COUNTRY REPORT

SLOVAKIA

MIPEX HEALTH STRAND

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EUROPEAN COOPERATION IN SCIENCE AND TECHNOLOGY

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MIGRANT INTEGRATION POLICY INDEX

HEALTH STRAND

Country Report Slovakia

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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/2g0GlRd. 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/29lXgf0), 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)	5.415.949	●●●○○
GDP per capita (2014) [EU mean = 100]	76	●●○○○
Accession to the European Union	2004	

Geography: Slovakia is a landlocked country of 49.035 km^2 located in Central Europe between Austria, the Czech Republic, Hungary, Poland, and Ukraine. The terrain consists of mountains in the central and northern part and lowlands in the south. The largest city is the capital Bratislava (pop. 401.000) and 54% of the population lives in urban settings (a relatively low percentage compared to the EU average of 75%).[2]

Historical background: Slovakia's roots can be traced to the 9th century state of Great Moravia. Subsequently, the Slovaks became part of the Hungarian Kingdom, where they remained for the next 1.000 years. After the dissolution of the Austro-Hungarian Empire at the close of World War I, the Slovaks joined the Czechs to form Czechoslovakia. In 1939 Slovakia became an independent state allied with Nazi Germany. Following World War II, Czechoslovakia was reconstituted and came under communist rule. The Communist Party was swept from power at the end of 1989, and Slovakia was created in 1992 after the dissolution of Czechoslovakia.

Government: Slovakia is a parliamentary democracy divided into 8 regions. The country joined the EU in 2004 and the Eurozone in 2009.

Economy: The Slovak Republic has a small, open economy, with exports accounting for 92% of GDP. The most important sectors of its economy in 2015 were industry (25%), wholesale and retail trade, transport, accommodation and food services (22%) and public administration, defence, education, human health and social work activities (14%).[3] As the result of the recent economic crises, the GDP growth rate reached a record low of -7,6% in early 2009. Since then, it has returned to growth (3,3% in 2016). In 2016 unemployment was down to 9,7%, after hitting a peak of 14,8% in early 2010.[4]

[2] http://www.eea.europa.eu/themes/urban
[3] https://europa.eu/european-union/about-eu/countries/member-countries/slovakia_en
[4] https://ec.europa.eu/info/sites/info/files/ecfin_forecast_winter_1317_sk_en_0.pdf

2. MIGRATION BACKGROUND

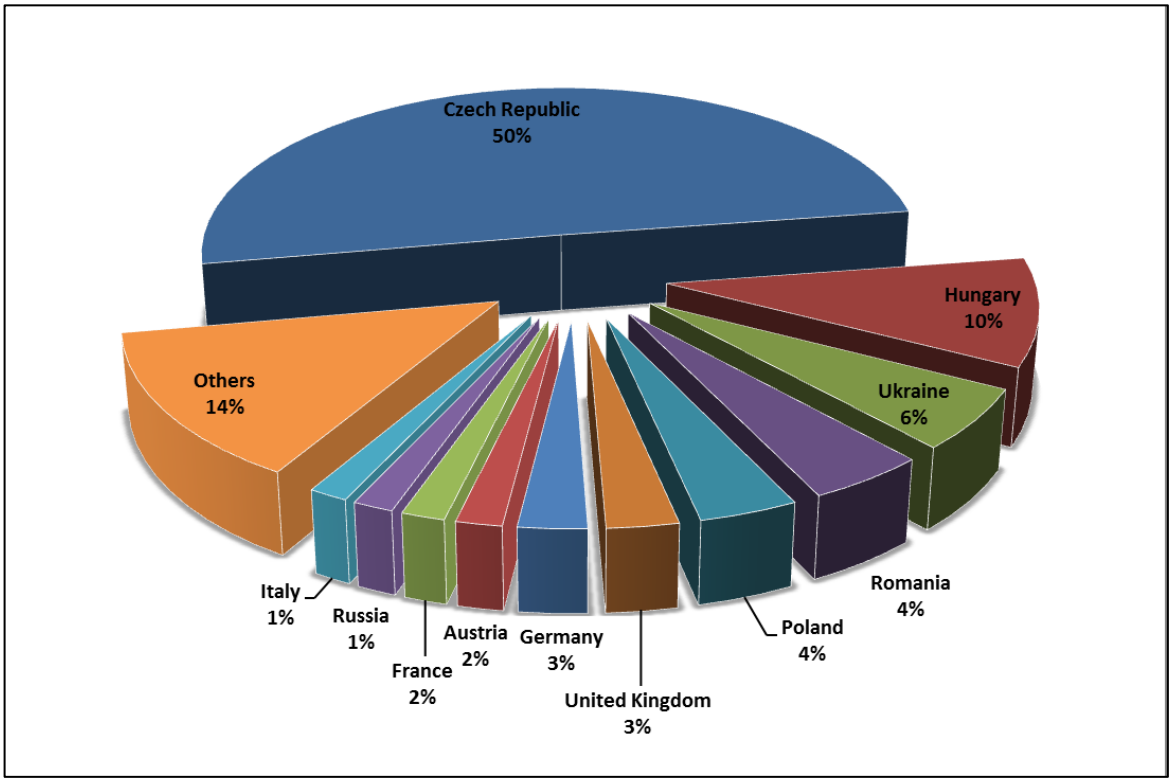
KEY INDICATORS (2014)		RANKING
Foreign-born population as percentage of total population	3,2	●○○○○
Percentage non-EU/EFTA migrants among foreign-born population	16	●○○○○
Foreigners as percentage of total population	1,1	●○○○○
Non-EU/EFTA citizens as percentage of non-national population	19	●○○○○
Inhabitants per asylum applicant (more = lower ranking)	16.412	●○○○○
Percentage of positive asylum decisions at first instance	61	●●●●○
Positive attitude towards immigration of people from outside the EU (Question QA11.2, Eurobarometer)	31	●●○○○
Average MIPEX score for other strands (MIPEX, 2015)	38	●○○○○

