Migration and health in 2019

A summary report of the track on Migration and health

at the 12th European Public Health conference 2019 in Marseille, France

The 12th European Public Health conference was held between 20 - 23 November

2019 in Marseille, France. This report summarises the key messages from the track on

Migration and health.

| Key Messages

1. Building bridges for solidarity means leaving no one behind; migrants, regardless of status or definition, must be included in health policies just as migration policies must include health. Anti-science, anti-immigration and xenophobic sentiments, justify politically coloured health policies that increase health inequities for migrants.

2. Evidence-informed health policies should ensure the health needs of migrants are fully addressed and no one should die or be put in danger by limited or no access to healthcare. The public health narrative needs to evolve to support greater health equity.

3. Migrant health research, is crucial to generate valid data to inform policy makers in order to plan, implement and adjust health interventions and services. Diversity in our societies must be acknowledged; practices and interventions should be adapted and evaluated taking into account the needs and context.

| Content

| Defining the problem: Difficulties in classifying immigrants and its policy implications

"Immigration leads to strong and polarized public and political debates in Europe and the Western world more generally. In some of these debates, migrants are described as either having little choice but to migrate (involuntary) or as migrating out of their own free choice (voluntary). In two studies and using a social psychological perspective, native Dutch respondents were asked about their support for policies aimed at rights and public assistance to perceived voluntary and involuntary migrants… Stronger agreement with migration being voluntary was associated with lower policy support, while agreement with migration being involuntary was independently associated with higher support… Perceived involuntariness of migration elicited feelings of empathy and therefore higher support for newcomers. In contrast, perceived voluntariness elicited stronger anger and therefore less support."[1]

One of the most interesting discussions of the week took place in the pre-conference session on migrant health, as participants sat down in small groups to discuss some of the fundamental questions of migrant health. First and foremost, who is a migrant? The entire premise of a migrant health track, or migrant centered approaches to health care presupposes an ability to define and classify migrants. Yet, as attendees of this session discussed, classifying migrants is actually much more difficult than it first appears, and definitions are much less objective than lawmakers would have us to believe.

Most of us are familiar with terms such as 'refugee', typically defined as a person who has been forced to flee their country of origin and cross-national borders to find safety. Most of us have also heard of 'internally displaced persons', who have had to flee their homes but remain within their country of origin. 'Asylum seeker' may apply to either of these categories. But other descriptive terms may also be used to classify to migrants, such as 'forced' and 'economic', that seem to imply to the listener very different levels of urgency and deservingness of state resources and public sympathy. 'Legal', 'undocumented', or 'irregular' are also terms frequently used to describe migrants and their relationship to citizenship records in a country of

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[1] Verkuyten, Maykel, Kieran Mepham, and Mathijs Kros. "Public attitudes towards support for migrants: the importance of perceived voluntary and involuntary migration." *Ethnic and Racial Studies* 41.5 (2018): 901-918.

residence, and correlate, in turn, with an expectation of how a person should or will interact with state institutions.

With anti-immigrant sentiments running high in almost about every country, terms that describe the conditions under which a migrant is presumed to have enter the country may be highly predictive of the type of treatment they can expect to receive from the government and the general public. These types of classifications are rarely as objective as many people tend to think, and their connotations have not remained static overtime. In the 20th century, after the world had begun to reckon with the scale of the destruction of World War II, multilateral institutions such as the United Nations and the WHO came into existence and, with them, international human rights norms and treaties on the recognition and treatment of refugees. In the aftermath of the war, refugees were viewed as highly sympathetic and, for the most part, deserving of shelter and support. In recent decades, mounting dismissal of international institutions and norms, corresponding a wave of populism and pseudo-fascism, has reversed some of these 20th century trends. The neediest (insofar as people can be quantified on a neediness scale), might be perceived as no longer welcome, but shunned as a burden on the state. Those who already have professional qualifications and good financial standing (in other words, the least needy) are usually more welcomed as contributors and 'productive' citizens. Nor should race be ignored as a powerful factor in these calculations. The very existence of Western identity is, for some, being called into question as majority-white countries in Europe receive migrant flows comprised predominantly of people of color. White migrants, for example from former Soviet states, on the other hand are viewed as less troublesome, given their ability to visually merge with the country's existing population. The fact, however, that a shift in the racial phenotype of a European population could so deeply shake the identity of many is telling. National identity is closely linked to theories of the state, and for those with a narrow and racially homogenous conception of national identity, a theory of state that excludes newcomers or those who cannot conform to an existing ethnic or religious identity results logically in the denial of state resources, such as healthcare, to migrants.

