services is made available, i.e., only acute care or pain relief as part of necessary medical care or dental care are provided for this group. Thus, treatments which cannot be delayed because of suddenly occurring cases of illness, as well as medicines necessary for healing and curing are covered. This is also valid for chronic diseases, e.g. hypertension or diabetes, if the omission of care were to lead to an acute status and would endanger the patient. Pregnant women are entitled to the same care services as those insured under statutory health insurance (preventive medical examination, delivery and midwife-care), while minors have access to the full range of care.

In several Federal States, migrants who are only entitled to a limited scope of care have to present an authorisation from the responsible authority to the health care provider. This authorisation, which is issued by a civil servant of the authority, is subject to criticism as nonmedical staff are required to decide on the urgency of treatment. Additionally, this entails a bureaucratic burden and may cause longer waiting times for migrants. Despite this, it is considered to be an adequate means of control and cost containment for the responsible authorities.

The experience of hospitals in the Federal States where this system of prior authorisation applies has been mixed. In some of them the cooperation between health care providers and the responsible authorities works well as patients show up with the entitlement document and hospitals get reimbursed shortly after invoicing for the treatment. However, in some other Federal States hospitals reported problems concerning the fulfilment of formal prerequisites as well as timely reimbursement. This applies particularly in the numerous cases when patients show up at the emergency department or without prior authorisation.

High risk of default for hospitals

Hospitals are legally bound to deliver health care and rejecting a patient may subject them to criminal prosecution. German hospitals completely fulfill their responsibility. At the same time, the default risk for assuming the treatment costs of migrants is borne by hospitals as securing reimbursement from the responsible authorities is difficult for practical and legal reasons. On the one hand, claims from the hospital for medical assistance provided at emergency departments to patients in urgent need, but without any entitling documents, are in the first instance transferred to the patients and can only be further settled with their cooperation. On the other
hand, linguistic and cultural barriers as well as time constraints in emergency departments can make it problematic for a hospital to fulfil the legally-imposed burden of proof. This problem becomes extremely relevant for migrants who are not registered as there is no responsible authority for them and thus, hospitals have only a very limited chance of obtaining reimbursement for their treatment.

An (unpublished) survey, conducted by the German Hospital Federation in late 2015/early 2016, found that at the end of 2015 a total of €50 million was owed to clinics/hospitals for health care to migrants and for required extra services, e.g. translation services. However, the figures are not completely reliable as it remains unclear whether the amounts were still pending payments or whether they were lost completely. The ratio of claims considered to be depreciated is 10% higher for ambulatory services (compared to inpatient services) and 20% higher for ambulatory services (compared to inpatient services) and 20% higher for ambulatory services (compared to inpatient services).

**Migrants’ health card does not solve the problems**

As an alternative to the system of prior authorisation, migrants in some Federal States can present a “migrants’ health card” that entitles them to the limited version of the health care basket during the first fifteen months. With the Asylum Process Accelerating Act passed in late 2015, regional governments were given the opportunity to contract with statutory health funds in their region in order to provide migrants with their own health insurance card. With this card, migrants can attend the health care provider directly without first having to obtain prior authorisation from the responsible authority. After treatment, the health care provider directly invoices the health insurance fund issuing the relevant card and gets reimbursed. Finally, the health insurance funds get the money back from the responsible authority, including an added service fee. This arrangement is called the “Bremer Modell” as this kind of cooperation was invented in the Federal State of Bremen and implemented since 2005, joined by the Free State of Hamburg since 2012.

After the Asylum Process Accelerating Act was passed, a further six Federal States made use of this new opportunity (Berlin, Brandenburg, Niedersachsen, Nordrhein-Westfalen, Schleswig-Holstein, Rheinland-Pfalz) and contracted with their regional statutory health insurance funds in late 2015 and early 2016. Their eight agreements differ with regard to claims for benefits and also with regard to the added service fee for the funds, which in the case of Nordrhein-Westfalen reached 8% of treatment costs without any ceiling. In the case of Nordrhein-Westfalen this was considered unacceptable by the responsible authorities and led to the health insurers refusing to opt-into the contract provided by the regional government. Finally, at least in the larger Federal States, the health insurance card for migrants is not used in a comprehensive manner, creating confusion for hospitals and problems in obtaining reimbursement.

Regardless of having a migrant health card, no progress has been made on clearly defining the limited services that new migrants (i.e., those who have been in the country for less than fifteen months) are entitled to. The Asylum Process Accelerating Act required the federal associations of cities and municipalities and the statutory health insurance funds to negotiate a framework agreement to define the scope of the health care basket for migrants, to harmonise invoicing and scrutiny procedures, as well as reimbursement for the expenses of the health insurance funds. The negotiations led to the signing of an agreement at the end of May 2016 but left open a number of questions on which the negotiators could not reach consensus. Thus, a catalogue of health care services that are guaranteed to migrants who have not been in the country for more than fifteen months still does not exist, either as a positive or as a negative list.