Migration has become a major issue and a top policy priority in today's world. For Slovak society, it is a relatively new and burning issue. Slovakia took longer than most other EU accession countries to develop policies on migrant integration.[5] In the 2015 round of MIPEX, only Cyprus and Latvia had a lower score for the average of the other seven strands of integration policy apart from health. The 2009 *Concept of Foreigners' Integration in the Slovak Republic* led in January 2014 to the first *Integration Policy of the Slovak Republic*. In February 2015 the government approved the *National Strategy of Human Rights Protection and Promotion in the Slovak Republic*. The strategy summarises in a separate annex the legal framework for the protection of migrants in Slovakia. In 2014 Slovakia submitted a draft National Programme to the EU's Asylum, Migration, and Integration Fund for activities between 2014 and 2020 (Bachtíková and Oboňová 2015), for which the Fund allocated €13 million.[6]

Under communism, migration was strictly restricted and controlled. After 1989 Czechoslovakia underwent democratization and a painful process of economic transition; there were few migrants and the topic had a low priority on the political agenda. In 1992 Slovakia separated by mutual agreement from the Czech Republic; 50% of the foreign-born residents of Slovakia in 2014 were born in the Czech Republic, many of whom acquired Slovak nationality. Only one in 200 of the Slovak population was born outside the EU/EFTA, the lowest proportion in any member state. Figure 1 shows the countries of birth of the main migrant groups. It can be seen that most come from neighbouring countries (Czech Republic, Hungary, Ukraine, Poland and Austria), as well as from Romania, the UK and Germany. About 2.100 migrants born in the USA also live in the country, along with some 2.000 Vietnamese and 1.000 Chinese (Pleschova 2007), as well as 500 South Koreans. Apart from the groups mentioned here, third country nationals (TCNs) as they are known in most Western European countries are very rare in Slovakia.

[5] See http://www.mipex.eu/slovakia
[6] http://ec.europa.eu/transparency/regdoc/rep/3/2015/EN/3-2015-5127-EN-F1-1.PDF

