



COUNTRY REPORT

IRELAND

MIPEX
HEALTH STRAND

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MIGRANT INTEGRATION POLICY INDEX *HEALTH STRAND*

Country Report Ireland

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READER'S GUIDE TO THE REPORT

This report was produced within the framework of the IOM's EQUI-HEALTH project, in collaboration with Cost Action IS1103 ADAPT and the Migrant Policy Group (MPG). Full details of the research and its methodology are contained in Sections I and II of the Summary Report, which can be downloaded from the IOM website at <http://bit.ly/2g0GIRd>. It is recommended to consult this report for clarification of the exact meaning of the concepts used.

Sections 5–8 are based on data from the MIPEX Health strand questionnaire, which covers 23 topics, in 10 of which multiple indicators are averaged. Each indicator is rated on a 3-point Likert scale as follows:

- 0 no policies to achieve equity
- 50 policies at a specified intermediate level of equity
- 100 equitable or near-equitable policies.

'Equity' between migrants and nationals means that migrants are not disadvantaged with respect to nationals. This usually requires equal treatment, but where migrants have different needs it means that special measures should be taken for them. Scores relate to policies adopted (though not necessarily implemented) by 31st December 2014. However, some later developments may be mentioned in the text.

To generate the symbols indicating a country's ranking within the whole sample, the countries were first ranked and then divided into five roughly equal groups (low score – below average – average – above average – high). It should be remembered that these are relative, not absolute scores.

The background information in sections 1-4 was compiled with the help of the following sources. Where additional sources have been used, they are mentioned in footnotes or references. It should be noted that the information in WHO and Eurostat databases is subject to revision from time to time, and may also differ slightly from that given by national sources.

Section	Key indicators	Text
1. Country data	Eurostat	CIA World Factbooks, BBC News (http://news.bbc.co.uk), national sources
2. Migration background	Eurostat, Eurobarometer (http://bit.ly/2grTjIF)	Eurostat, national sources
3. Health system	WHO Global Health Expenditure Database ¹ (http://bit.ly/1zZWnuN)	Health in Transition (HiT) country reports (http://bit.ly/2ePh3VJ), WHO Global Health Expenditure database
4. Use of detention		National sources, Global Detention Project (http://bit.ly/29IXgf0), Asylum Information Database (http://bit.ly/1EpevVN)

These reports are being written for the 34 countries in the EQUI-HEALTH sample, i.e. all EU28 countries, the European Free Trade Area (EFTA) countries Iceland, Norway and Switzerland, and three 'neighbour' countries – Bosnia-Herzegovina, FYR Macedonia and Turkey.

All internet links were working at the time of publication.

¹ For the definition of these indicators please see p. 21 of the WHO document *General statistical procedures* at <http://bit.ly/2lXd8JS>

1. COUNTRY DATA

KEY INDICATORS		RANKING
Population (2014)	4.605.501	●●○○○○
GDP per capita (2014) [EU mean = 100]	132	●●●●●
Accession to the European Union	1973	

Geography: The Irish Republic is located in Western Europe, occupying five-sixths of the island Ireland in the North Atlantic Ocean, west of Great Britain. The terrain is mostly flat to rolling interior plain surrounded by low mountains and sea cliffs on the west coast. The largest city is the capital Dublin with 1,11 million inhabitants. 63% of the population live in urban settings.

Historical Background: In 1921, Ireland gained its independence from the UK in 26 southern counties; six northern counties remained part of the UK. Unresolved issues in Northern Ireland erupted into years of violence known as the 'Troubles' that began in the 1960s.

Political Background: The Irish Republic is a parliamentary democracy divided into 23 counties, with four major cities (Dublin, Cork, Limerick and Galway). It joined the EU in 1973 and the European Monetary Union in 1991.

Economic background: The Irish economy is dominated by the export sector. Ireland's low corporation tax (12,5%) and a pool of skilled high-tech workers encourage business investment. GDP growth averaged 6% in 1995-2007, but economic activities dropped sharply during the global financial crisis. Unemployment went from a pre-crisis rate of about 5% to about 15% at the worst moments of the crisis (2010-2012). In 2010, the budget deficit reached 32% of GDP - the world's largest deficit in terms of GDP. Some commentators have criticised the extent to which economic growth has depended on providing a tax haven for large American corporations: in 2010, 20% of GDP consisted of "profit transfers" for the benefit of foreign companies that raised little tax for Ireland and did little to reduce the unemployment rate.² However, in 2014 the economy rapidly picked up and GDP grew by 4,3% in 2016. The recovering economy helped to reduce the budget deficit to less than 1% in that year.³

² https://economix.blogs.nytimes.com/2010/05/20/irish-miracle-or-mirage/?_r=0

³ https://ec.europa.eu/ireland/news/winter-2017-economic-forecast_en

2. MIGRATION BACKGROUND

KEY INDICATORS (2014)		RANKING
Foreign-born population as percentage of total population	16,1	●●●●●
Percentage non-EU/EFTA migrants among foreign-born population	36	●○○○○
Foreigners as percentage of total population	11,8	●●●●●
Non-EU/EFTA citizens as percentage of non-national population	31	●○○○○
Inhabitants per asylum applicant (more = lower ranking)	3.176	●●○○○
Percentage of positive asylum decisions	38	●●○○○
Positive attitude towards immigration of people from outside the EU (Question QA11.2, Eurobarometer)	48	●●●●○
MIPEX Score for other strands (MIPEX, 2015)	51	●●●○○

Population figures

Ireland has changed from being a country of mass emigration to one of unprecedented immigration, with 16% foreign-born residents in 2014. Between 1845 and 1852 the country lost about a quarter of its population to deaths and emigration caused by the Great Famine, the result of potato blight in combination with political factors. For 90 years, between 1871 and 1961, net emigration was consistently higher than natural population increase; the population shrank from about 4,4 million in 1861 to 2,8 million a century later.⁴ In the 1970's inflow exceeded outflow for a short time, but a definitive turning point only came when economic growth finally got under way in the 1990's. Up to 2002, returning Irish nationals formed the largest group of immigrants;⁵ later, EU enlargements in 2004 and 2007 led to major and unprecedented inflows. A total of 133.258 social insurance numbers were issued to immigrant workers from Accession States between May 1 2004 and Sept 30 2005. In the UK, a country whose population is fifteen times that of Ireland, the figure for the same period was 293,000 (MacEinri, 2007). A surge in asylum applications also occurred between 1998 and 2003 (see Fig. 3 below). The economic downturn in 2008 impacted on rates of immigration, but not as much as was expected. Since 2013 the economy has been recovering, and immigration is likely to remain both an economic necessity and a significant feature of Irish society. Fig. 1 shows the changing pattern of recent emigration and immigration in Ireland; Fig. 2 shows the main countries of origin.

Legal migrants

People from EU/EFTA countries are entitled to work in Ireland without an employment permit and to have dependants live with them. Those from other countries generally need a visa and an employment permit, and are required to register with the immigration authorities. There are nine different employment permits, including a Critical Skills Employment Permit and a General Employment Permit.

⁴ <http://www.migrationpolicy.org/article/ireland-rapid-immigration-recession>

⁵ <http://bit.ly/2oVap3K>

Foreign nationals who are legally working in Ireland have the same rights under employment legislation as Irish nationals.

