Ensuring equal access to and quality of health services for refugees and migrants
25th International HPH Conference. Vienna, 2017

MED Task Force

Cultural [Migrant] Equity in Healthcare Organizations: the Relation between Organizational Standards and Provider Competences

Manuel García-Ramírez
CESPYD – University of Seville

International Network of Health Promoting Hospitals & Health Services

CESPYD

Motivation

Can Equity Standards contribute to the European response of migrant influxes?

The massive arrival of impoverished migrants and help seekers to Europe's Mediterranean regions urges to respond their complex health needs

The EU's Health Programme (2014-2020) calls to improve the response of protection systems for CMF:

- **To ensure responsiveness in organizations**
- **To improve access to services**
- **To build capacity among service providers**

Equity Healthcare Standards (EHS) developed by the TF HPH Migrant Friendly Hospitals seek to becoming an approved framework of equity within organizations providing health care to migrants, minorities and other groups at-risk of vulnerability.

Introduction

Complex Migration Flows (CMF)

CMF refer to people fleeing from wars or who look for thriving away from their impoverished homeland.

CMF challenge traditional classification used by recipient countries to regulate civic rights and services' entitlements of newcomers.

An **asylum seeker** is a person fleeing persecution and seeking protection
An **economic migrant** is a person whose primary motivation for fleeing is poverty
A **refugee** is an asylum seeker whose claim has been approved.

This categorization is non-operational in border regions since they travel together sharing vulnerable conditions and receiving similar treatment at reception settings where their basic rights are systematically violated.

Restrictive laws deny the refugee status.
Help seekers refuse to apply due to the **restriction of Dublin II** regulation
Economic migrants are unemployed or obligated to accept **precarious jobs**

Introduction

Complex Migration Flows (CMF): Stranded Migrants

Stranded migrants refers to migrants without any means to go back or forth, and had to rely on local communities at border regions

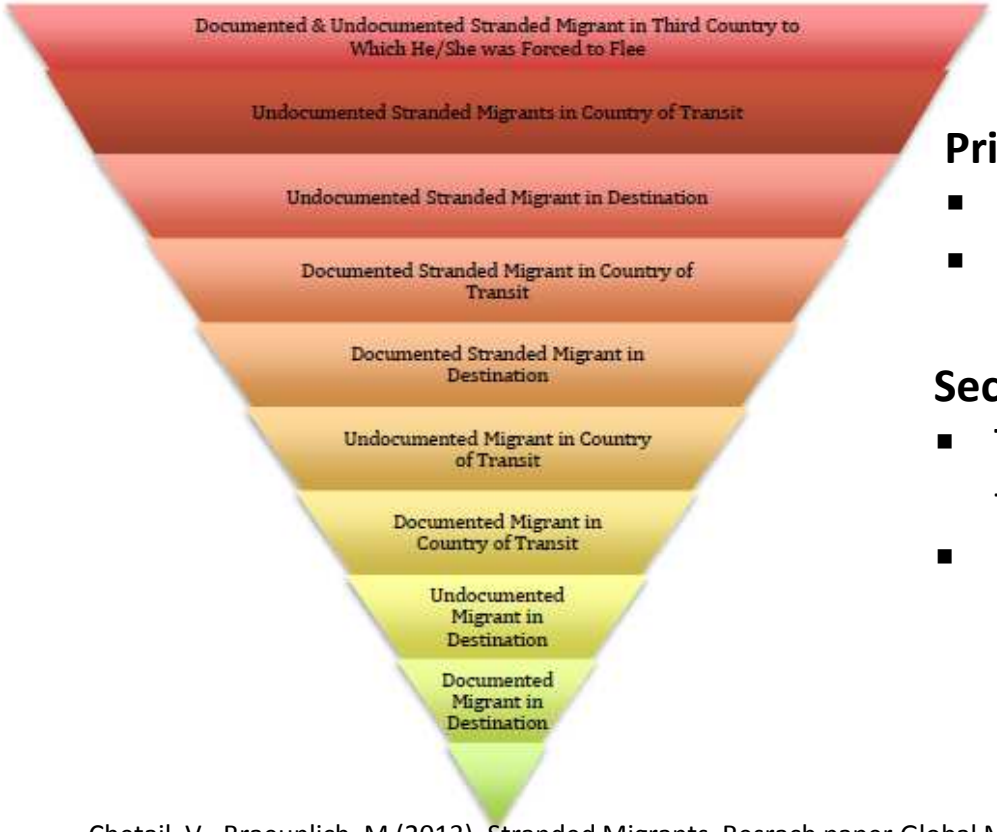
1. Stranded migrants appear to come from **anywhere**
2. Migrants may become stranded during **any part of their migration movement** (departure, travel, destination, or return)
3. Not being able to move can be due to **objective reasons** (widespread violence, civil unrest, natural disaster) and **subjective reasons** (unwillingness to return, economic reasons, health issues or abuse by employers)
4. Stranded migrants can be **documented or undocumented**
5. Many stranded migrants are **asylum seekers or victims of human trafficking** (Iraqi refugees in Syria; Syrian displaced in Melilla)
6. Especially vulnerable migrants to becoming stranded are **unaccompanied minors, women, elderly**

Chetail, V., Braeunlich, M (2013). Stranded Migrants. Resrach paper.Global Migartion Centre

Introduction

Complex Migration Flows (CMF): The vulnerability of stranded migrants at border regions

Border regions become a trap for stranded migrants and a source of multiple and continued vulnerabilities and inequities.



Primary vulnerability factors:

- Ability to move
- Documented vs. undocumented

Secondary vulnerability factors:

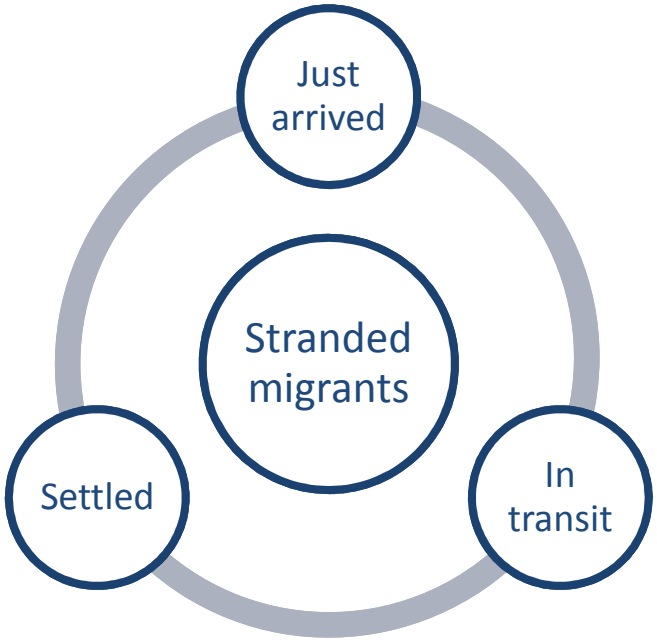
- The migration journey . Migrant in transit are invisible
- Humanitarian crisis and migrants' human rights

Chetail, V., Braeunlich, M (2013). Stranded Migrants. Resrach paper.Global Migartion Centre

Introduction

Complex Migration Flows (CMF): Health care challenges and multiple providers

First aid, basic health checks, trauma support.
Continuity of care, sexual and reproductive needs, psychosocial support
Legal protection. Spiritual support. Housing.
Entitlement to local resources and public services



Multiple stakeholders are involved and see their natural capacity to respond surpassed.