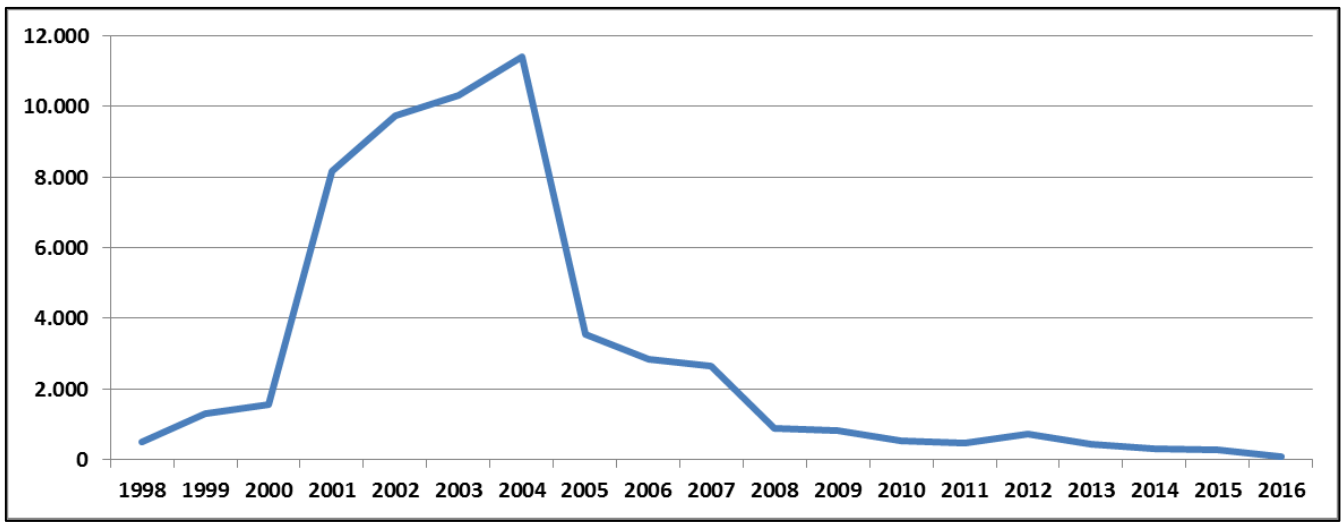
Figure 1. Foreign-born population in 2014 by country of birth (Eurostat)



Until 2004, Slovakia (like Poland and Hungary) was regarded mainly as a transit country rather than a destination for migrants. This changed after accession to the EU, when new migrants started arriving from other EU countries. Their arrival was accompanied by rapid economic growth, but the financial crisis in 2008 hit Slovakia hard, bringing very high levels of unemployment and discouraging immigration.

As Figure 2 shows, the number of **asylum applications** in Slovakia peaked in 2004, the year of accession to the EU. The main countries of origin in 2006 were India, Russia, Moldova, Georgia, China, Bangladesh, Pakistan and China.[7]

Figure 2. First-time asylum applications to Slovakia, 1998-2016 (Eurostat)



[7] Data from UNHCR: http://popstats.unhcr.org/en/asylum_seekers

The rate of asylum applications dropped sharply after Slovakia's accession to the EU, but it is hard to understand why it did not drop even further. Admittedly, EU membership should normally increase a country's attractiveness to asylum seekers; but in the case of Slovakia, most asylum seekers and/or smugglers would presumably be aware that almost all applications were rejected (99,1% between 2000 and 2006). Many applicants probably intended to travel on to richer countries like Germany or the UK: between 2000 and 2006, 90% of applications were terminated because the applicant could not be traced.[8] However, if this was their intention then applying for asylum application would make little sense (unless they were forced to make it): even if they reached their destination, they would be sent back to Slovakia under the Dublin regulation if their fingerprints had been taken there. Asylum seekers seem to have taken notice of all this only slowly, because asylum applications took a long time to reach their present low level (cf. Fig. 2). Between 2006 and 2014 the number of applications dropped, but the rate at which some form of protection was granted (not usually full 'Geneva' refugee status) increased to 61% at first instance, and the percentage of cases terminated because of premature departure fell to 38%.[7]

In 2015 the Dublin regulation was partially and temporarily suspended and more than a million people, most of them forcibly displaced from Syria, trekked across Europe until the stream was halted by border fences in Hungary and Macedonia. This influx provoked an angry backlash from the Slovakian government. Like Hungary, Slovakia denied *a priori* that these 'illegal immigrants' had any right to international protection. In September 2015 the government announced that it would take legal action against the European Commission to block a scheme for resettling Syrian refugees (a threat which was never carried out).[9] In May 2016 the prime minister, Robert Fico, declared there was "no place for Muslims in Slovakia",[10] and in November of that year Slovakia passed legislation to effectively block Islam from gaining official status as a religion in the country.[11] Although the trek of displaced persons across Europe relieved an enormous humanitarian problem, in many countries it strengthened the hand of politicians opposed to both immigration and Islam. Slovakia, the Czech Republic, Hungary and Poland (the 'Visograd' countries) responded in very similar ways: in all these countries, the influx reinforced long-standing negative attitudes. In the words of one commentator (Malangone 2015):