Figure 1. Net migration in Ireland, 1987 – 2015⁶

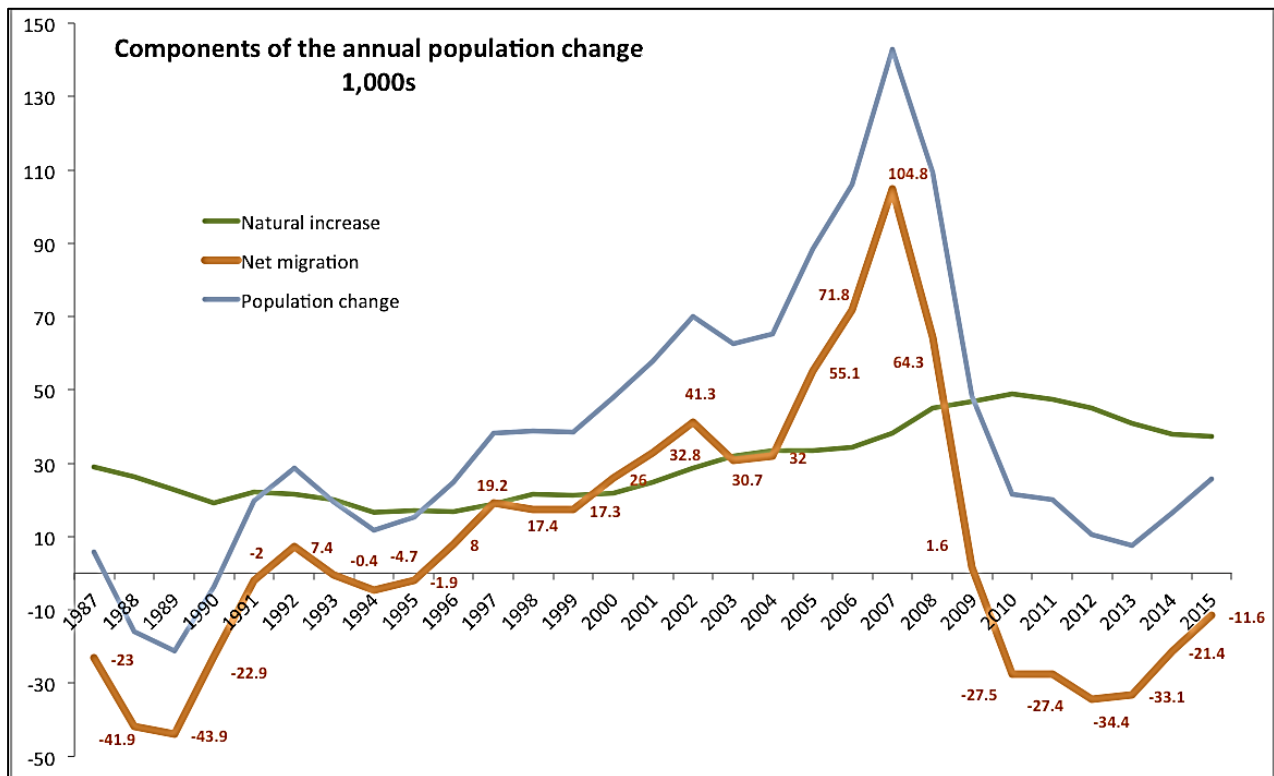
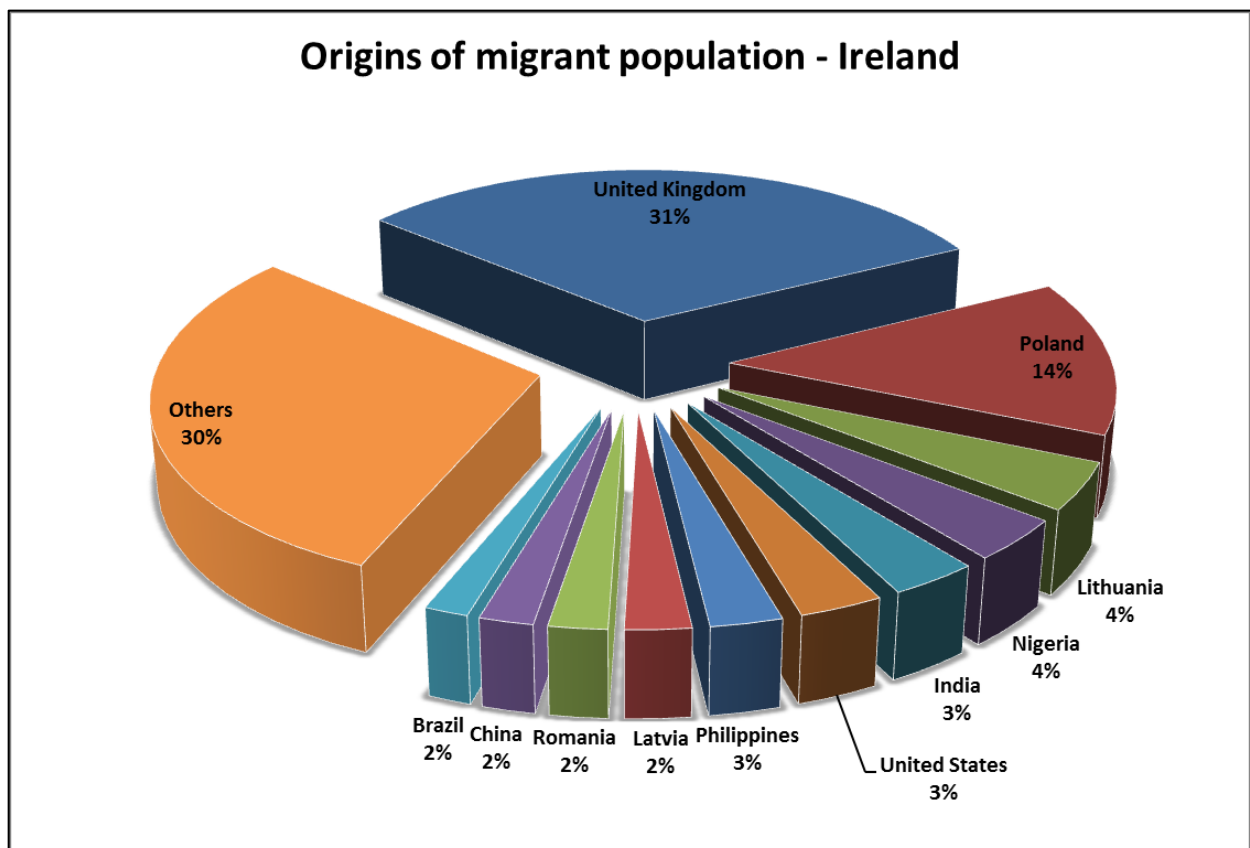


Figure 2. Foreign-born population in 2014 by country of birth (Eurostat)



⁶ <http://trueeconomics.blogspot.nl/2015/08/29815-migration-natural-changes-in.html>