Nurses, Physicians. Psychologists
Social workers. Law enforcement officers
Educators. Religious service providers
Volunteers. Activists …and more

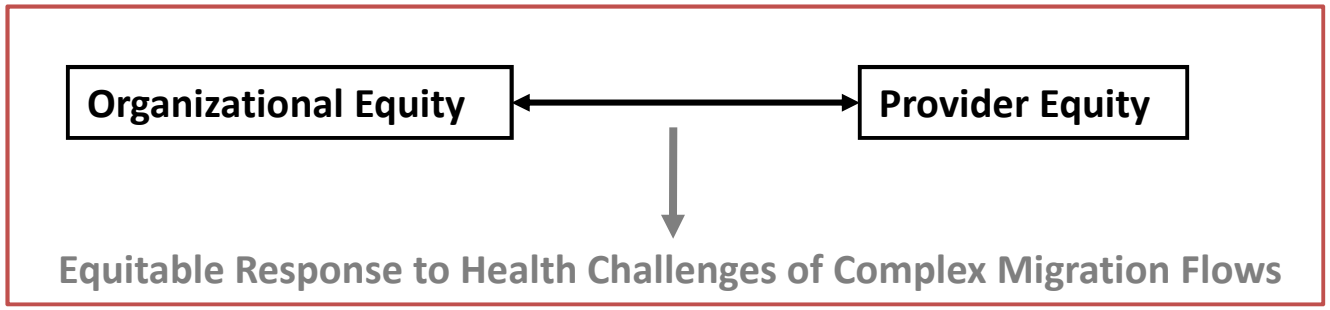
These challenges can be addressed from an cultural equity-based capacity building

Theoretical Framework

Cultural Equity-based Capacity Building (CECB)

CECB is a multi-level process that transforms organizational infrastructures to **identify strengths** and **increase organizational and individual capacity** to ensure the implementation of **equitable health care** for migrants and diverse populations.

Culture shapes values, beliefs and worldviews**. If culture is not explicitly considered, there is an implicit assumption that the dominant culture provides the functional standard.**



(Suarez-Balcazar et al., 2009; Wallace & Villa, 2003)

Theoretical Framework

CECB: Organizational Equity

Organizational factors provide the **critical infrastructures for optimal CECB**

Equity healthcare standards (EHS) developed by the TF MFH overcome the narrow cultural criteria and **adopt an equity approach.** This approach allows recognizing the **multiple sources of vulnerability [primary and secondary]** of migrants and displaced persons associated with migrant status, ethnicity, religious beliefs, sexual orientation, poverty, violence, less access to services, worse housing, precarious employment, etc.

Policy: Ensuring the creation of an equity mission, monitoring and assuring equity in all relevant organizational processes;

Access: Identifying barriers, promoting communication and assuring access for excluded people;

Quality: Acknowledging the unique characteristics of the individual and acting on theses to improve individual health and wellbeing;

Participation: Ensuring collaborative organizational atmosphere and effective user involvement in service planning, delivery and evaluation;

Promotion: Sponsoring activities to deliver innovative services to disadvantaged diverse populations.

Theoretical Framework

CECB: Provider Equity

Becoming ***cultural [migrant] equitable competent*** is "an on-going contextual, developmental and experiential process of personal growth that results in improved ability to adequately serve users who look, think and behave differently from us" (Suarez Balcazar et al., 2011, p.5).

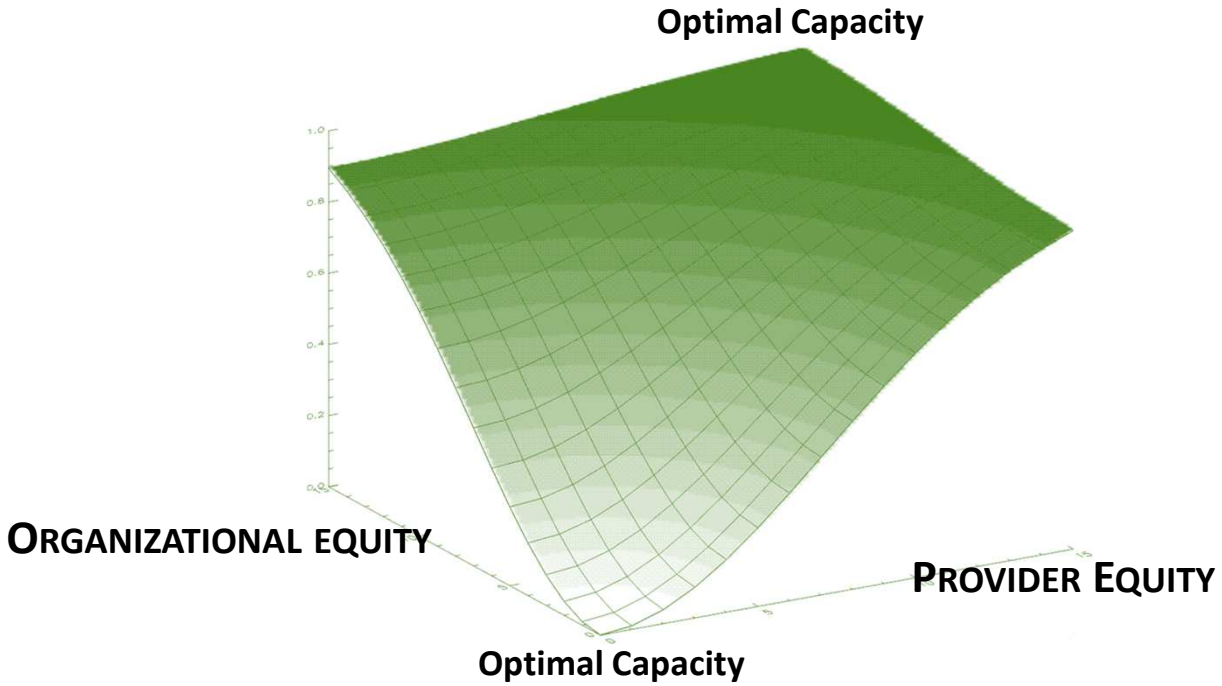
Capacity building of providers are infused with cultural elements that inform which approaches are more successful with a given population (SenGupta et al. 2004)

Skills: Understanding and appreciating differences in health beliefs and behaviors, as well as recognizing and respecting for the unique circumstances that displaced persons are suffering.

Organizational influence: Being able to influence within their organizational settings to adjust their professional practices to provide effective interventions.