> It is unbelievable that only 646 migrants were granted asylum and 636 afforded subsidiary protection in Slovakia since 1993. That is only 1.282 people out of 58.019 applicants, the equivalent of two full boats. While in one May weekend in 2015, the Italian Coast Guard saved more people than all asylums and subsidiary protections ever granted by Slovakia in 22 years.

In fairness to the Slovakian government, it should be pointed out that rates of granting protection have increased since 2006 from their absurdly low level (0,9%) up to that year; the main reasons why so few have been granted protection in the last ten years are firstly that applications have declined to a trickle (see Fig. 2), and secondly that many applicants still did not wait to hear the outcome of their case, but instead moved on to other countries. Moreover, during a period of recession and high unemployment humanitarian issues easily get overshadowed by political and economic ones. Nevertheless, the

[8] http://bit.ly/2p9Sy6Q
[9] http://bit.ly/2qtcfKB
[10] http://ind.pn/27VojCd
[11] http://reut.rs/2gyfybC

Slovakian government (like that of all 'Visegrad' countries) has gone to great lengths to make clear to would-be asylum seekers that they are totally unwelcome, especially if they happen to be Muslims.

Finally, it is worth mentioning that Slovakia has a large Roma community, many of whose members originally came from Hungary. As is usually the case with this group, no definite figures are available regarding its size: census data (which suggest about 2% of the population are Roma) are unreliable, because many Roma are unwilling to have their ethnicity recorded. Higher estimates of about 400.000 (i.e. 7,5%) are reported by researchers and NGOs.[12] Slovakia's policies on Roma integration are not the subject of this report, but some activities have taken place concerning inequities in health and health services for Roma, which have increased awareness of the need to adapt health services to diversity.

[12] http://www.neweasterneurope.eu/interviews/2061-real-and-imagined-problems-of-the-roma-community-in-slovakia

3. HEALTH SYSTEM

KEY INDICATORS (2013)		RANKING
Total health expenditure per person (adjusted for purchasing power, in euros)	1.512	●●○○○
Health expenditure as percentage of GDP	8,0	●●○○○
Percentage of health financing from government National health system (NHS) / social health insurance (SHI)	7	SHI
Percentage of health financing from out-of-pocket payments (higher percentage = lower ranking)	23	●●○○○
Score on Euro Health Consumer Index (ECHI, 2014)	665	●●●○○
Overall score on MIPEX Health strand (2015)	31	●●○○○

As the above figures show, health expenditure in Slovakia is below the EU/EFTA average in terms of both the amount per person and the percentage of GDP, though these levels are normal for EU13 countries. The health care system in Slovakia is based on universal coverage, compulsory health insurance, a basic benefit package, and a competitive insurance model with selective contracting and flexible pricing. Health care is provided to the insured free at the point of service as benefits-in-kind (paid for by a third party). After fulfilling certain explicit criteria, there are no barriers to entry to health care provision and health insurance markets. As of 2010, three health insurance companies operate in the market, one of which is state-owned (66% of insured) and two privately owned. Major health reforms in the period 2002–2006 introduced a new approach based on managed competition (Szalay et al 2011).

Having health insurance in Slovakia is obligatory, and proof of health insurance is required in order to obtain a residence permit. Before leaving their countries of origin, foreigners must ensure they are covered by their current health insurance on the territory of Slovakia, or take out new insurance before or on arrival in Slovakia. Based on *Act No 580/2004 Coll. on Health Insurance* and the *Act No. 577/2004 Coll. on the Scope of health care provided on the basis of public health insurance*, there are two types of health insurance in Slovakia – mandatory and individual (commercial) health insurance. Mandatory public health insurance applies to every person with permanent residence on the territory of the Slovak Republic, or without permanent residence but fulfilling specific conditions (for example, self-employment). Commercial health insurance is compulsory for everyone who does not fall within the scope of the public health insurance.[13]