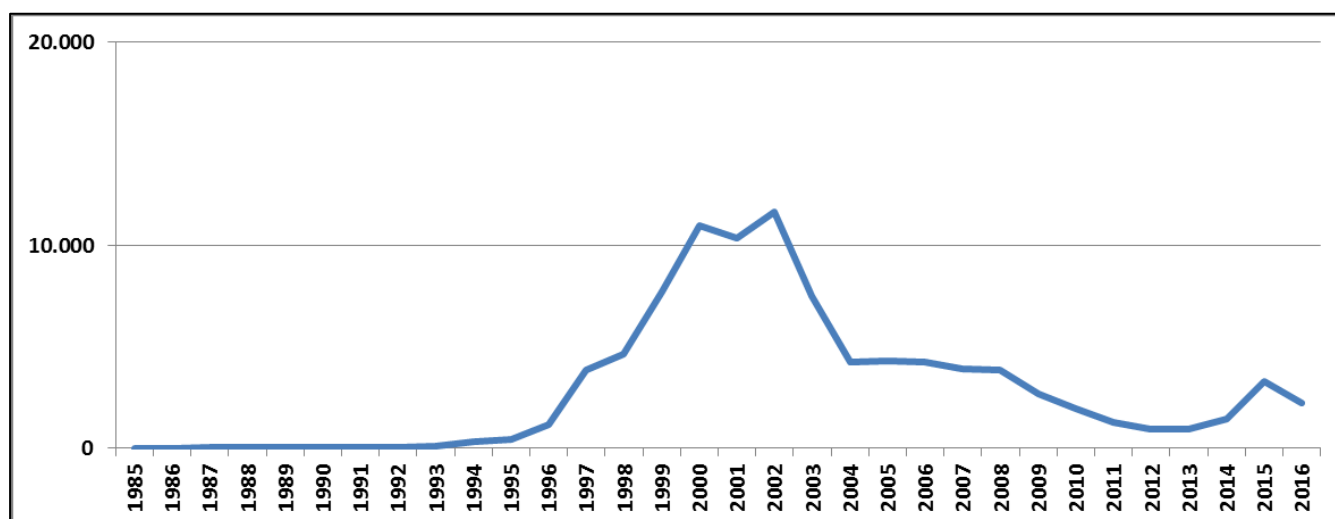
Undocumented migrants

From the late 1990s onwards, a huge demand for labour generated unprecedented levels of inward migration. Policies and legislation were not in place to deal with this development, and so *ad hoc* policies were developed over time. This has contributed to the emergence of irregular migration in Ireland. The economic downturn in 2008 resulted in a severe constriction of employment and the employment permit system (see above). However, many workers and families who had come to Ireland during the boom remained in the country. Current estimates are that there are between 20.000 and 26.000 undocumented migrants living in Ireland (MRCI, 2014); 81% of them have been in Ireland for at least five years, and 21% for more than 10 years. The majority (86,5%) entered the country legally but became undocumented as a result of misleading information or lack of knowledge of correct procedures, exploitation by an employer, or deception about work permit renewal (MRCI, 2014).

Introduced in 2004 in response to EU enlargement, the Habitual Residency Condition (HRC) is a qualifying condition for social welfare payments. There are specific challenges for undocumented migrants: the HRC seeks to ascertain whether the claimant has established his or her 'centre of interest' in the host state by examining family connections, length of stay, employment history, etc. All persons seeking means-tested social welfare payments and child benefits are required to satisfy this condition, which applies to Irish citizens and non-Irish citizens alike. It is easier for Irish citizens to show sufficient connection to the state; migrant groups are disproportionately affected by the application of the condition (FLAC, 2010). A 'right to reside' test was introduced in December 2009, which provides that a person must have a lawful right to reside in Ireland in order to satisfy the HRC. This rule precludes undocumented migrants from accessing social protection and is particularly problematic for members of the Roma community

Asylum seekers

Figure 3. First-time asylum applications to Ireland, 1985-2016 (data from Eurostat)



Despite the country's high level of GDP, numbers of asylum seekers in Ireland and rates of granting international protection were below the EU/EFTA average in 2014 (see Key Indicators, above).

As of January 2015, there were 7.937 people in the asylum system, one third of whom were children, 55% of whom had been in the system at least five years and 20% seven years or more. Newly arrived

asylum seekers are initially accommodated in a short-stay reception centre in the Dublin area for a period of assessment. They are then assigned full board accommodation, known as Direct Provision, at one of 34 regional centres spread across the country. Of the total number of asylum seekers in 2014, 4,453 people, including 1,482 children, made use of Direct Provision. The average length of stay is almost four years. (RIA Monthly Statistics Report January 2015)

Each adult receives the Direct Provision allowance of €19,10 per week. This allowance is a reduced rate of the Supplementary Welfare Allowance (SWA), a basic minimum income for people whose means are insufficient to meet their needs. When first introduced in 2000, the Direct Provision Allowance was equivalent to 20% of the SWA, but it equates to 10% of today's payment, notwithstanding the dramatic rise in the cost of living over this period. The allowance introduced for children in 2000 was €9,60 per week per child. In 2016, this was increased to €15,60 per child per week.

There are significant problems with the impact of Direct Provision on asylum seekers in Ireland. In a study published in 2007, asylum seekers were five times more likely to be diagnosed with psychiatric illnesses than Irish citizens (McMahon et al., 2007). The Department of Justice established a working group in October 2014 to explore aspects of this system and to make recommendations for its improvement. Its report, known as the McMahon report,⁷ was published in June 2015, and not surprisingly recommended major reforms. In February 2017, the Department claimed that 92% of the recommendations are now fully or partially implemented, or are 'in progress'.⁸ A landmark Supreme Court ruling in May 2017 could have significant consequences for asylum seekers and the right to work in Ireland⁹ which, in turn, has significant implications for health and well-being.

⁷ <http://bit.ly/1GYBUL5>

⁸ <http://bit.ly/2IZUvSM>

⁹ See <http://dorasluimni.org/right-to-work>

3. HEALTH SYSTEM

KEY INDICATORS (2013)		RANKING
Total health expenditure per person (adjusted for purchasing power, in euros)	2.760	●●●●○
Health expenditure as percentage of GDP	8,0	●●○○○
Percentage of health financing from government National health system (NHS) / social health insurance (SHI)	67	NHS
Percentage of health financing from out-of-pocket payments (higher percentage = lower ranking)	17	●●●●○
Score on Euro Health Consumer Index (ECHI, 2014)	644	●●●○○
Overall score on MIPEX Health strand (2015)	59	●●●●○

The role of the Department of Health is to advise on the strategic development of the health system including policy and legislation, to evaluate the performance of services, and to work with other sectors to enhance health and well-being. The Health Service Executive (HSE) is the public health service responsible for the provision of health and personal social services for everyone living in Ireland.

Health services are delivered via direct service provision by the HSE or through service-level arrangements with a range of statutory and voluntary agencies contracted to deliver services on its behalf. In terms of health expenditure, 2015 marked the end of a seven year period of retrenchment for the HSE as a direct response to the financial crises.

The 2001 Primary Health Care Strategy (Department of Health and Children 2001) proposed that multi-disciplinary Primary Care Teams (PCTs) be introduced to deliver accessible primary care services to a defined population, determined by geographical boundaries and/or the practice population of participating GPs. The members of the team would include GPs, nurses, physiotherapists, occupational therapists, social workers, home helps, and administrators. Each team would be supported by a wider network of primary care professionals, including speech and language therapists, dieticians, pharmacists, Community Welfare Officers, chiropodists, and psychologists. This emphasis on community-based and needs-driven primary care should have specific relevance for migrants in terms of adaptations to team membership or team priorities that reflect their health needs. However, there is no evidence that this is the case in practice to date. In fact, primary care providers rated community participation as one of the least important factors for effective team working (Tierney et al., 2016).

A more recent government policy in relation to health and social care services is set out in *Future Health: A Strategic Framework for Reform of the Health Service 2012–2015* (Department of Health, 2012). This is a detailed framework containing 48 actions, one of which is the progression of actions towards a system of universal health care coverage. Further restructuring of the HSE is currently under way, driven by this framework. A related report (HSE, 2014) sets out how health services outside of the acute care hospitals will be organised. The aim is to deliver more integrated and responsive services in

the most appropriate setting and to ensure equal access based on need. Nine Community Healthcare Organisations have been established, incorporating 90 local Primary Care Networks. The objective is to ensure that hospital- and community-based health services operate within the same geographical boundaries in the future.

These strategies reflect the central role that general practitioners play in the Irish health service. At present, there are almost 2,500 General Practitioners (GPs) working in Ireland, located in traditional style group or single practices, or in some of the newly established primary care health centres. The GP is often the first person from whom a person seeks medical advice; they are key gatekeepers to other services. Most GPs are private practitioners, but the majority also provide services on behalf of the HSE to people who are eligible for state-supported care. A new GP contract is currently being negotiated and this is likely to have a major impact on resources in GP and primary care settings which, in turn, will impact on responsiveness to migrant health needs. The time frame for its finalisation is not clear.