Theoretical Framework

CECB: A multilevel process

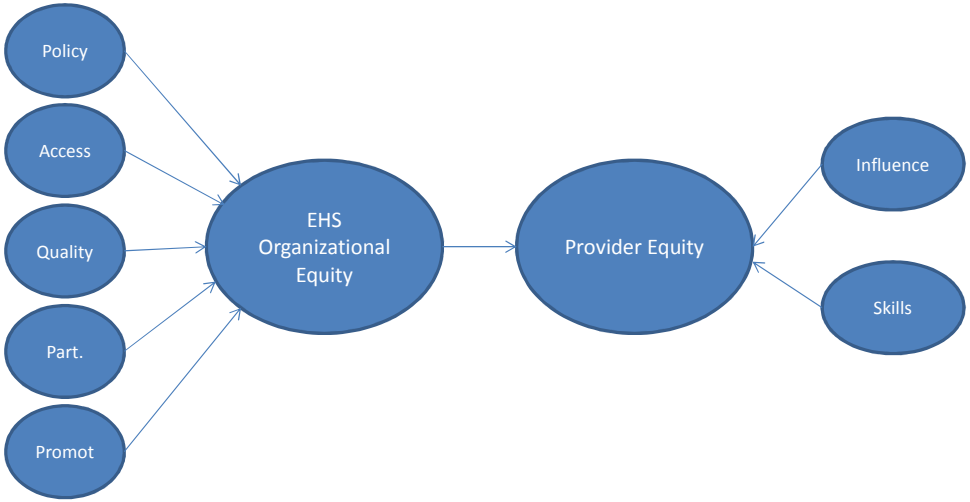


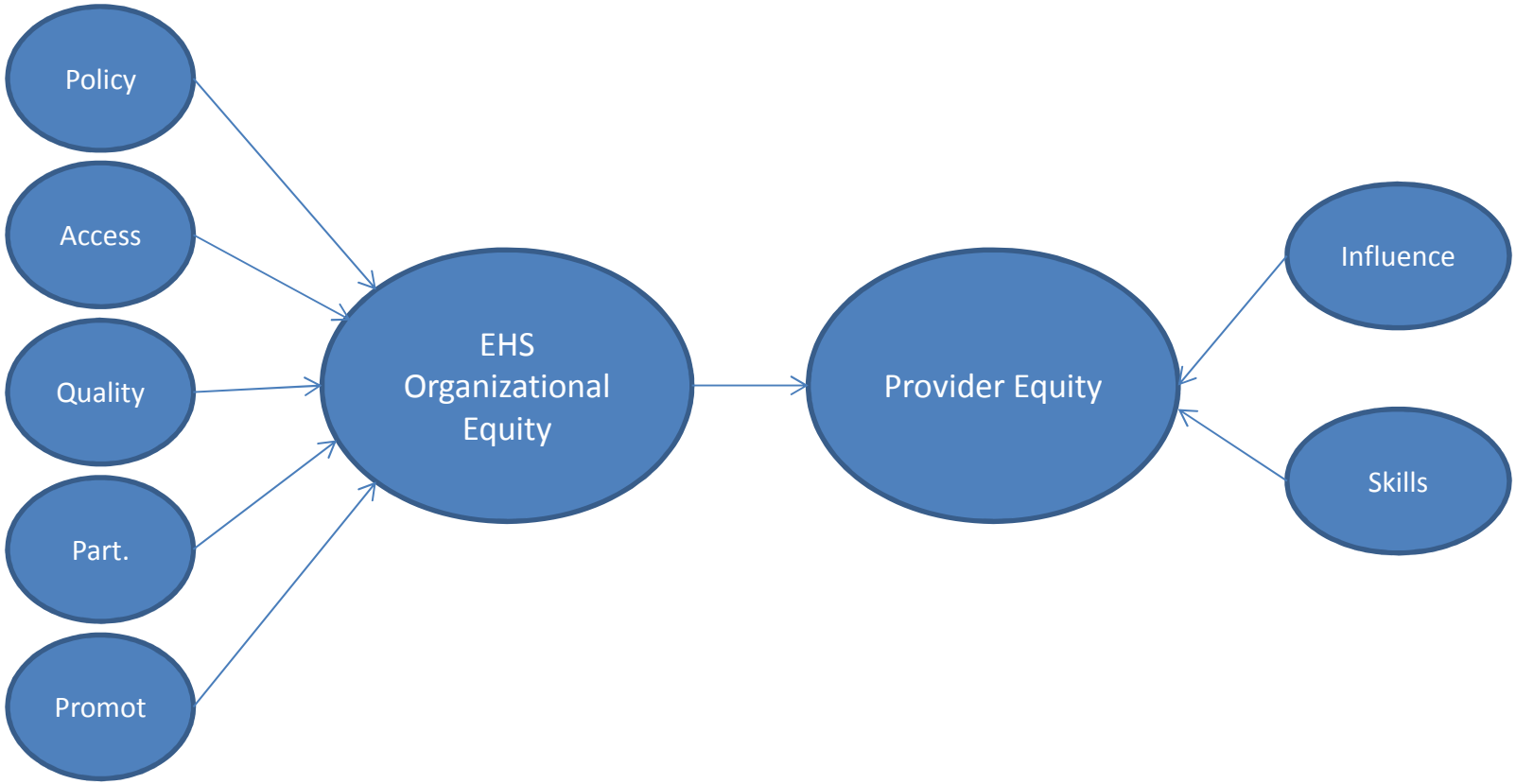
CECB is facilitated when organizational standards are present **along with** strong provider readiness and competence, and when attention is given to culture and context

Objective and Questions

The purpose of this study is to offer preliminary evidences that Equity Healthcare Standards increase the capacity of providers to effectively respond to needs of CMF in Europe's Mediterranean regions.

- Are EHS critical organizational predictors of cultural equity at organizational level?
- Are cultural/migrant skills and organizational influence critical predictors of cultural equity at provider level?
- Are organizational and provider predictors interrelated?

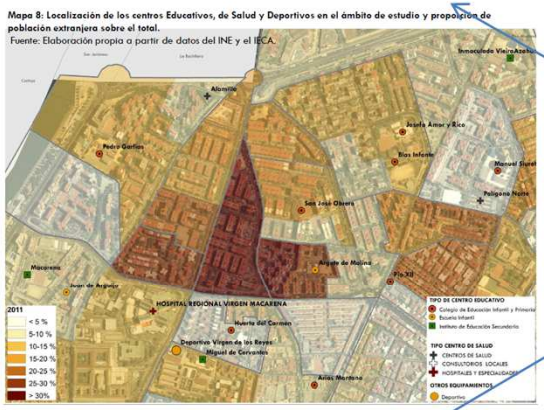


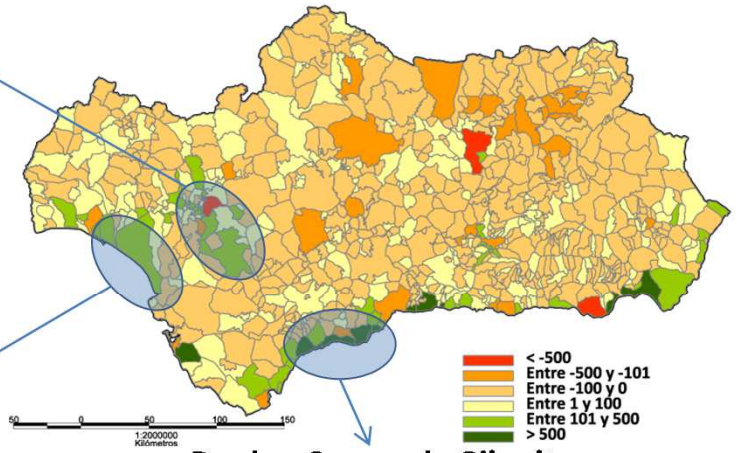

Policy
Access
Quality
Part.
Promot
EHS Organizational Equity
Provider Equity
Influence
Skills

