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Migrant crisis in Europe: implications for intensive care specialists

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Europe is currently facing a sudden and dramatic influx of migrants the like of which has not been experienced since the Second World War. In Germany alone, the number of migrants in 2015 has already exceeded 500,000 and current estimates suggest that the final figure may well be over a million by the end of the year (Fig. 1) [1]. This article discusses first the general implications of this sudden change in the population size and then the possible impacts for critical care.

In Germany, the treatment of these people is initially organized into a three-level structure:

- First, every newly arrived person undergoes a kind of "triage" at an emergency pick-up camp, usually located in a large industrial or sports hall or a collection of military tents. Due to the high workload and the exhaustion of the refugees, the personnel of these camps comprises security staff, professional interpreters, administrators, and—of course—physicians and nurses. This first inspection is planned to identify patients who potentially require immediate hospital treatment, due either to conditions endangering others, i.e., contagious, infectious diseases such as open tuberculosis (an initial chest X-ray is mandatory), scabies or lice, or to life-threatening diseases (extreme fatigue, obvious organ dysfunction, critical pregnancy, severe infections such as endocarditis etc.). According to a rough estimate, between 1 and 2 % of the refugees are selected by this procedure.
- The vast majority of people pass this initial triage and are transported to central camps. Here, there is a more sophisticated medical examination including vaccination status. In parallel, an extended process of registration takes place to prepare the formal applications for political asylum.
- Finally, the refugees are distributed to all 16 federal states of Germany according to predefined quotas. In addition, they receive a "health ID" to improve the organization of medical services.

Most of the refugees are basically young and "healthy" (otherwise they would never be able to complete such a strenuous journey), and the main challenge at present is the administrative effort to organize the three types of

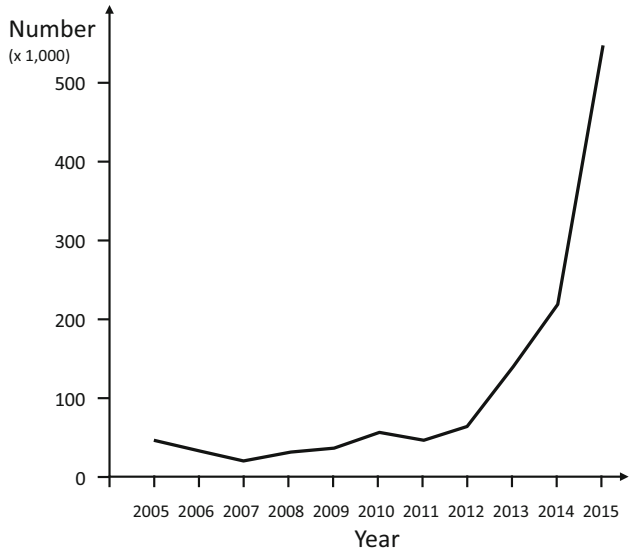

Fig. 1 Number of applications for political asylum in Germany from 2005 until 2015 (estimated)

camps. Of note, the refugees' areas of origin are quite heterogeneous (ESM1) [2]. Although the top country is Syria, the next three countries (Albania, Kosovo, Serbia) are all from the Balkans and are not classified as "war regions" (this is partially different in other European Union countries). Hence, these people's applications for political asylum are mostly turned down (ESM1), in contrast to refugees from Syria, Iraq and Eritrea, for example.

This sudden change in population size clearly has implications for the delivery of health care and may entail some issues for the high-end specialities such as ours. Critical care is a costly specialty to run in terms of both financial resource requirements and staffing. The high costs mean that the numbers of beds hospitals offer for this level of care are sometimes restricted, perhaps even below the level of demand. Many countries have recently woken up to the fact that the future demand for critical care is going to increasing due to the changing population (increasing, growing older and with a higher prevalence of co-morbid conditions). This future requirement for expansion is challenging, as it requires planners to provide both additional resources and additional trained staff. The planning procedures do not take into account sudden changes in population size of the kind that may occur during a migration crisis. This has the potential for destabilizing the status quo and may result either in patients who would previously have been admitted to critical care now being denied this option or in patients being discharged prematurely to create space for others.

Since the number of intensive care unit (ICU) beds per unit of population in Germany is rather high compared with other European countries [3], the challenge for the hospitals is not completely about capacity, but also involves the reimbursement of costs. The German health care system is based on insurance (i.e., it is not tax-based), but the insurance companies are not responsible for newly arrived refugees and migrants. Reimbursement has to be organized from local and/or regional social security offices, which is both a huge administrative effort and a considerable threat for the budgets of these offices. Finding a fair, quick and feasible process for providing adequate medical service for refugees is currently a major challenge for politicians in Germany.

Workforce planning for critical care is an extremely complex issue. It can take well over 10 years to train the next cadre of intensive care specialists, so predicting future requirements well in advance is clearly important. Many countries restrict the numbers of doctors going through training programs for economic reasons, making it difficult to increase numbers in one specialty without affecting other medical disciplines. Similar issues are faced in nursing. The net result of these relatively fixed staffing numbers is that adjusting for short-term changes in need, for instance when the population suddenly swells, can be particularly challenging. One of the governing principles of the European Union (EU) is free movement of workers between European member states. This has worked well in medicine, with many doctors and nurses migrating from some of the southern European countries to the north for work experience and training and then returning home later in their careers. This has worked well for those northern European countries that have come to depend on this medical and nursing workforce. As the politics of the current migration crisis evolve, we fear that moves to tighten up national borders may have an unintended consequence on how hospitals run these important services, by restricting access for the staff. The flip side to this coin is that some migrants are also physicians. According to national laws, they are not allowed to work in hospitals in their new country unless they can prove their credentials, which is likely to be extremely difficult. They could, however, make very useful contributions to the ICU team: language, culture, expertise. The governments of the EU should move to ease the necessary authorization for being recognized as MD.

In most European countries, plans for expanding hospital capacity have been developed for surge situations such as pandemic influenza or large-scale terrorist attacks [4–6]. Some of the proposals for expanding ICU capacities are summarized in ESM2. Some solidarity between regions and countries within Europe will inevitably be necessary, meaning that the consequences we have described for Germany may be replicated in other parts of the continent, perhaps in areas where the health care services are less well resourced and therefore may find it less easy to adapt. Organization of European ICUs should allow admission of migrants requiring acute care. Admission and discharge policies based on the need for

ICU treatment (distributive justice) should be defined [7, 8]. Prioritization should be based solely on severity and expectation of recovery, irrespective of the patient's origin or religion.

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