The Irish health system is mainly financed from tax revenues, but private insurance accounts for 13% of expenditure. At present, the population of Ireland (including migrants residing legally in the state) is divided into two groups for the purposes of eligibility for free or subsidised public health services: medical card holders (category I or full eligibility) and non-medical card holders (category II or limited eligibility). To be eligible for these services means that the person will need to provide documentation to prove they meet the eligibility requirements. If so, they are eligible or qualified to receive the services should sufficient staff, capacity, and funding exist to provide the service. This is different to an 'entitlement' to free or subsidised public health services, whereby the services must by law be provided to the individual when the need is identified. All persons 'ordinarily resident' in Ireland are entitled to receive public health care. However, a person may be required to pay a (subsidised) fee for certain health care received (depending on income, age, illness, or disability), unless they are eligible for a Medical Card (see below).

Assessing eligibility is an administrative procedure that can vary across HSE service providers and is generally carried out by the administrative staff of a service. Eligibility can be determined at different points in the process of accessing care, depending on the type of service accessed, e.g. prior to arranging outpatient appointments or following access to emergency services.

People who are receiving welfare payments, low earners with certain long-term or severe illnesses and in certain other cases are eligible for a Medical Card. Full entitlement to free use of public health services is thus available only to those with particular needs: apart from the introduction of free health care for children under six in 2015, there is no universal health care coverage although there are active plans toward universal health coverage in the future in the Programme for Government.

The Medical Card entitles holders to free public hospital care; GP visits; dental, optical, and aural services; prescription drugs; medical appliances; maternity and infant care services; and a range of community care and personal social services.

To qualify for a Medical Card, a complex means analysis of income, savings, and investments is undertaken. In situations where a person has an ongoing medical condition that requires exceptional and regular medical treatment (causing or likely to cause undue financial hardship), a discretionary

Medical Card may be granted to that individual or family, even if their income is greater than the guidelines.

If the applicant's income is above the guidelines to qualify for the Medical Card, the applicant will automatically be assessed for the GP Visit Card, which has higher income limits and allows free visits to the family doctor. The person can also apply for the Drugs Payment Scheme, where a maximum monthly payment of €144 is made for approved prescribed drugs, medicines, and certain appliances for use by the person or their family. As of June 2016, refugees arriving under the Irish Refugee Protection Programme (as well as Asylum seekers in Direct Provision) are now exempt from paying prescription charges.¹⁰

Even those entitled to receive free or subsidised public health care are subject to out-of-pocket payments at the point of service, which according to WHO statistics for 2013 account for 17% of total health expenditure (slightly below the EU/EFTA average).

¹⁰ <http://www.hse.ie/eng/services/list/1/schemes/mc/prescriptioncharge/>

4. USE OF DETENTION

The EU's Returns Directive (2008) aimed to harmonise Member States' policies on entry bans for certain categories of migrants, as well as deportation procedures and the use of detention. Ireland, the UK and Denmark did not opt in to this Directive, so – for example – Ireland has no 18-month maximum for the detention of migrants as required by the Directive. However, most are detained for three days or less.¹¹ The following categories may be detained (excluding children under 18):

- Non-nationals refused “permission to land”;
- Rejected asylum seekers;
- Non-nationals with final orders of deportation;
- Non-nationals awaiting trial for a criminal immigration-related offence(s).

Detention is used on a rather small scale in Ireland: the number of those detained fell steadily between 2009 and 2015, from 673 to 342.¹² There are no separate detention facilities for migrants, so despite the fact that most of them have not committed a crime, they are housed in designated prisons alongside remanded and sentenced criminals.

There have been reports of overcrowding in some prisons used for detaining migrants, but access to health services is provided along with the normal safeguards that apply to regular prisoners.

¹¹ <http://www.europarl.europa.eu/document/activities/cont/201110/20111014ATT29338/20111014ATT29338EN.pdf>

¹² <http://www.jrs.ie/photo-gallery/detention>

5. ENTITLEMENT TO HEALTH SERVICES

Score 56 Ranking ●●●○○○

A. Legal migrants

Inclusion in health system and services covered

In general, nationals of non-EU/EFTA countries need to prove to the HSE that they are 'ordinarily resident' (see Section 3) and that they intend to live in Ireland for at least a year. People considered 'ordinarily resident,' if they are not entitled to Category I (Medical Card), will be considered as Category II and entitled to a range of public health services that are free or subsidised. Dependants of non-EU/EFTA nationals considered 'ordinarily resident' are not automatically eligible themselves, and have to satisfy the ordinarily resident condition in their own right.

Special exemptions

Full inclusion is guaranteed for legal migrants under either Category I or Category II eligibility, so no exemptions are necessary.

Barriers to obtaining entitlement

The main barrier to obtaining entitlement is the inordinately complex Medical Card system. This system is more convoluted than in any other EU country. For example, before an application for a Medical Card or GP Visit Card can be considered, the HSE must establish that the person is 'ordinarily resident' in the country. The following documentary evidence is required from all non-EU/EFTA legal migrants (with the exception of Switzerland):

- Proof of property purchase or rental, including evidence that the property in question is the person's principal residence;
- Evidence of transfer of funds, bank accounts, pensions, etc.;
- A residence permit or visa;
- A work permit or visa, statements from employers, etc.;
- In some instances, the signing of an affidavit (a sworn written statement) by the applicant.

Then, to qualify for a Medical Card, an extensive means test takes place with special attention paid to weekly income savings, investments, and property (except for the applicant's own home). Discretionary Medical Cards are given to those who are over the income limit but assessed as being under financial stress due to illness.

Another issue is that many migrant workers do not know their own rights and entitlements. Patients from outside the EU are often directed by the health service administrative or other staff to their local HSE office to seek clarification on their entitlements; in the meantime they are charged the full cost of the care they receive. Also, there is a lack of information and training for health service providers about the rights and entitlements of migrant workers (see Section 6). This means that there can be delays or errors, resulting in some migrants not being able to access, or being refused, essential medical treatment because of their inability to pay (Cairde 2011). To address this, the HSE developed a new

social inclusion microsite in 2017¹³ which produces translated information on entitlements for migrants. The Citizen's Information Bureau offers useful information as well.

B. Asylum seekers

Inclusion in health system and services covered

An asylum seeker is entitled to a Medical Card if he/she fulfils the means test described above in Section 3. This occurs in almost all cases due to the limited income of most of this cohort. The Medical Card is not granted automatically: a Direct Provision resident has to apply for the scheme themselves. Application forms are available at the local Health Centre, where staff can answer queries in relation to eligibility criteria and assist in filling out the form. There is also a page on the main HSE website containing information on all aspects of the application process and a low call cost number for queries. Department of Social Protection representatives and local Citizens Information Centres also provide information. If a person has left or been expelled from Direct Provision, the Medical Card can be withdrawn.

Asylum seekers can use all the services to which a Medical Card gives access (see section 4), as well as some additional entitlements that are not available to Irish nationals (see below). However, resources for both screening and psychological services are very limited. Migrant Screening Guidelines have been developed.

Special exemptions

- **Free medical screening:** The service includes screening for certain infectious diseases such as TB, Hepatitis B, Hepatitis C and HIV and checking for vaccination needs. The outcome of any medical tests does not affect the application for refugee status (Citizens Information Board 2011b).
- **Psychological services:** Asylum seekers have access to the dedicated asylum seeker psychological service operating from St Brendan's Hospital, Dublin 7.

Barriers to obtaining entitlement

Asylum seekers are obliged to apply personally to an HSE office for a Medical Card and as already described, the procedures are quite complex and challenging. Concerns have also been expressed that HSE offices may be physically inaccessible from Direct Provision accommodation and that only the most basic services are available: for example, there is little access to translated information or interpreting services (FLAC 2009: 119).

Administrative discretion will almost invariably be exercised when evaluating the information submitted. In the case of discretionary Medical Cards, it is applied by definition.

¹³ <http://www.socialinclusion.ie>

C. Undocumented migrants

Inclusion in health system and services covered

Migrants who are not legally resident in Ireland, and therefore cannot meet the 'ordinarily resident' condition applied by the HSE, are not eligible for free or subsidised public health services. Access for undocumented migrants (including children) to the public health care system is therefore limited to 'essential medical treatment.' The HSE has discretion to reduce or waive the charges in cases of hardship.