Methods

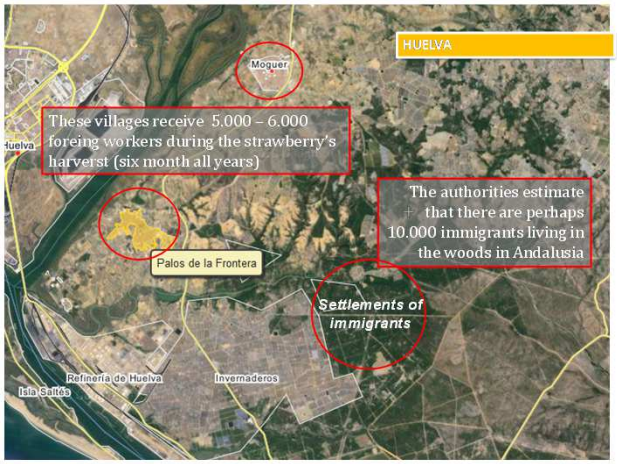
Study design: Andalusia enclaves

Urban: Distrito Macarena- Sevilla





Rural: El Condado - Huelva



Border: Campo de Gibraltar

13

Methods

Study design: Multiple services and health providers

PRIMARY HEALTHCARE CENTER HOSPITALS

NURSERY SCHOOLS

NGO,s CSO,s

SOCIAL CARE

LAW ENFORCEMENT INSTITUTIONS

Nurses, Physicians

Teachers Educators

Activists Volunteers Religious services

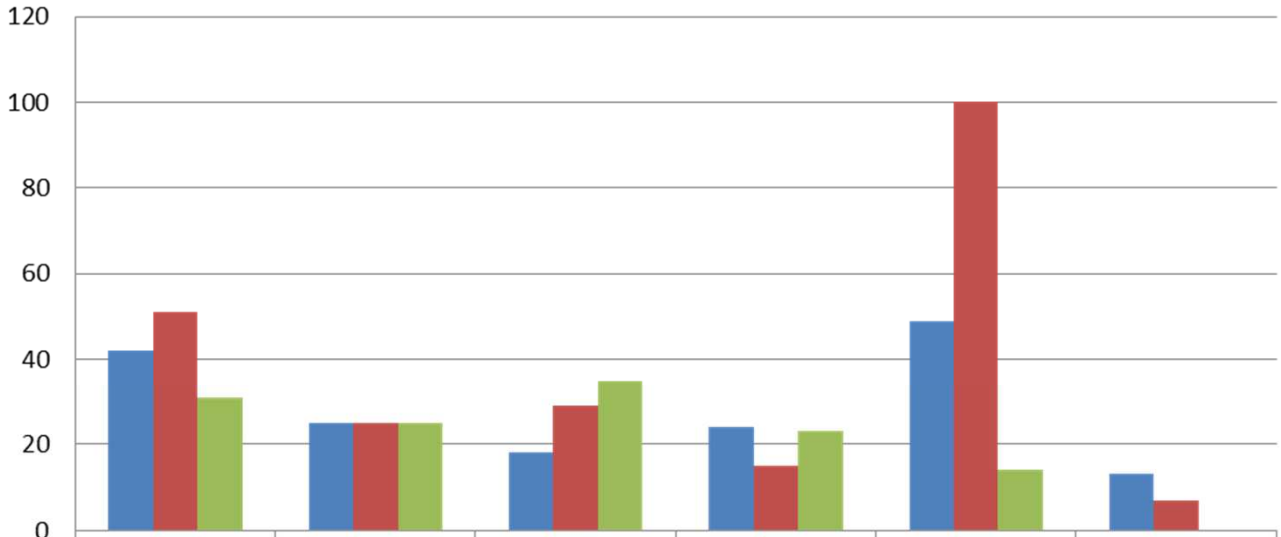
Social workers Psychologists

Police officers

Methods

Study design: Respondents

Sampling was intentional. It was conducted by organisations in three multicultural areas: Huelva (rural), Seville (urban) and Algeciras (border).

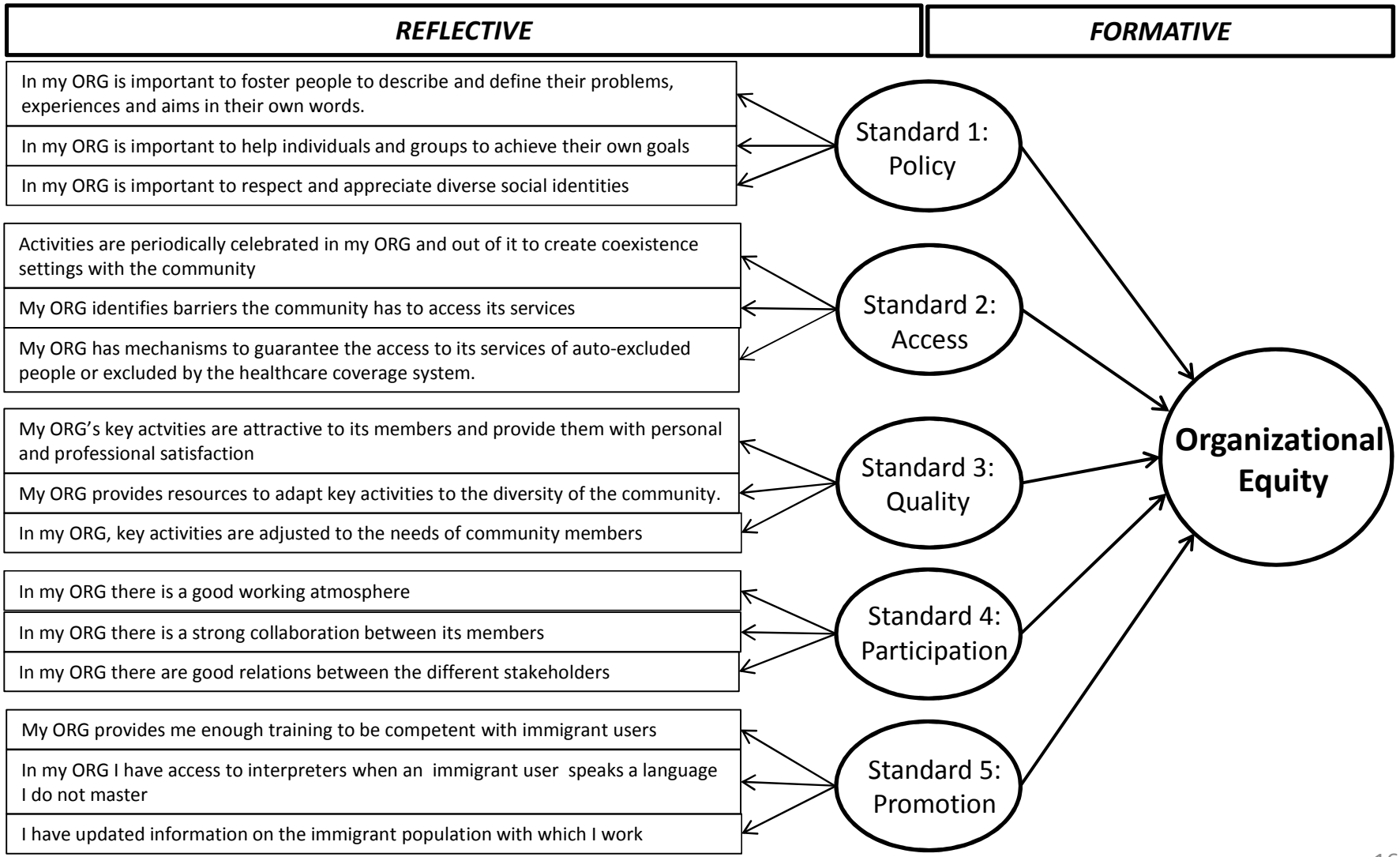


	Educators	Healthcare providers	Social care providers	CBO providers	Law enforcement officers	Religious FBO providers
Urban (N=171)	42	25	18	24	49	--
Border (N=227)	51	25	29	15	100	7
Rural (128)	31	25	35	23	14	0

N= 522. 32.2% was women & 47.8% was men. The mean of years working in their organization was 12.90 (dt=10.29)