[13] Euraxess Slovakia: https://www.euraxess.sk/en/main/info/living/health-insurance

4. USE OF DETENTION

Immigration detention in Slovakia is regulated by the **2011 Act on Residence of Aliens,** which incorporates the EU Directive on Returns and on Reception Conditions. In accordance with this Act, non-citizens subject to administrative expulsion proceedings may be detained to ensure their expulsion:

- when the authorities determine there is a risk of absconding or a risk of evading deportation;
- in order to execute the expulsion;
- when it is considered necessary to ensure transfer under the Dublin convention;
- to facilitate a migrant's return to the country of origin if they have irregularly entered the territory, or if they are residing irregularly in the country.

The law also provides specific grounds for detention of asylum seekers in order to ascertain and verify their identity or their nationality, as well as to investigate and verify the facts that constitute the basis of their asylum claim.

With the transposition of the EU Returns Directive into national law, the maximum duration of detention increased. The initial length of detention is six months, which can be extended to 12 additional months (except for families with children, vulnerable persons, and asylum seekers not detained for national security reasons or public order).

Two alternatives to detention are foreseen: the financial guarantee and the report of residence, measures which can be granted if the person can prove they have accommodation as well as financial coverage. According to the Human Rights League (HRL) and the Forum for Human Rights (FORUM), meeting all the requirements set by the law is practically impossible for ordinary persons – especially for families with children – and it is therefore very rare for these alternatives to be applied in practice (HRL/FORUM 2015).

According to national law, detention of families with children shall be considered as a "measure of last resort, when strictly necessary and for the shortest possible time." However, in reality police frequently detain families with children for several months. In addition, HRL and FORUM (ibid.) have expressed great concern about the detention of families with children in centres not adapted to their needs, in particular the lack of education for children during the first three months of their detention.

Unaccompanied minors are housed in a special shelter in Medzilaborce, but if they apply for asylum, they are transferred to the reception centre of the Migration Office and later to an accommodation centre for vulnerable groups, together with other adult asylum seekers (HRL/FORUM 2015).

Detention facilities

Slovakia has two long-term immigration detention centres – the so-called 'Police Detention Facilities for Aliens' in Medved'ov, near the Hungarian border, and the centre in Sečovce, close to the Ukrainian border. A separate section of the building is used to detain women, families, children, and other vulnerable groups.

Conditions at immigration detention centres

The two centres are similar to prisons, with iron-barred windows, barbed wire fencing, and prison-like regimes, including strict police surveillance.

Detainees can move freely only within the designated sector and have access to open air only twice a day for one hour under supervision. Mobile phones are confiscated and detainees have no access to internet. Furthermore, detainees are supposed to cover the cost of their detention, particularly the food. In case the detainee is not able to do so, the state will cover costs related to detention.

In 2015, with the increasing number of displaced persons, the centre reached its full capacity and all the common spaces previously dedicated to leisure and free time were changed into accommodation rooms. Moreover, in the summer of 2015 authorities decided to use the Medved'ov centre as a holding facility for families with children, even though it was not adapted for this purpose.

According to Slovak law, **health services** for detainees are covered by public health insurance provided by the Slovak state. Nonetheless, detainees might be required to cover costs for some treatments and medications. Medical care in immigration detention centres is provided by nurses, available every working day, and doctors, who visit on a regular basis.

However, some problems have been reported. The centre's medical personnel do not often speak English and interpreters and/or cultural mediators are rarely made available during medical check-ups. This results in frequent communication problems between the detainees and the medical personnel in the centres. In addition, some families reported receiving insufficient medical treatment.

Access to psychiatric and psychological care is not foreseen in immigration detention centres. Some basic services are sometimes provided by NGOs. Overall, the HRL reported serious deterioration of the psychological state of parents as well as children as a result of their detention (HRL/FORUM 2015).

5. ENTITLEMENT TO HEALTH SERVICES

Score 50 **Ranking** ●●○○○

A. Legal migrants

Inclusion in health system and services covered

Health insurance (compulsory public health insurance or private commercial health insurance) is a required condition for legal stay in Slovakia. There is an obligation to pay public health insurance in case of already granted permanent residence, and also in case of no permanent residence permit and no health insurance coverage in another EU/EEA member state. TCNs have to prove within 30 days of arrival that they are covered by either state or private health insurance.