Undocumented migrants are only entitled to:

- "medical treatment or services, where such provision while the foreign national is present in the State is essential, and the foreign national does not have sufficient resources to pay for that treatment or those services;
- medical or other services necessary for the protection of public health;
- such other benefits or services (however described) as may be prescribed, being benefits or services that, in the opinion of the Minister:
 - are of a humanitarian nature;
 - are provided for the purpose of dealing with or alleviating emergencies, or;
 - are provided by way of assistance towards the repatriation of foreign nationals"(Government of Ireland, 2010).

Changes brought about through the Immigration, Residence, and Protection Act of 2008 have raised concerns regarding the unclear definitions of 'essential medical treatment' (Immigrant Council of Ireland 2010).

Permission to remain in the country is not always granted to undocumented migrants, including children, who have health needs, even in situations where they are at risk of dying if they are returned to their countries of origin.

It should be noted that an emergency Medical Card exists that can be granted regardless of the legal status of the person involved. However, this facility is rarely accessed and is granted only for urgent or ongoing medical care for those who are homeless or have a serious medical condition, foster children, asylum seekers or terminally ill persons receiving palliative care.

To address such problems of access to health care, the HSE Social Inclusion Office has funded specific, additional primary care services for vulnerable groups, and undocumented migrants do utilize these services. For example, the HSE Social Inclusion Office funds a Roma Clinic, which is a mobile service in a geographical location convenient for these migrants. Only initials and date of birth are required from service users. They also fund a number of low threshold clinics in Limerick city and Dublin.

Special exemptions

Special entitlements exist for victims of trafficking and unaccompanied minors if they are in foster care.

Victims of human trafficking: The HSE undertakes to provide specific health and medical services for victims of human trafficking under the government's National Referral Mechanism (NRM), established

by the Anti-Human Trafficking Unit in the Department of Justice and Equality. A new plan was published in 2016.¹⁴ It contains 65 actions designed to crackdown on individuals and gangs involved in the crime, to support victims, to raise public-awareness, and to enhance training for those likely to encounter victims.

The NRM provides referrals to a range of assistance and support services available to potential and suspected victims of human trafficking, including medical care and care planning, and psychological assistance. The HSE's Women's Health Project provides a range of services for victims of trafficking and migrant women in prostitution, including a drop-in service and sexual health screening and counselling service (including HIV and Hepatitis A, B and C testing, vaccinations, smears, counselling, contraception, pregnancy testing and advice, support, referral, and education). Services include individualised Care Plans for victims of trafficking who have been referred to the Women's Health Project by *An Garda Síochána* (Irish Police Force), with the victim's consent. A Care Plan covers a range of issues, including general health screening, referral to a General Practitioner, mental health service and counselling, as well as non-health-related interventions such as housing and legal support.

The HSE's Women's Health Project also involves referrals to, and very effective partnerships with, support organisations such as Ruhama, for services such as counselling, health and social support, and support in gaining independence and in exiting prostitution.

TUSLA, the State's Child and Family Agency, is responsible for the protection, care and welfare of children under the Child Care Act of 1991 and the Children First Guidelines. This includes care of separated children/unaccompanied minors and children identified as victims of trafficking, who receive a care plan and health care, psychological and counselling support.

Unaccompanied minors in foster care: From 1996 to 2001, there was a sharp increase in the number of unaccompanied minors arriving in Ireland, followed by a gradual decrease thereafter. All unaccompanied minors who are referred to the Separated Children Seeking Asylum (SCSA) Service of the HSE undergo a full needs assessment and medical examination by a GP, and a Medical Card is issued by the HSE. SCSA receives referrals primarily from the Office of the Refugee Applications Commissioner and immigration officials at ports of entry.

Under the Child Care Act, 1991 and the Refugee Act, 1996 (as amended), the HSE is responsible for the total care needs of separated children who seek asylum in the State, e.g. providing immediate and ongoing care placements, social, medical and psychological services, liaison with educational and youth services and tracing relatives, providing assessments and reunification where safe and possible as well as supporting children throughout the asylum process. In terms of medical care, social workers from the SCSA have reported that in practice it can be challenging to obtain financial cover for any medical expenses not covered by the Medical Card (Quinn et al. 2014: 56).

Barriers to obtaining entitlement

Many undocumented migrant workers do not access medical services, often due to fear of detection and/or apprehension. Many ignore minor illnesses and only attend hospital following accidents or emergencies. Out-of-pocket payments may also deter them from accessing medical services. The cost of

¹⁴ <http://www.justice.ie/en/JELR/Pages/PR16000294>

general practitioners is prohibitive for many workers earning the minimum wage (and often less). They cannot travel home to seek medical attention as they are not in a position to move freely in and out of the country. This risks driving migrant workers to use uncertified medical practitioners and self-medication. Many women report that they do not consistently return for medical check-ups after they give birth, which jeopardises their gynaecological and reproductive health (MRCI 2010).

The amount and nature of the documentation required for obtaining Medical Cards is highly problematic for undocumented migrants, particularly the need to produce evidence of a residence permit or visa. Front line staff and/or administrative staff in hospitals and primary care settings also have discretion to make decisions about whether care is essential for UDMs, but they generally lack training and information in this area (see Section 6).

6. POLICIES TO FACILITATE ACCESS

Score 55 Ranking ●●●○○○

Information for service providers about migrants' entitlements

Up-to-date information for service providers (organisations and their employees) about migrants' entitlements is not regularly received, and communication from the Department of Health to the HSE on this topic is very infrequent. For example, guidelines on the Ordinarily Resident Condition for Eligibility for Health Services were last issued by the Department of Health to HSE Health Boards and Voluntary/Joint Board Hospitals in July 1992 (Circular 13/92). Training on the Condition is not currently undertaken (Quinn et al. 2014:29).

Information for migrants concerning entitlements and the use of health services

There is no formal policy at this time about providing information to migrants on their entitlements to health care, although the Department of Justice and Equality introduced a National Integration Strategy in February 2017 which is to address this issue. The development of the second National Intercultural Health Strategy (see section 8) is one specific action prioritised in this report and it is due to be published in Q3 2017.

However, there are several examples where information dissemination is adapted in order to reach and influence migrants more effectively. The Citizen's Information Board is a one-stop shop statutory body and national agency responsible for supporting the provision of information, advice, and advocacy on social services through online, telephone, and face-to-face services. Most of the information provided online is available in French, Romanian, and Polish. It includes entitlements to public health services for migrants, asylum seekers, and refugees (Citizens Information Board 2011b)

The public information website of the Department of Social Protection also provides information on entitlements to public health services for people moving to Ireland, translated into 16 languages.

The Department of Justice and Equality has responsibility for migration policy. It is regularly kept informed about work undertaken by the HSE relevant to migrant health. It also operates a website containing links to a wide range of translated information, available in 20 languages.¹⁵ However, the inclusion of up-to-date translated resources is patchy and ad hoc. Connolly Hospital (an HSE-run general hospital) is one example of a hospital providing relevant information in the Patient Information Booklet available from its website and translated into seven languages. While a number of hospitals do provide translated information, this may often be difficult to source on hospital websites.

The HSE website **hse.ie** contains some translated information about entitlements. However, difficulties in navigating such a complex website may render this information inaccessible to migrants. Work has begun on the development of a dedicated microsite for the HSE National Social Inclusion Office, accessible from the main HSE website. This will contain a range of translated information in relation to entitlements to health services, targeted health promotion activities, links to translated health

¹⁵ <http://www.integration.ie/website/omi/omiwebv6.nsf/page/Information%20for%20Migrants-mlresourceshealth-en>

information, relevant social inclusion health policies, publications, guidelines, and services. In addition, there are several examples of HSE Social Inclusion and NGO partnerships that are designed to address gaps in services for migrants.