Methods

Assessment of organizational equity. Instrument

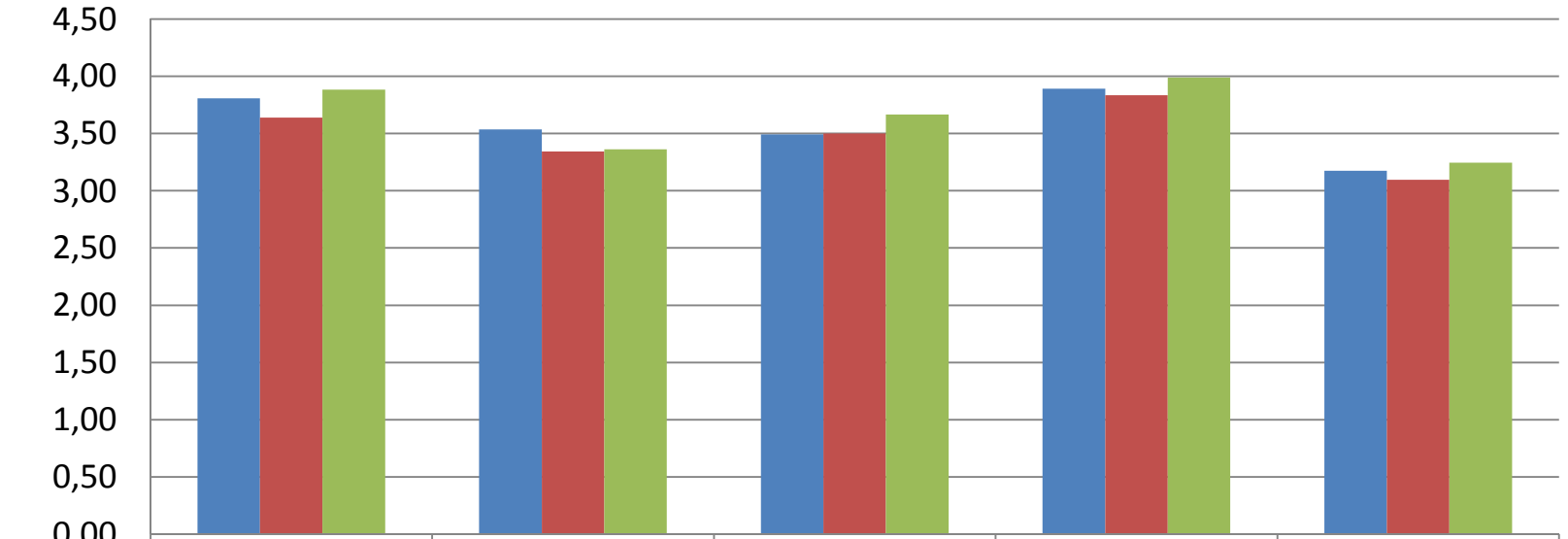


Methods

Assessment of organizational equity:

EHS Descriptive data

Mean scores in Equity standards by type of contexts



	Equity in Policy	Equity in Access	Equity in Quality	Equity in Participation/ Relations	Promoting Equity
Urban	3,81	3,54	3,49	3,89	3,18
Rural	3,64	3,34	3,50	3,83	3,10
Border	3,88	3,36	3,67	3,99	3,25

Respondents: Descriptive data

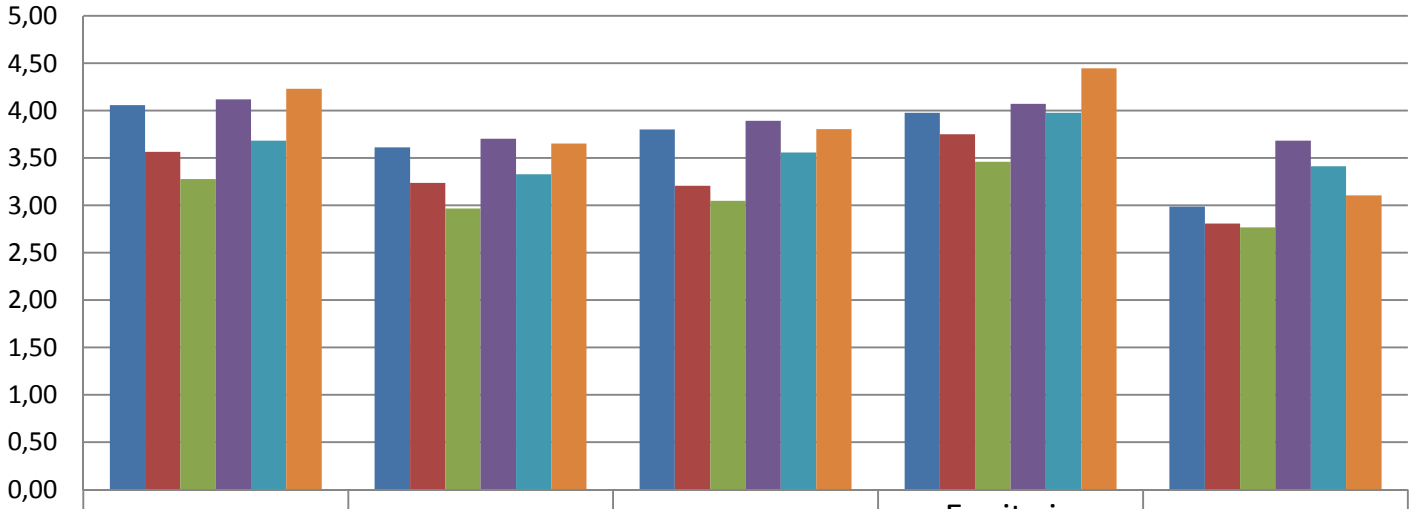
Mean scores in Equity standards by type of context

		Suma de cuadrados	gl	Media cuadrática	F	Sig.
Equity in Policy	Inter-grupos	4,81	2,00	2,41	5,03	**0,007**
	Intra-grupos	248,82	520,00	0,48		
	Total	253,63	522,00			
Equity in Access	Inter-grupos	3,77	2,00	1,88	3,07	**0,047**
	Intra-grupos	318,59	519,00	0,61		
	Total	322,36	521,00			
Equity in Quality	Inter-grupos	3,60	2,00	1,80	2,29	0,103
	Intra-grupos	403,55	513,00	0,79		
	Total	407,15	515,00			
Equity in Participation/Relations	Inter-grupos	2,18	2,00	1,09	1,57	0,209
	Intra-grupos	360,77	519,00	0,70		
	Total	362,95	521,00			
Promoting Equity	Inter-grupos	1,84	2,00	0,92	1,09	0,338
	Intra-grupos	440,95	520,00	0,85		
	Total	442,80	522,00			

Methods

Assessment of organizational equity: EHS Descriptive data

Mean scores in Equity standards by type of organization



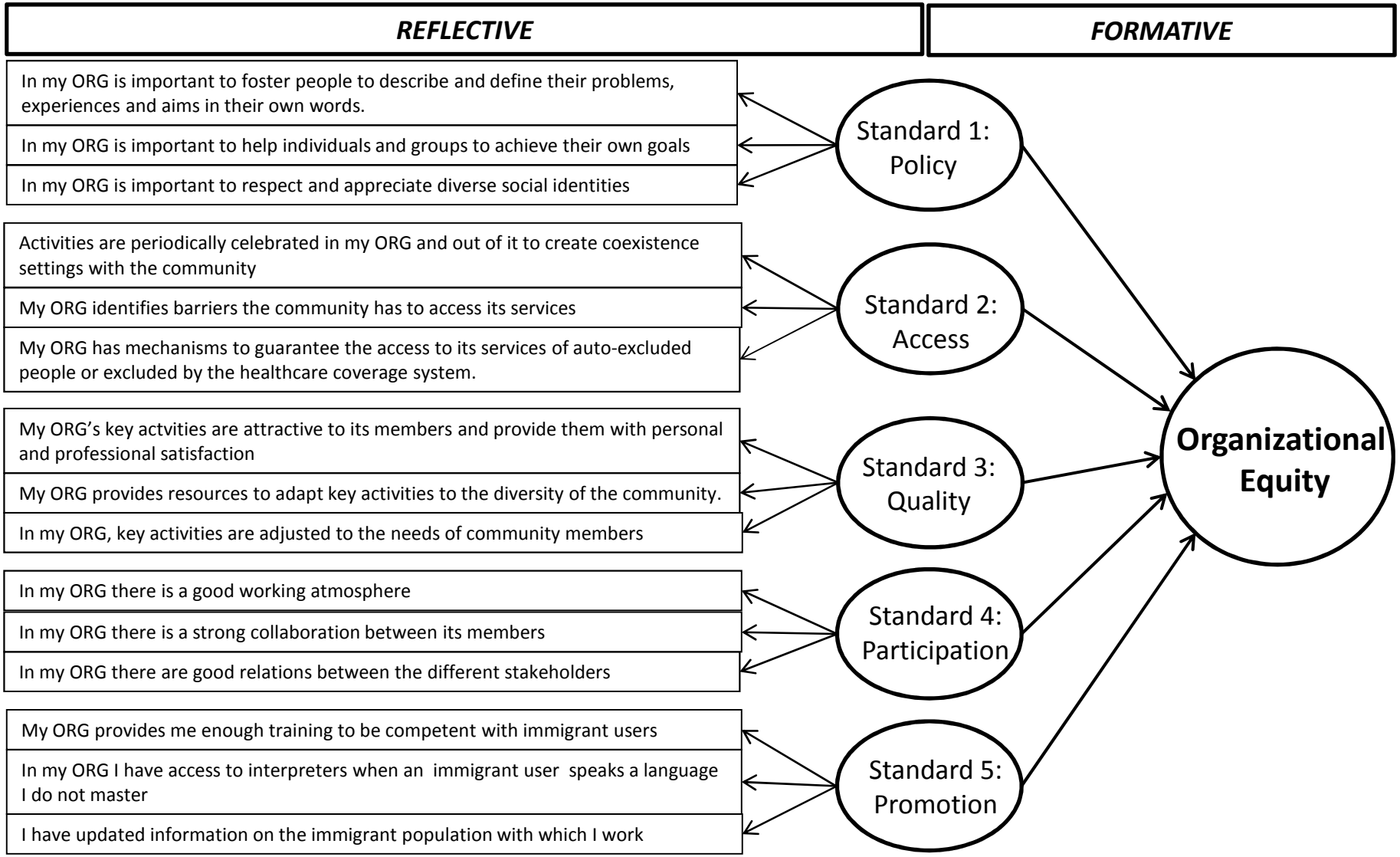
	Equity in Policy	Equity in Access	Equity in Quality	Equity in Participation/ Relations	Promoting Equity
Educators	4,06	3,61	3,80	3,98	2,99
Healthcare providers	3,57	3,24	3,21	3,75	2,81
Social-care providers	3,28	2,97	3,05	3,46	2,77
C-BO providers	4,12	3,70	3,89	4,07	3,68
Law Enforcement Officers	3,68	3,33	3,56	3,98	3,41
F-BO providers	4,23	3,65	3,80	4,45	3,11