Equal rights to health and health care are stipulated by the Constitution of the Slovak Republic (*460/1992 Coll., Amendment: 232/2012 Coll.* with effect from 1st September 2012) and the *Act No. 576/2004 Coll. on healthcare, healthcare related services and on changes and amendments to some acts*, *as amended* (Art.1, §11). All insured persons are entitled to equal health services. The extent of health care provided depends on the type of health insurance, not on the type of legal stay; the extent of coverage in the case of public health insurance is guaranteed by legal regulations. Anyone under any circumstances is always entitled to free emergency health care.

Health care for holders of 'tolerated residence' permits (320 in 2007, 254 in 2013) is not covered by the state; they cannot take advantage of public health insurance (*Act No. 576/2004 Coll*). They are usually without public health insurance and despite their legal status, only entitled to urgent health care for free (delivery, emergency circumstances), though they may purchase commercial health insurance.

After collecting a residence document, a migrant must submit within 30 days to the Alien Police a medical report not older than 30 days, confirming that they do not suffer from a disease endangering public health, based on *Act No. 404/2011 Coll. on residence of aliens and on changes and amendments to some acts, as amended* (see Bargerova and Divinsky 2008; MIC 2010:14).

Special exemptions

There are no special exemptions defined. Only emergency care is provided unconditionally.

Barriers to obtaining entitlement

Documents required to claim entitlement are in principle not harder for legal migrants to provide than for nationals. Acceptance or rejection is not subject to administrative discretion.

B. Asylum seekers

Inclusion in health system and services covered

Asylum seekers are required to stay 30 days in quarantine in an asylum centre, in order to check their health status. The state guarantees health care for asylum seekers outside the regular framework of health insurance. While they are in the reception, detention, or collective facilities, costs are paid by the Interior Ministry from its budget. They do not have the option of choosing a health care provider. If they wish to live outside the Interior Ministry's facilities, they have to fulfil the conditions provided by law (ability to pay all living, housing, and other expenses from one's own financial resources). Conditions are set out in *Act No. 480/2002 Coll. on asylum and on changes and amendments to some acts, as amended.*

The extent of health care services depends on the individual health needs assessment of asylum seekers in the centres. There, they receive healthcare authorization papers. Limitations of coverage and/or a lower quality of health care are possible.

Special exemptions

Special exemptions for asylum-seekers are defined in *Act No. 480/2002 Coll. on asylum and on changes and amendments to some acts, as amended,* which defines the term 'persons requiring special care'. The need for special care is important when Migration Office of the Ministry of Interior decides to which asylum centre an applicant will be sent (there is one special reception centre among the three existing asylum centres in Slovakia).

Barriers to obtaining entitlement

None.

C. Undocumented migrants

Inclusion in health system and services covered

Unauthorised foreigners detained on the territory of the Slovak Republic are placed in detention centres. The state pays health insurance for persons in detention or serving a prison sentence.

However, an estimate of the total number of UDMs runs into tens of thousands, and we assume there is no access to health care (apart from emergency care) for the majority of undocumented migrants who live outside the detention centres, who must pay the full price of health care services. They could be deterred from seeking help by cost and/or by the fear of detection. Unfortunately, there is no research or data on undocumented migrants and their access to health care. Undocumented migrants are usually isolated in their communities and likely to receive no support from public bodies.

Special exemptions

None

Barriers to obtaining entitlement

The decision about whether or not emergency care is required is subject to the discretion of the attending physician.

6. POLICIES TO FACILITATE ACCESS

Score 43 Ranking ●●○○○

Information for service providers about migrants' entitlements

There is no systematic provision of information for service providers about migrants' entitlements.

Information for migrants concerning entitlements and use of health services

Targeted information for migrants is not routinely provided by public authorities; such activities are carried out by the Migration Information Centre (MIC),[14] an organization set up by IOM Slovakia in 2006.[15] MIC is a one-stop shop providing information as well as legal, social, and employment counselling to migrants, in order to promote their integration into the labour market and Slovak society. It has assisted over 9.700 clients and their families in the area of integration and has helped to return and re-integrate into normal life 140 victims of human trafficking, as well as assisting 1.500 migrants to return to their home countries.[16]

MIC has offices in Bratislava and Košice and also organises activities in Banská Bystrica, thus covering west, east and central Slovakia. It publishes a booklet entitled *Welcome to Slovakia* in three languages (Slovak, English and Arabic) with an overview of basic information about Slovakia, practical advice, and information about migrants' obligations under Slovak legislation. Another publication, *Residence of Foreign Nationals in Slovakia*, is available in Slovak, English, Russian, Vietnamese, Chinese and Arabic. Further information about the activities of MIC is provided by Bachtíková and Oboňová (2015:35).