The general level of funding available from the HSE for non-statutory partnerships has decreased due to the economic recession. However, it is worth noting that efforts were made to protect funding to all vulnerable groups and to minimise the severity and impact of these funding cuts, although the outcome of these efforts is hard to quantify. It has been reported that from 2008 to 2012 funding for the voluntary and community sector contracted by 35%. In response, the sector was forced to sharply reduce spending, dismiss staff, and close services (Harvey, 2012).

Some examples of work arising from HSE and NGO partnerships to provide information to migrants about their entitlements include:

- *Crosscare* provides a range of social care and community services across the Dublin Archdiocese and receives funding from the HSE. It provides an information and advocacy service for legal and illegal migrants living in Ireland as well as a website containing information, links and practical advice in English, Chinese, Brazilian-Portuguese, Arabic, and Russian.
- *Cairde* is a Dublin community development organisation working to tackle health inequalities among ethnic minority communities by improving access to health services and participation in health planning and delivery. It provides translated information and application forms as well as supportive outreach and information sessions in relation to entitlements to health services and how to access services.
- *Doras Luimni* is a development organisation for refugees, asylum seekers and all migrants living in the Limerick area. It provides face-to-face advice and information to assist migrants in accessing their rights and entitlements as well as providing an online 'Guide to Limerick' for migrants. It also provides training for professionals and organisations that includes reference to entitlements for migrants in relation to social services.
- The Immigrant Council of Ireland (ICI) is a national voluntary organisation and legal centre that promotes the rights of legal and illegal migrants through information, legal advice, advocacy, lobbying, research and training. It does not receive government funding. The organisation provides translated written information and interpreter services for *face-to-face and telephone contact or instruction* in relation to entitlements to social services. It also provides specialist information and support to staff of the Citizens Information Centres operated by the Citizens Information Board.

Health education and health promotion for migrants

The National Health Strategy 2001 emphasises health education and promotion, and espouses values of a health service that is fair and accessible to all. More recent policy developments in the spheres of health education and health promotion highlight the increasing emphasis on 'whole of government'

approaches to health and wellbeing, and show evidence of awareness about migrants as a specific group in the population. These are strong policies that seek to achieve positive change for migrants and are further described in Section 8.

However, there is no formal policy about health education and health promotion activities specifically targeted at migrants. In practice, there is a modest amount of activity within the HSE Social Inclusion Office and other statutory agencies in relation to health promotion and health education for migrants. The method of dissemination is generally the only aspect that is adapted in order to reach and influence migrants more effectively.

The HSE health promotion website contains downloadable information leaflets in a range of languages, and a translated cervical screening information sheet is available from a dedicated website. A Language Aid for radiographers undertaking breast cancer screening is also translated into a number of languages. Translated *information relating to registering births and childhood and adult vaccinations is also available.*

Generally, only legal migrants and asylum seekers are targeted by the aforementioned information in relation to health education and health promotion. This information is translated into the languages identified as most spoken (besides English) in the national Census, e.g. Polish, French, Spanish, and Russian. However, undocumented migrants can also access the information on the internet.

Provision of cultural mediators or patient navigators to facilitate access for migrants

These are provided on an ad-hoc basis, although there is no formal policy in relation to this.

A wide-ranging national consultation with service users and service providers took place from May 2006 to January 2007. A number of issues, key messages, and associated recommendations arose from the process. One of these recommendations was that consideration be given to how cultural mediators can be optimally used at community level to assist service providers to deliver a culturally sensitive service, empower minority ethnic communities, act as brokers or link workers, and help in the planning and delivery of services and the development of information materials. Given the variety of models available and the lack of evidence about which one should be resourced, a conclusion of the consultation process was to further explore possible models for the Irish context. This was written into the National Intercultural Health Strategy 2007–2012 (HSE 2008a; described in Section 8).

Access Ireland, a refugee integration organization with a focus on health issues and social well-being, developed cultural mediation services for immigrant groups but this is no longer in place. It received limited support from the HSE.

A Roma Cultural Mediation project was funded by EQUAL Community Initiative from 2005 to 2008. Although cultural mediation training is not recognised under the National Framework of Qualifications in Ireland, some training programmes have been developed with European funding in recent years. While unrecognised, these programmes contain much of the information that could inform future training. The only current use of cultural mediators in the health services is in the aforementioned HSE funded Roma mobile health clinic.

Is there an obligation to report undocumented migrants?

There is no obligation for health care professionals or organisations to report undocumented migrants, and no relevant legislation or professional codes of conduct.

Are there any sanctions against helping undocumented migrants?

There are no legal or employment sanctions for professionals against helping undocumented migrants or migrants who cannot pay.

7. RESPONSIVE HEALTH SERVICES

Score 58 Ranking ●●●●●

Interpretation services

There is no requirement to provide qualified interpreting services for patients with inadequate proficiency in English. However, a working group was established in 2016 to synthesis information on levers and barriers to the implementation of the routine use of trained interpreters in the Irish healthcare system. An initial report is due in December 2017 for the HSE. This work is also being reviewed by WHO Europe as part of the implementation of the *Strategy and Action Plan for refugee and migrant health in the WHO Europe region*.¹⁶ There are resources for interpreting in secondary care, but less clarity exists about the resources available in primary care, with the end result that service provision is inconsistent and fragmented.

There are some contractual arrangements in place between the HSE and commercial interpreting services that cover face-to-face and telephone interpreting. Paid staff are not required to have formal accredited training as interpreters. There are also some established migrants who have trained as community interpreters and who work freelance or with commercial companies.

Some innovative projects have been launched to support communication with service users who are not proficient in English, e.g. the Emergency Multilingual Aid helps to address language barriers in emergency settings while awaiting the services of an interpreter. In September 2005, the HSE initiated a free pilot interpreting service in the area now known as the HSE Eastern Region. An assessment of use after six months showed low uptake by GPs. Barriers identified included lack of knowledge of national policy about intercultural health, scepticism about the availability of resources, lack of awareness of the pilot among GPs and ethnic minorities, lack of training for GP staff regarding the implementation of interpreted consultations, and perceived and actual time and economic pressures. A number of recommendations arose from this assessment for consideration in any future projects relating to this area (MacFarlane and O'Reilly-de Brun, 2009). The *Lost in Translation* resource¹⁷ is an example of a resource designed to support staff in doing quality translation of health information.

Requirement for 'culturally competent' or 'diversity-sensitive' services

While there are no explicit requirements for such services, there are standards and guidelines to promote and support them. *Guidelines for Communication in Cross-Cultural General Practice Consultations*¹⁸ (HSE; NUI Galway; HRB; Centre for Participatory Strategies Galway) and the *HSE Intercultural Guide*¹⁹ are examples of resources produced to support and guide culturally competent service delivery.

¹⁶ <http://bit.ly/2sQ9cO3>

¹⁷ <http://www.hse.ie/eng/about/Who/primarycare/socialinclusion/>

¹⁸ <http://www.icgp.ie/go/library/catalogue/item/80AB1584-8138-4423-8B41A4EE460854FA/>

¹⁹ <http://www.hse.ie/ema/>

Training and education of health service staff

The HSE National Intercultural Health Strategy 2007–2012 (HSE 2008a; see Section 8) emphasised the critical importance of providing responsive, culturally competent services and has supported some staff training in this regard.

Training courses are available for health service staff to enhance cultural competence (generally or with attention to specific skills), but these are not obligatory. The aforementioned *Doras Luimni* provides intercultural awareness training for professionals and organisations in the Limerick area. *Cairde* provides support to health care practitioners in cultural and linguistic competency in relation to death and bereavement. *Pavee Point* provides training workshops and guides in relation to Roma health, and has had positive engagement with the HSE and the aforementioned TUSLA staff.