19

Respondents: Descriptive data

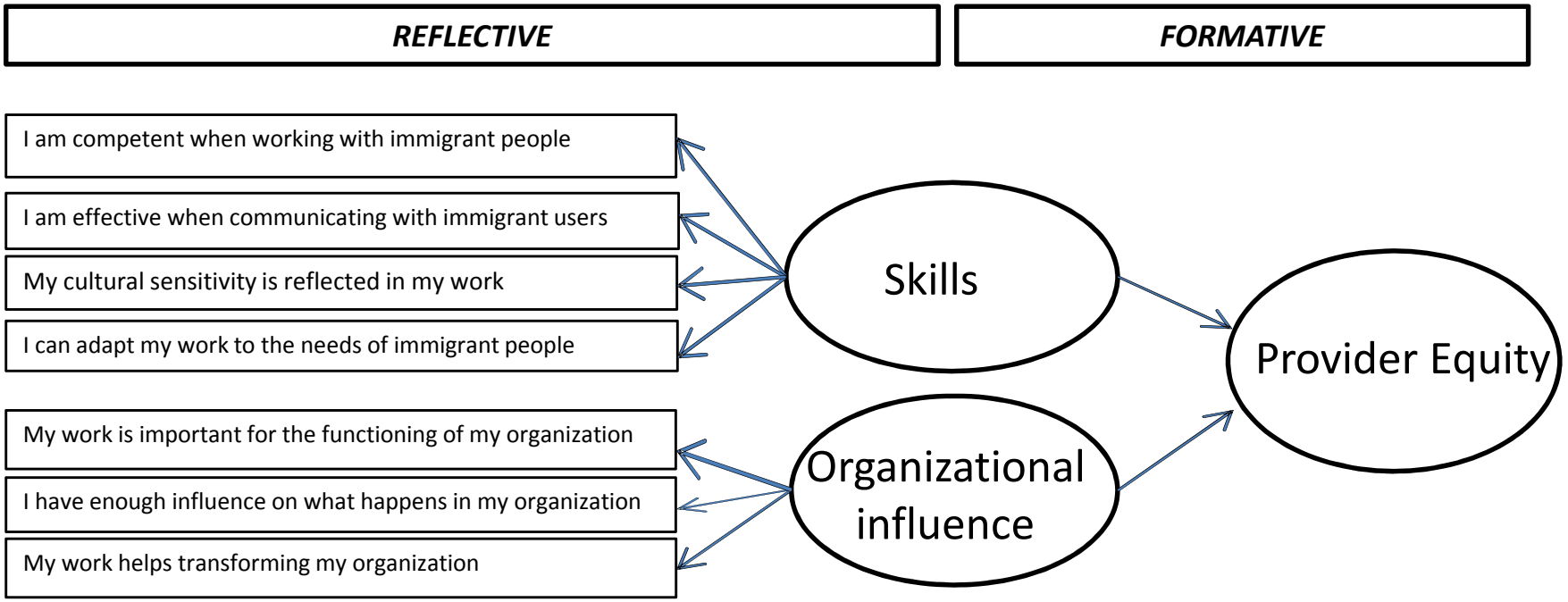
Mean scores in Equity standards by type of organization - ANOVA

		Suma de cuadrados	gl	Media cuadrática	F	Sig.
Equity in Policy	Inter-grupos	42,53	5,00	8,51	20,83	**0,00**
	Intra-grupos	211,10	517,00	0,41		
	Total	253,63	522,00			
Equity in Access	Inter-grupos	28,30	5,00	5,66	9,93	**0,00**
	Intra-grupos	294,06	516,00	0,57		
	Total	322,36	521,00			
Equity in Participation/Relations	Inter-grupos	22,59	5,00	4,52	6,85	**0,00**
	Intra-grupos	340,37	516,00	0,66		
	Total	362,95	521,00			
Equity in Quality	Inter-grupos	41,69	5,00	8,34	11,64	**0,00**
	Intra-grupos	365,45	510,00	0,72		
	Total	407,15	515,00			
Promoting Equity	Inter-grupos	55,40	5,00	11,08	14,79	**0,00**
	Intra-grupos	387,40	517,00	0,75		
	Total	442,80	522,00			


REFLECTIVE
FORMATIVE
In my ORG is important to foster people to describe and define their problems, experiences and aims in their own words.
In my ORG is important to help individuals and groups to achieve their own goals
In my ORG is important to respect and appreciate diverse social identities
Activities are periodically celebrated in my ORG and out of it to create coexistence settings with the community
My ORG identifies barriers the community has to access its services
My ORG has mechanisms to guarantee the access to its services of auto-excluded people or excluded by the healthcare coverage system.
My ORG's key actvities are attractive to its members and provide them with personal and professional satisfaction
My ORG provides resources to adapt key activities to the diversity of the community.
In my ORG, key activities are adjusted to the needs of community members
In my ORG there is a good working atmosphere
In my ORG there is a strong collaboration between its members
In my ORG there are good relations between the different stakeholders
My ORG provides me enough training to be competent with immigrant users
In my ORG I have access to interpreters when an immigrant user speaks a language I do not master
I have updated information on the immigrant population with which I work
Standard 1: Policy
Standard 2: Access
Standard 3: Quality
Standard 4: Participation
Standard 5: Promotion
Organizational Equity