Health education and health promotion for migrants

There is a general policy on vulnerable groups, but it is mainly focused on the Roma. Health promotion leaflets and targeted information are available only in Slovak. Migrants are mentioned as a vulnerable group, along with other groups, in the Health Promotion Programme for Disadvantaged Communities in Slovakia for 2007-2008 and 2009-2015 (programmes principally aimed at Roma populations). The EU's 'Healthy Inclusion' project investigated migrants' participation in health promotion activities (Marcinkova and Majdan 2009).

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

No laws or policies support the provision of cultural mediators, but there is active cooperation between the MIC and migrant communities making use of mediators selected from migrant communities. Cultural mediators from IOM, as community representatives, ensure the exchange of information between their community and the population at large, represent the community, and participate in activities that aim to raise the visibility of the community. Asylum seekers are not a target group for MIC´s cultural mediators, but within asylum-seeker and detention centres social workers perform a mediating function.

[14] http://www.mic.iom.sk/en

[15] The activities of MIC are classified in this report as part of the regular health system, since the Slovakian government contributes to them. Other funding comes from the the IOM, the European Commission and the US Government.

[16] http://www.iom.sk/en/press-room/introduction-of-iom

Is there an obligation to report undocumented migrants?

Unauthorised border crossing or presence on Slovak territory is not a criminal offence, but an administrative offence which can be followed by voluntary departure or forced expulsion.

Are there any sanctions against helping undocumented migrants?

There is no legal basis for any such sanctions.

7. RESPONSIVE HEALTH SERVICES

Score 0 **Ranking** ●○○○○

Interpretation services

Qualified interpretation services are generally not available to migrants. From time to time family members or friends serve as interpreters. There is partial assistance for asylum seekers in the reception and accommodation centres, involving legal services, social assistance, psychological and health care, supplementary material assistance, and support services such as translations and interpreting. Costs of these are paid from EU projects and the Ministry of Interior's budget. However, given the small number of asylum seekers in Slovakia (only 167 in 2014, according to UNHCR),[17] this does not affect the scoring of this item.

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

No relevant standards or guidelines exist.

Training and education of health service staff

Despite the specific needs of migrants, training is not identified as a priority by service providers because of the low numbers. The majority of health professionals do not work with migrants. There are no official training programs under the Continuing Medical Education system in Slovakia which focus on migrant and ethnic minority topics, or on 'migrant-friendly' health care services. The only trainings that exist have been set up in the context of EC-supported projects such as MEM-TP[18] or SH-CAPAC.[19] In the framework of the Biennial Collaborative Agreement (BCA) between the Slovak Ministry of Health and WHO/Europe for 2016-17, a workshop "Improving the health response to refugees, asylum seekers and other migrants" was organized by WHO/Europe with the support of the SH-CAPAC project on 25-26 October 2016 in Bratislava.[20] The Public Health Department of the Slovak Ministry of Health plans to continue further development of training and educational activities for health services staff in cooperation with Society of General Practitioners of Slovakia.

Involvement of migrants

Migrants are involved in the dissemination of information not as part of policy measures but rather as part of IOM project activities and on their own initiative.

Encouraging diversity in the health service workforce

This is not generally thought to be needed because of the small number of migrants. People with migrant backgrounds do participate in the workforce, but their numbers are low.

[17] http://www.unhcr.org/pages/49e48e016.html
[18] http://www.mem-tp.org/
[19] http://www.sh-capac.org/
[20] http://bit.ly/2p0V6bD

Development of capacity and methods

There are currently no activities in this area. There is a plan to assess health-system capacity in 2017/2018 with the WHO *Toolkit for assessing health system capacity to manage large influxes of refugees, asylum-seekers and migrants.*

8. MEASURES TO ACHIEVE CHANGE

Score 29 **Ranking** ●●○○○

Data collection

The statistical office of the Slovak Republic and the National Health Information Centre[21] do not collect routine statistical data on migrant health at national level due to the antidiscrimination law (Act n. 365/2004, updated 2008). For the purposes of medical records and medical databases, data on migrant status (country of birth) and ethnicity are collected when the criteria of self-identification and use of Roma language are fulfilled.[22] Health care providers must probe for information on country of origin because there is a need to know which health insurance coverage will cover treatment costs.