In the HSE National Service Plan 2016, intercultural health training is budgeted for to enable staff to deliver services in a culturally competent manner. This training is targeted at staff delivering services to asylum seekers in Direct Provision and to refugees arriving under the recently established Irish Refugee Protection Programme.²⁰ A Task Force directs this programme with cross government representation, including the HSE. This is a high level group chaired by the Tanaiste (Deputy Prime Minister) and a number of operational groups function beneath this. (Other migrants are not mentioned.)

In the HSE South East region, a guide for a model of Intercultural Awareness and Practice in Health and Social Care was launched in June 2017.

Involvement of migrants

A Department of Health/HSE *National Strategy for Service User Involvement in the Irish Health Service* was agreed in 2008 (HSE 2008b); however, the key lever for *migrant* involvement comes from the HSE National Intercultural Health Strategy 2007–2012 (see Section 8). This strategy was developed in consultation with migrants and NGOs working with migrants. The HSE Social Inclusion Office has extensive experience of collaborative partnerships with academics and non-statutory agencies to involve migrants in research, projects to improve information provision and dissemination, and service design and delivery. However, migrants are not involved in service design and delivery as a general rule.

As mentioned above, there are some examples of good practice within the HSE Social Inclusion Office. Migrants are involved in research about health services undertaken at universities, e.g., the University of Limerick and NUI Galway. The EU-funded RESTORE initiative, co-ordinated from the University of Limerick with partners at NUI Galway and universities in Glasgow, Liverpool, Nijmegen, Vienna, and Crete, focuses on research into the implementation of guidance and training initiatives designed to support communication in cross-cultural consultations in primary care settings. Its aim is to improve health care for migrant groups in Europe with different origins and language backgrounds. Participatory Learning and Action fieldwork undertaken in five countries focuses on groups of key stakeholders, including migrants, primary care providers, policy makers, and interpreters working together to implement guidelines or training initiatives in their local primary care settings.²¹

²⁰ <http://www.justice.ie/en/JELR/Pages/PR16000275>

²¹ <http://www.fp7restore.eu/>

Encouraging diversity in the health service workforce

At present there are no efforts to encourage diversity in the health service workforce. No record is kept of diversity in the workforce; however, efforts are under way to compile an outline of diversity in the workforce across professions and levels/grades/seniority. However, in 2016 a Human Resource Lead in the HSE was appointed for 'Equality, Inclusion and Diversity'.

A New Traveller and Roma Inclusion Strategy launched in June 2017 contains broad recommended actions around supporting members of these groups to access employment in the health service. However, recruitment measures to operationalise this or to encourage participation of people with a migrant background in the health service workforce cannot take place at this time. This is due to a moratorium on employment in the HSE, introduced in 2009 and renewed for three more years in 2013.²²

Development of capacity and methods

There is no specific policy in relation to the development of capacity and methods for diagnostic procedures and treatment methods to take account of variations in sociocultural backgrounds. With some exceptions, policies are currently focused on standardisation rather than adaptation.

These exceptions are influenced by the National Intercultural Health Strategy 2007–2012 (see section 8). For example, a Female Genital Mutilation Clinic was established in 2013 on foot of research estimating that 3,800 women/girls in Ireland may have undergone the procedure. This is the first specialist service for the treatment of FGM in Ireland and marked a significant development, on the foot of the National Plan of Action on FGM (2008) and criminal legislation enacted in 2012. This development is a good example of how the HSE has worked in partnership with organisations such as AkiDwa (an NGO national network of migrant women living in Ireland) and the Irish Family Planning Association, and also drew extensively on consultations with women's migrant organisations.²³ Legislation on extraterritoriality has also been introduced in 2017.

The FGM clinic provides free specialised care and professional counselling and is operated by the Irish Family Planning Association. This clinic is one element of a range of actions in relation to FGM funded by HSE Social Inclusion. Others include the development of a resource for health professionals, training and awareness-raising, the development of a Second National Action Plan to address FGM and other community-related actions carried out by AkiDwa.

Other, broader social inclusion initiatives may be relevant as well. A two year pilot primary health care service for marginalised groups opened in Limerick in 2014 in response to an identified need. It is part of a model of action research in primary care aimed at improving access to primary health care for the homeless, drug users, Travellers, migrants, and others. The project was undertaken by the Partnership for Health Equity (PHE),²⁴ a collaboration of clinicians, medical educators, social scientists and health care policy makers and planners. It was set up in 2011 and was funded by University of Limerick, North Dublin City GP Training Programme and the HSE's Social Inclusion and Primary Care Services. The project was supported by Safetynet, a networking organisation for doctors, nurses, and voluntary agencies that provide primary health care to homeless people and other marginalised groups including migrants.

²² <http://www.imt.ie/news/ban-on-employment-is-set-to-extend-but-with-recruitment-by-exception-17-04-2013/>

²³ <http://bit.ly/2rOSCtb>

²⁴ <http://www.ul.ie/gems/partnership-health-equity>

Issues relating to interpreting, continuity of care, prescription charges, mental health issues, etc. were dealt with in the clinical component of the Partnership for Health Equity.

The following reports of initiatives in the HSE South East region from 2017 are also relevant.²⁵

- An Intercultural Healthcare Pilot Project, based on a partnership between the HSE and the Integration and Support Unit (ISU), focused on the development of model of intercultural healthcare with and for asylum seekers.
- *Towards Care, Compassion, Trust and Learning* focused on health care and promotion work with the Roma Communities in counties Waterford and Wexford.
- The *Atelier Roma Men's Programme* is a workshop/skills based, developmental programme with primary health care and English language module for Roma men. This is run in conjunction with Wexford Local Development.

²⁵ <https://hse.ie/eng/services/news/media/pressrel/HSE-launch-reports-on-intercultural-health-projects-.html>

8. MEASURES TO ACHIEVE CHANGE

Score 67 Ranking ●●●●●

Data collection

Prior to the passing of the Health Identifiers Act in July 2014, collection of information about health status, country of origin, and ethnicity was optional, although a number of national surveys included these questions. In some settings (e.g. hospitals or addiction and homeless services) country of birth or ethnicity was also recorded, but in an ad hoc and inconsistent way. The new Act was part of the 'eHealth Strategy for Ireland' launched in 2013; it introduced an 'Individual Health Identifier' (IHI), a number that safely identifies a person who has used, is using or may use a health or social care service in Ireland. When plans are fully implemented, the IHI number will enable the linking of a person's health records from different systems to give a complete medical history. Place of Birth and Nationality are among the variables to be recorded in the National Register of Individual Health Identifiers.²⁶

Work has also been ongoing to introduce the collection of ethnic data in hospital and other settings. An online training package has been developed for staff and there are plans to pilot it in hospital settings. There are also plans to develop information materials and a communication strategy within the hospital and with relevant stakeholders locally. A range of challenges have been identified in the process, e.g. ensuring that the data is analysed and reported with the involvement of all stakeholders, gaining support from senior management as well as managing ongoing concerns relating to data protection. Under the auspices of the Partnership for Health Equity) a participatory health research project has been funded by the Irish Health Research Board in October 2015. This application was developed in partnership with migrant community organisations and the HSE Social Inclusion Office. It is now underway and a key objective is to identify levers and barriers to the implementation of an ethnic identifier in primary care

Support for research

Funding bodies have in recent years supported research on issues concerning service provision for migrants or ethnic minorities. The HSE has provided some funding contribution towards two PhD students and the Health Research Board has funded projects about communication in cross-cultural consultations (awarded in 2002 and 2009). As mentioned above, another proposal relating to migrant and minority ethnic health has been funded submitted by the HRB in 2015.

Health in all policies

The cross-government *Healthy Ireland* framework was launched in 2013 and is an important development. It emphasises the role of the HSE to proof all policies for vulnerable groups. However, within this there is little explicit consideration of the impact on migrant or ethnic minority health of policies in sectors other than health. Even though the National Intercultural Health Strategy 2007–2012 (HSE 2008) promotes the idea of a whole organisation approach, concern for migrant or ethnic minority health tends to be regarded as a priority for the HSE Social Inclusion Office, the specialised department for migrant and ethnic minority health.