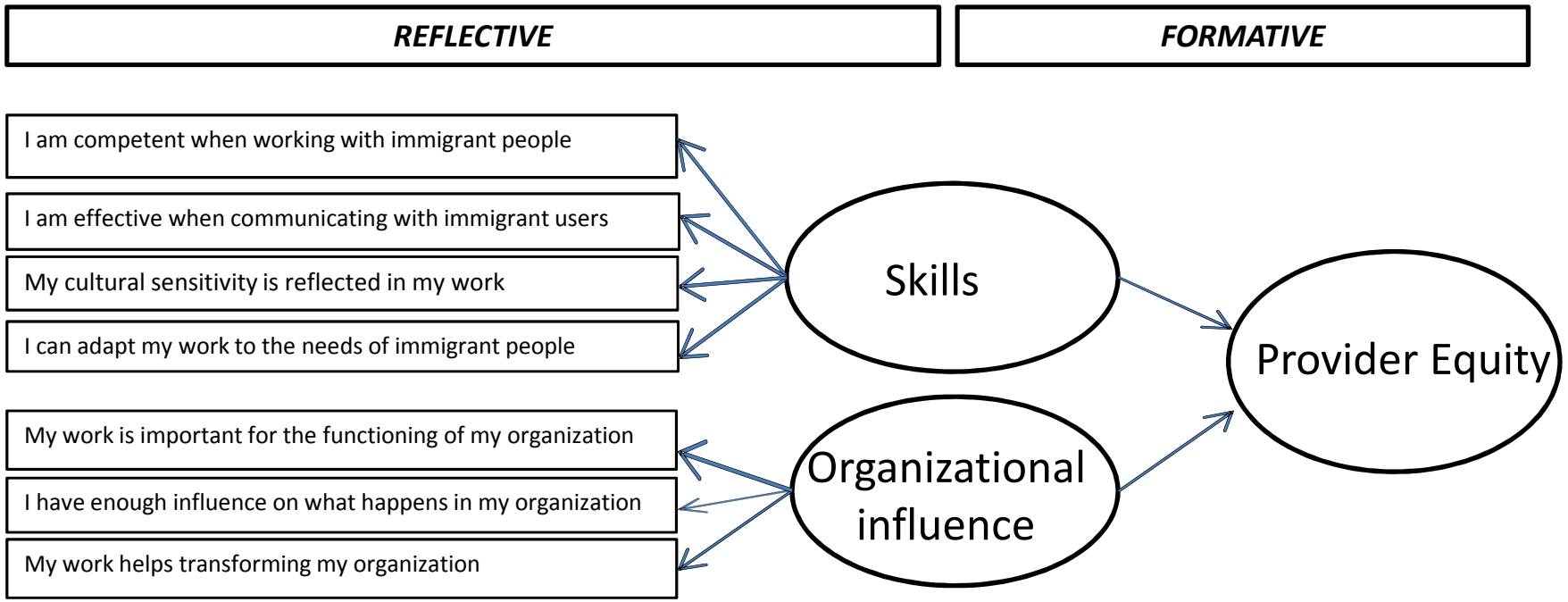
Methods

Assessment of provider equity. Instrument



Suárez-Balcázar et al., 2011. Cultural Competence Assessment Instrument

Albar et al, 2012. Spanish adaptation of the scale of psychological empowerment in the workplace



Suárez-Balcázar et al., 2011. Cultural Competence Assessment Instrument

Albar et al, 2012. Spanish adaptation of the scale of psychological empowerment in the workplace

Methods

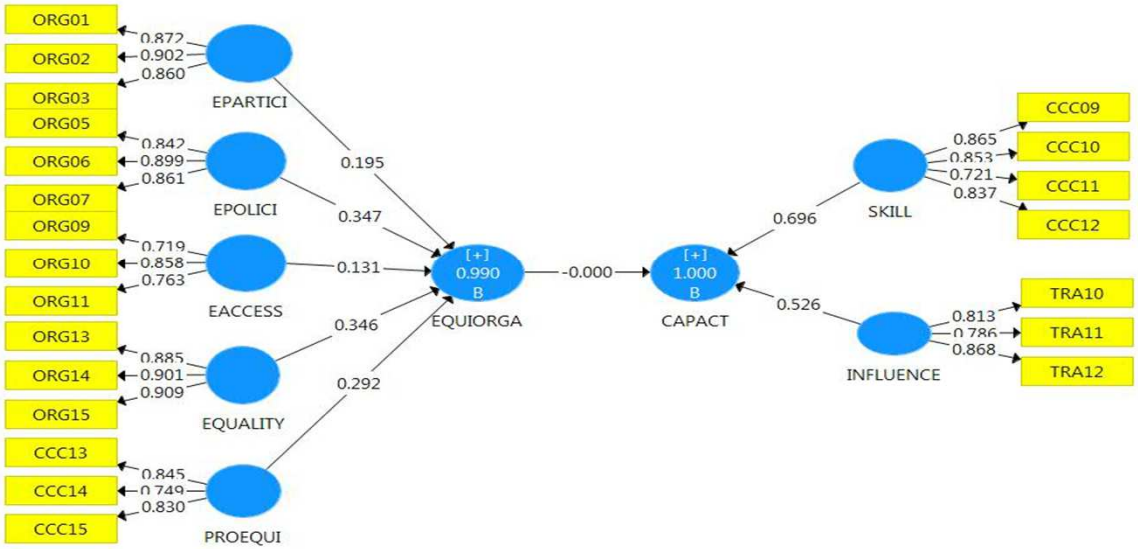
Statistical analysis: Partial Least Squares (PLS)

- PLS is a structural equation modeling as LISREL with a predictive focus rather that model fit focus
- PLS permits to test and optimize the model as a whole because it simultaneously tests the measurement model and structural model.
- PLS allows both formative and reflective constructs to be tested together

Results

Assessment of the measurement model

Reliability of reflective constructs and correlations of formative constructs



Internal consistency of reflective (first-order) constructs (standards)

	Cronbach's Alpha	rho_A	Composite Reliability	Average Variance Extracted (AVE)
SKILL	0.837	0.843	0.892	0.674
PROEQUI	0.748	0.790	0.850	0.655
INFLUENCE	0.762	0.766	0.863	0.678
EQUIORGA	0.893	0.913	0.907	0.401
EQUALITY	0.880	0.880	0.926	0.807
EPOLICI	0.835	0.835	0.901	0.753
EPARTICI	0.852	0.855	0.910	0.771
EACCESS	0.682	0.704	0.825	0.612
CAPACT	0.797	0.800	0.853	0.455

Impact of first order constructs in the second-order order construct (Equitable Multicultural Organization)

Outer Weights

Mean, STDEV, T-Val... | Confidence Interval... | Confidence Interval... | Samples | Copy to Clipboard: | Excel Format | R Format

	Original Sample (O)	Sample Mean (M)	Standard Deviation (STDEV)	T Statistics (|O/STDEV|)	P Values
EACCESS -> EQUIORGA	0.155	0.152	0.095	1.631	0.103
EPARTICI -> EQUIORGA	0.218	0.217	0.090	2.417	0.016
EPOLICI -> EQUIORGA	0.364	0.362	0.095	3.828	0.000
EQUALITY -> EQUIORGA	0.290	0.285	0.115	2.520	0.012
INFLUENCE -> CAPACT	0.654	0.649	0.072	9.048	0.000
PROEQUI -> EQUIORGA	0.296	0.297	0.078	3.793	0.000
SKILL -> CAPACT	0.573	0.574	0.073	7.849	0.000