Support for research

Between 2010 and 2015 research projects have been supported concerning the health of migrants, their access to health care, and health promotion services.

"Health in all policies" approach

No consideration is taken of the impact on migrant or ethnic minority health of policies in sectors other than health.

Whole organisation approach

No systematic attention is paid to migrant or ethnic minority health in any part of the healthcare system. Measures are left to individual initiative. Migrant health is usually an area of interest for academics, NGOs and organizations working with migrants, but only on an ad hoc basis and on individual initiative.

Leadership by government

Health of migrants as a vulnerable group is mentioned only incidentally in general policies published by the government.

Involvement of stakeholders

There is no systematic approach. Policymaking culture is still mainly oriented to contributions from politicians and lobbying groups with strong influence and good PR skills, rather than others like academics or migrant stakeholders.

Migrants' contribution to health policymaking

Immigrant organisations are not explicitly consulted on health policy.

[21] http://www.nczisk.sk/en/Publications/Pages/Edition-Analytical-Publications.aspx
[22] http://academos.ro/sites/default/files/biblio-docs/1309/1304606208_roma-healthpassword1.pdf

CONCLUSIONS

Among EU/EFTA countries Slovakia obtains a lower than average score on the MIPEX health strand; relatively little is done to make health services easily accessible to migrants and responsive to their needs. However, there is a considerable gap between the Health strand scores of the EU15 member states on the one hand, and the 13 countries that joined the EU after 2004 on the other: Slovakia's score is average for the EU13. Like most countries in this group, Slovakia has little experience of receiving migrants, and numbers (especially of migrants coming from outside the EU/EFTA) are very small. Between 2004 and the onset of the economic crisis in 2008 there was a brief period during which the Slovak economic grew rapidly and many migrants were attracted to the country, but before and after that period there was very little immigration.

The 'refugee crisis' of 2015-2016, in which several countries on the borders of the EU like Slovakia felt themselves to be overrun by migrants – even though these migrants left as soon as they could – played into the hands of politicians appealing to anti-migrant and anti-Islam sentiment: the crisis hardened existing negative attitudes to migrants still further. The four Visegrad countries (Slovakia, Hungary, Poland and the Czech Republic) formed a bloc to oppose EU policy on migration and religious tolerance. Against this background, it is difficult to find official support for 'migrant-friendly' initiatives. Efforts to improve policies on migrant integration have continued, furthered by projects of NGOs, the IOM, and the EU, but the combined effects of the economic crisis and the refugee crisis have led to a standstill in the development of migrant health policies.

In this situation it needs to be repeated that efforts to improve health policies for migrants have nothing to do with wanting to be nice to them. Firstly, it is a question of human rights: all EU/EFTA countries have committed themselves to international treaties guaranteeing the right to health and freedom from discrimination for all on their territory. Secondly, such efforts are a matter of common sense: neglecting the health of a segment of the population jeopardises the health of all, while accessible and effective health care reduces costs in the long run.

In Slovakia, it would be in the country's own interests to speed up efforts to promote the integration of migrants, especially in the field of health. It is true that numbers are small, but locally there is probably enough demand to justify investment in (for example) interpretation services, cultural mediators and staff training. Many (but not all) of the problems resemble those facing the Roma community, so useful synergies could be created.

The Migrant Integration Centre, set up and run by the IOM and virtually unique in Europe, is providing much of the support that mainstream services are failing to give. After 11 years the question should perhaps be asked whether this support is not weakening, rather than strengthening, central government's readiness to take ownership of these tasks. None of the expertise that has been built up need be wasted – but outsourcing migrant health to an external organisation sends the message that migrants do not belong in Slovak society. However, experience shows that top-down, centralised management is also not the best way to improve health services for migrants (or Roma, for that matter): a combined effort by a coalition of national and local authorities, NGOs, IGOs, universities, health services, professionals and lay people (including migrants) has much more chance of success.

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