²⁶ <http://www.ehealthireland.ie/Strategic-Programmes/IHI/>

Whole organisation approach

As noted above, the context in Ireland is unusual in that there is a major national strategy devoted to intercultural health which promotes a whole organisation approach. However, in practice, there is a tendency across the HSE to regard migrant or ethnic minority health as exclusively or primarily the domain of the HSE Social Inclusion Office. The office continues to work with this challenge and to promote the idea of a whole organisational effort.

Leadership by government

The following strategies are relevant here:

1. The Health Service Executive Intercultural Health Strategy 2007–2012.
2. National Migrant Integration Strategy – introduced in February 2017 by the Department of Justice and Equality;

1. This Strategy aims to provide a comprehensive framework within which the care and support needs of service users from diverse cultures and ethnic backgrounds may be effectively addressed. The underlying mission of the Strategy is to integrate services and ensure that they are accessible and responsive. The principles, themes and recommendations support staff and service users to participate actively and meaningfully in the design, delivery and evaluation of health care provision to minority ethnic service users.

Substantial consultations took place with migrant groups in the drafting of the Strategy, and community organisations such as Dublin-based NGO Cairde carry out regular consultations with migrant service users on issues such as mental health, primary care and wellbeing. This consultative approach has been important in informing policy developments and building capacity for local health implementation.

The HSE Intercultural Health Strategy 2007–2012 was launched and endorsed by the government's Department of Health in 2007. The Strategy has informed thinking and practice on intercultural health, and is a key area of work carried out by the HSE Social Inclusion Unit.

Implementation has not been as thorough as one might hope. This is due in part to the economic recession and funding cuts. The policy does not provide for monitoring or sanctions in the case of non-implementation, and the impact of the Strategy has not been formally evaluated. However, numerous initiatives were launched and had an impact on migrants' health experiences. For example, the Intercultural Health Strategy 2007–2012 led to the development of the aforementioned HSE-produced document, *Lost in Translation*: a resource to support quality, cost-effective information translation (HSE 2012). The strategy also led to the development of a Roma health clinic and to new services for addressing female genital mutilation.

2. The National Migrant Integration Strategy envisages the development of a second National Intercultural Health Strategy. Invitations for submissions were advertised on community websites and HSE sites in 2016. A range of organisations and individual stakeholders responded. The submissions are being analysed to devise key recommendations. As mentioned earlier, this Strategy is due to be launched in 2017.

There are other relevant national policies:

- The national framework on mental health, *A Vision for Change* (Government of Ireland, 2006), and *The National Policy Framework for Children & Young People* (Government of Ireland, 2014) make specific commitments regarding different migrant groups. For example, Vision for Change notes that ‘Culturally sensitive mental health services will be aware of the different understanding of such things as mental health, mental health services, healing, family structure, sexuality and spirituality that exist in other cultures’ (p. 40). The Framework for Children and Young People recognises that specific groups of children and young people are particularly at risk and so need additional supports and protections mentioning child victims of trafficking and Roma, migrant and asylum-seeking children.
- The HSE/National Women’s Council of Ireland gender mainstreaming framework *Equal but Different* (2012) focuses on the social determinants of health across different population groups, including migrants (in the case of the gender mainstreaming framework, women migrants). This framework has been implemented through pilot projects and training for HSE staff.
- The cross-government health and wellbeing framework, *Healthy Ireland: A Framework for Improved Health and Wellbeing 2013–2025* (HSE 2013), is designed to improve health across all groups and to address health inequalities. This is now the national framework for action to improve health and wellbeing, with a primary focus on prevention. It aims to increase the proportion of people who are healthy at all stages of life, reduce health inequalities, and protect the public from threats to health and wellbeing. It also aims to create an environment where individual people and sectors can participate in the achievement of these aims by taking a cross-government and cross-society approach. The strategy refers to the numbers of people born outside Ireland and flags the importance of health literacy in provision of health information.

However, across these documents there is little explicit reference to the *unique* needs of migrants and little *development* of what their needs are. There is no overarching body and no established mechanism for co-ordinating actions within or across sectors.

Involvement of stakeholders

The National Strategy for Service User Involvement in Ireland does not focus explicitly on involving migrants in the design of migrant health policies.

The National Intercultural Health Strategy 2007–2012 was striking in its attention to involving migrants in a consultation exercise, documented in a separately published report, to inform the content of the strategy.

Since that work, examples of good practice are evident but they have developed and are supported by ad-hoc cooperation, relationships, and partnerships.

Migrants' contribution to health policy making

As mentioned above, migrants were involved in the development of the National Intercultural Health Strategy 2007–2012. More generally, contributions are rare and ad hoc because of the broader policy context.

The HSE's National Advocacy Unit has advocated and promoted service user consultations and involvement in general. There have been difficulties in this area, as service user involvement is still very underdeveloped in practice in Ireland (and abroad) for everyone, including migrants. More work is needed to improve public involvement in general and migrants' involvement in particular.

CONCLUSIONS

Given Ireland's history of emigration, rather than inward migration, the health service was not designed with much attention to cultural diversity in general, or migrant health needs in particular.

The two-tier healthcare system is characterised by an under resourced primary care system, with significant challenges in relation to interdisciplinary team working and community participation to shape service development and responsiveness to specific needs, such as migrants' needs. The healthcare system is also characterised by an eligibility system that is *inordinately complex*. The rules for eligibility are far more complicated than in most other European countries. A major consequence of the labyrinth of regulations is that many migrants miss out on their entitlements. Simplifying the system is urgently needed. Universal health coverage, as per the Future Health Framework, from the Department of Health (2012) is an essential policy goal.

There are important examples of initiatives to improve migrants' access to services within policies from the Department of Health and the Department of Justice and Equality. There are initiatives 'on the ground' as a result of the Health Service Executive and NGOs partnerships that do make a real difference to migrants' access to healthcare. Admittedly, a lot of promising initiatives have been hampered by spending cuts as a result of the economic downturn, but there is still a strong will and drive to address long-standing or emergent inequities in access to healthcare. Given changing patterns of inward migration through, for example, the new Irish Refugee Protection Programme, means this is needed more than ever.

The most important policy, promoting whole organisational approaches to achieve change, is the HSE Social Inclusion Office's national Intercultural Health Strategy 2007-2012. However, despite the quality of this document, in terms of the consultative approach taken for its development and its use to guide policy and practice, there is an underlying problem. Concern for migrant or ethnic minority health still tends to be regarded by the wider system as a priority for this office. Consequently, co-ordinated working across the HSE and between the HSE and relevant government Departments is not as strong as it needs to be.

Overall, at this time, Ireland is much stronger on "responsiveness" than on "inclusiveness." The forthcoming second Intercultural Health Strategy (due December 2017) is important in two regards. First, it is an updated strategy to guide the development of inclusive health services in a rapidly changing context with due attention to the *unique* needs of migrants. Second, as this is considered a key action in the National Migrant Integration Strategy (2017), its launch may act as an important lever for strengthened co-ordinated actions.

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Websites

Statutory websites

<http://www.citizensinformation.ie/en/>

<http://www.integration.ie/>

www.welfare.ie

HSE websites

www.healthpromotion.ie

www.breastcheck.ie

www.cervicalcheck.ie

www.immunisation.ie

<http://www.hse.ie/go/birth/>

NGO websites

<http://drugs.ie/>

www.ruhama.ie

<http://www.newcommunities.ie/resources/category/ncppublications/>

www.womensaid.ie

www.drcc.ie

<http://www.ifpa.ie>

<http://www.migrantproject.ie/>

www.cairde.ie

<http://dorasluimni.org/>

www.mrci.ie

<http://www.immigrantcouncil.ie/>





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