Results

Assessment of the measurement model

Reliability and convergent validity of the reflective measurement model

Construct	Survey items	Loading	CR	AVE
Organizational Equity standards				
Equity in Policy	Policy1. In my organization it is important to foster people to describe and define their problems, experiences and aims in their own words	0.842	0.901	0.753
	Policy2. In my organization is important to help individuals and groups to achieve their own goals	0.899		
	Policy3. In my organization is important to respect and appreciate the diverse social identities of people	0.861		
Equity in Access	Access1. Activities are periodically celebrated in my organization and out of it to create coexistence settings with the community	0.719	0.825	0.612
	Access2. My organization identifies barriers the community has to access its services (e.g., identifying potential users)	0.858		
	Access3. My organization has mechanisms to guarantee the access to its services of auto-excluded people of excluded by the healthcare coverage system	0.763		
Equity in Quality	Quality1. My organization's key activities are attractive to its members and provide them with personal and professional satisfaction	0.885	0.926	0.807
	Quality2. My organization provides resources to adapt key activities to the diversity of the community	0.901		
	Quality3. In my organization, key activities are adjusted to the needs of community members	0.909		
Equity in Participation	Participation1. In my organization there is a good working atmosphere	0.872	0.910	0.771
	Participation2. In my organization there is a strong collaboration between its members and users	0.902		
	Participation3. In my organization there are good relations between the different stakeholders (leaders, providers, users)	0.860		
Equity Promotion	Promotion1. My organization provides me enough training to be competent in my work with immigrant users	0.845	0.850	0.655
	Promotion2. In my organization I have access to interpreters when an immigrant user speaks a language I do not master	0.749		
	Promotion3. I have updated information on the immigrant population with which I work (demographic, cultural, and epidemiological)	0.830		
Capacity to Act of Providers				
Migrant Competency	Skill1. I am competent when working with immigrant people	0.865	0.892	0.674
	Skill2. I am effective when communicating with immigrant users	0.853		
	Skill3. My cultural sensitivity is reflected in my work	0.721		
	Skill4. I can adapt my work to the needs of immigrant people	0.837		
Organizational Influence	Influence1. My work is important for the functioning of my organization	0.813	0.863	0.678
	Influence2. I have enough influence on what happens in my organization	0.786		
	Influence3. My work helps transforming my organization	0.868		

Results

Assessment of the measurement model

Factor structure matrix of loadings and cross-loadings

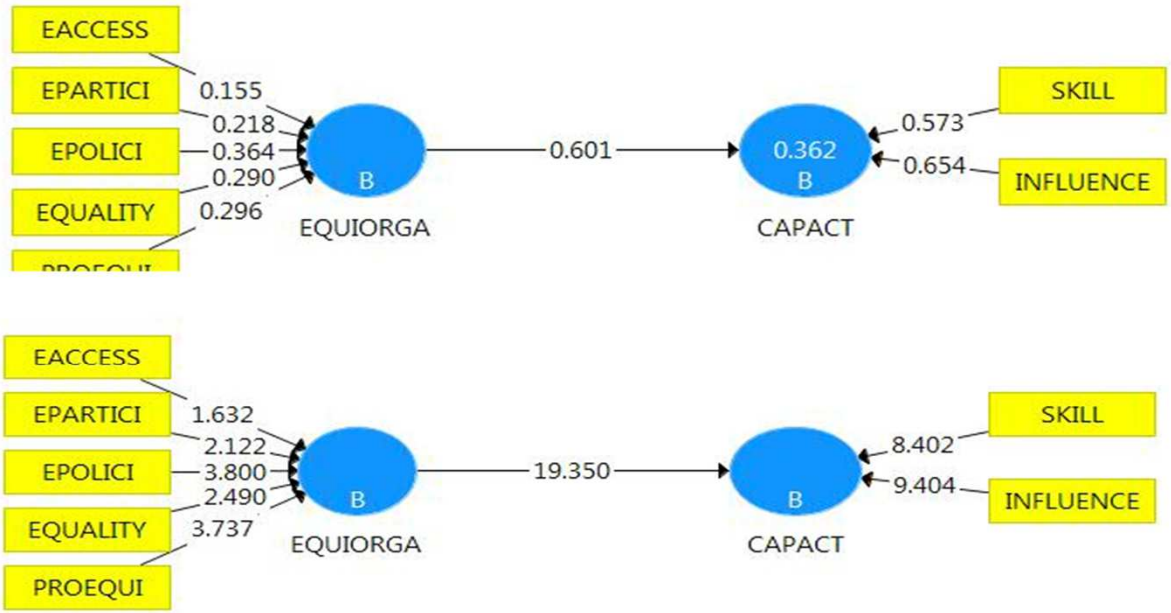
	Equity in policy	Equity in access	Equity in quality	Equity in participation	Equity promotion	Migrant competency	Organizational influence
Policy1	0.842	0.426	0.483	0.390	0.227	0.253	0.395
Policy2	0.899	0.453	0.447	0.280	0.208	0.253	0.351
Policy3	0.861	0.399	0.434	0.350	0.231	0.317	0.329
Access1	0.373	0.719	0.505	0.307	0.255	0.151	0.208
Access2	0.465	0.858	0.529	0.370	0.338	0.339	0.345
Access3	0.302	0.763	0.492	0.285	0.258	0.281	0.255
Quality1	0.457	0.589	0.885	0.471	0.547	0.395	0.395
Quality2	0.473	0.569	0.901	0.454	0.504	0.399	0.367
Quality3	0.484	0.590	0.909	0.462	0.417	0.352	0.346
Participation1	0.287	0.320	0.412	0.872	0.352	0.222	0.298
Participation1	0.372	0.361	0.434	0.902	0.371	0.254	0.340
Participation3	0.368	0.399	0.504	0.860	0.366	0.264	0.385
Promotion1	0.254	0.401	0.563	0.384	0.845	0-419	0.326
Peomotion2	0.083	0.104	0.241	0.225	0.749	0.142	0.136
Promotion3	0.237	0.301	0.437	0.357	0.830	0.241	0.224
Skill1	0.230	0.228	0.339	0.214	0.267	0.865	0.274
Skill2	0.233	0.254	0.324	0.213	0.293	0.853	0.282
Skill3	0.297	0.333	0.317	0.241	0.284	0.721	0.250
Skill4	0.286	0.303	0.417	0.263	0.342	0.837	0.266
Influence1	0.379	0.242	0.291	0.315	0.188	0.294	0.813
Influence2	0.335	0.286	0.358	0.318	0.270	0.227	0.786
Influence3	0.309	0.337	0.370	0.332	0.291	0.282	0.868

Note: Factor loading with its associate construct in bold

Results

Assessment of structural model

PLS results of proposed research model



Path Coefficients

Mean, STDEV, T-... | Confidence Inte... | Confidence Inte... | Copy to Clipboard: | Excel Format | R Format

	Original Sample (O)	Sample Mean (M)	Standard Deviation (STDEV)	T Statistics (|O/STDEV|)	P Values
EQUIORGA ...	0.601	0.611	0.030	19.852	0.000

Discussion and Conclusions

- The five standards included in the model allow to characterize the degree of equity in the organizations which participated in this study
- Each standard are properly measured through selected performance indicators.
- Indicators of skills and organizational influence of provider are good predictors of their individual capacity to equitably serve migrant users
- The degree of equity at organizational level is a good predictor of the capacity of providers to effectively respond to the health needs of CMF at border regions

Discussion and Conclusions

Regarding EHS developed by the TF HPH

- The structure that conform the five standards allows to define organizations as **Cultural Equitable Organization.**
- The **set of evidences** of sub-standards developed in this study allows to measuring EHS from the **perspective of multiple providers and stakeholders**.
- Our results offer a preliminary **empirical validation of EHS** for their application to **organizations** that provide care to **CMF in at-risk [border] communities which confront similar challenges than Andalusia**.

Discussion and Conclusions

Implications

- This findings highlight the importance to continue deepening in the evaluation of standards at
  - different levels (i.e. organizational, providers, users)
  - multiple and different stakeholders
  - in vulnerable geographical contexts with different population living in extreme poor conditions.
- These findings encourage to use multiple methods and strategies to assure equity health care worldwide.

Discussion and Conclusions

Implications

- **At policy level**, EHS will help in the design of health **policies based in human rights** from multiple sectors and contexts to cope with CMF's challenges.
- **At organizational level**, standards facilitate the assessment of equity , the **improvement of capacity to respond of providers**, as well as the establishment of **collaborative relations** with other organizations.
- **At community level,** standards guide organizations to **empower and take care of users** and community's health.

Cultural [Migrant] Equity in Healthcare Organizations: the Relation between Organizational Standards and Provider Competences

Manuel García-Ramírez
CESPYD – University of Seville

International Network
Health
Promoting
Hospitals & Health Services