Another problem has been that since it is not possible to visually mark the health insurance cards for migrants issued under this regime, hospitals needed certainty about the legal status of the patient showing the card when attending. Thus, a technical marker was agreed upon by the “Gematik” (the society for telematics applications), providing a special technical code on the card for migrants, thus enabling the hospital to know that only the limited scope of the health care basket applies for this patient. This distinction has been possible from the beginning of 2016 and helps to prevent hospitals from having to pay back parts of invoices for the delivery of services for which a patient was not entitled to.

**Extra-budgetary accounting of migrants**

Knowing the residence permit status of patients is not the only relevant information that hospitals need when determining what health care basket applies in each case. They also have to prove that patients were treated under the special regime of the “code on services for asylum seekers” as special financing rules apply for these groups: hospitals are allowed, for accounting purposes, to count them as “extra-budgetary”, even retroactively for the whole of 2015. This political opportunity was provided to hospitals in order to prevent them from losing out during price cuts based on the Hospital Structure Reform Act that came into force at the beginning of 2016 in response to the extraordinary rise of cases.

**Conclusions**

The enormous influx of migrants since late 2014 has created the need for several additional efforts in the German health care system. From early on, hospitals have taken their full responsibility, as evidenced by their pragmatic approach to the many organisational challenges, as well as by the personal commitment of hospital staff in a lot of cases, where many provide their services for free. Although problems regarding the provision of care do not occur nationwide, lack of financing and personal capacities are severe challenges in some regions.

Migration continues to increase due to global political, economic and climate developments. This has caused many

† Several mechanisms are in place to restrictively steer the development of the number of cases. Hospitals have to accept relevant price cuts for every case delivered beyond a ceiling in the budget negotiations. Additionally, fixed costs are deducted for a special group of cases.
people to search for shelter and a better life abroad. UNHCR estimates that 65 million people actually are displaced from their homes. According to projections presented by the Federal Government, approximately 200 million migrants are estimated to reside in third countries, and a large part of them might come to Europe and to Germany. Thus, migration most probably will become a permanent challenge for health systems. The special responsibility of hospitals requires a political and legal acknowledgement by politicians and systematic, adequate financing for delivering these services, which in general are the responsibility of the whole of society.

References


Professorship in Global Health and Development

Job description

The University of Tampere (Finland) is seeking applicants for a new professorship in Global Health and Development. By global health we mean a system-based and transdisciplinary approach to education, research, and practice. This field places priority on improving wellbeing, health and equity worldwide. It emphasises complex transnational issues and the search for sustainable solutions. It involves many disciplines and engages with a wide range of stakeholders.

The successful candidate is required to have broad experience in the field of researching Global Health, and especially expertise and promise in inter- or transdisciplinary study of the interaction between global phenomena, health and human wellbeing. Candidates from a diverse disciplinary background are considered and invited, but previous work and degrees must show both formal competence and a strong track record in knowledge of the intersection of Health and Social Sciences. A higher education degree is required in Public Health or Medicine (licentiate, medical doctor) or Social Sciences, and formal studies or demonstrated strong knowledge in the other two fields. An appropriate doctoral degree is essential. The professorship will be filled on a permanent basis, starting as soon as possible (to be negotiated).

Background

University of Tampere will merge by 2018 with Tampere University of Technology and Tampere University of Applied Sciences. The profile of the new University will build on three major areas of focus: Society, Technology and Health. Within the focus, Global Wellbeing will play a major role. As a hub, including Global Health and Development, it is envisioned that it will enhance joint activities of disciplines in different faculties, such as Social and Health Sciences, Medicine and Life Sciences, Technical Sciences, Educational Sciences, Economics, and Management. The hub will facilitate innovative education and transdisciplinary research on global issues and on national and local developments influenced by globalisation and regionalisation.

The appointed professor will participate in inter- and transdisciplinary education. In the area of research, s/he will be able to continue and expand her/his research field interests in so far as they contribute to Global Wellbeing. Examples of potential themes include:

- Global and Regional Policies;
- Socially Fit Health Technology;
- Urbanisation and segregation;
- Forced Migration;
- Global Environmental Health;
- Impacts of Globalisation on Health and Health systems;
- Human Rights and Bioethics;
- Global Governance.

The university is seeking a visionary person, who is able to utilise the potentials outlined, and shares the vision of Global Wellbeing.

For further information, please contact: Anneli Milen, Professor, Global Health and Development.

Email: anneli.milen@uta.fi
Tel. +358 50 318 7770 or +358 40 552 1337, Skype: AnneliMilen

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