| Social determinants of health and well-being

"[The] unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies [and] *unfair economic arrangements, where the already well-off and healthy become even richer and the poor who are already more likely to be ill become even poorer..."[2]*

Social determinants of health are elements of an individual's socioeconomic and environmental positionality, that impact their physical and mental health and determine how they interact with health systems and infrastructure which may be linked to migrant status as well. WHO includes the social determinants of health as the most important:

1. "Income and social status: higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health.
2. Education: low education levels are linked with poor health, more stress and lower self-confidence.
3. Physical environment: safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health. Employment and working conditions: people in employment are healthier, particularly those who have more control over their working conditions
4. Social support networks: greater support from families, friends and communities is linked to better health. Culture - customs and traditions, and the beliefs of the family and community all affect health.
5. Genetics: inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses. Personal behaviour and coping skills – balanced eating, keeping active, smoking, drinking, and how we deal with life's stresses and challenges all affect health.
6. Health services: access and use of services that prevent and treat disease influences health
7. Gender: Men and women suffer from different types of diseases at different ages."

Migrants, for structural and policy reasons, tend to experience some of the most detrimental social conditions which, in turn, affect their health in the short and

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[2] World Health Organization. *Closing the gap in a generation: Health equity through action on the social determinants of health.* World Health Organization, 2008.

long term. A migration background in itself is not a determinant of poor health, but many of the conditions and environments with which migration is associated (political violence, sexual violence, human trafficking, crowded and unsanitary conditions of refugee camps, poverty...etc.) are closely associated with poor health outcomes. Thus, the migrant status itself can be seen as an independent determinant of health and the outcomes could be in fact both positive and negative.

Although seemingly semantic, there is an important difference between poor health outcomes due to *having migrated*, and poor health outcomes due to *being a migrant*. Distinguishing between the two has important humanitarian and policy ramifications. If we accept that poor health outcomes are inherent to a person being a migrant - a claim which has been consistently debunked in the literature - we open the door to discriminatory policy that advocates for excluding migrants on the basis of their migrant identity which, of course, furthers gaps in health outcomes between people of different backgrounds and social strata, ultimately exacerbating the original problem. By contrast, when we identify the true social and environmental risk factors, the logical response is to create policy that seeks to ameliorate the unhealthy conditions currently associated with migration, to allow migrants to remain healthy or become healthier as they transition to life in a new country.

Unfortunately, even when we address some of the conditions that migrants encounter on their journey from their country of origin to their destination, and even when we seek to include migrants within existing systems in terms of allowing for comprehensive coverage for migrants, conditions that migrants face within their new home country that are seemingly unrelated to healthcare can also worsen health.

One clear example is immigration policy itself. In countries with strict and restrictive migration policies, migrants (and especially undocumented migrants) experience elevated levels of chronic stress, which is linked to higher instances of all types of ailments including heart disease, high blood pressure, high cholesterol, Type II diabetes, and depression, among others. So even if undocumented migrants are receiving full-spectrum healthcare, threats of possible deportation, incarceration or family separation, and barriers to integration into the job market, for example, can cause the health status of a migrant community to gradually deteriorate. **Again and again evidence demonstrates that a society that is hospitable to migrants across all policy nexuses will improve large-scale health outcomes. Societies that actively marginalize migrants and push them out of mainstream societal institutions, whether explicitly health-related or not, will erode health and quality of life.**

| Discrimination, access barriers and stigma

"A migration background is not itself a risk factor."

- Claudia Santos-Hövener, German Robert Koch Institute

This powerful pronouncement from Santos-Hövener, backed by data from numerous sources[3], at the beginning of one of her sessions, set the stage for a critical discussion on migration's correlation with poor health outcomes. An understanding of this fundamental premise is crucial for any discussion of migrant health. The main reasons why health gaps between host communities and populations with migration background arise and gape further are distinct risk factors migrants face, among them (structural) discrimination i.e. restrictions on entitlement, access barriers to adequate treatment and socioeconomic disadvantages. Stigma is reinforced and compounded by the populist-driven spread of fake news, which portrays immigrants as dangerous, costly intruders who overuse state infrastructure.

Bernadette Nirmal Kumar, president of the EUPHA Section on migration and ethnic minority health, emphasized this message in the plenary session on migrant inequalities in urban settings, saying "Migrants are not a burden to the health system, we have enough data to contradict those myths, we just have to look at them!" Contrary to populist talking points, migrant populations do not use health services more often than majority populations. Due to the barriers to access mentioned above and, especially in the case of mental health, stigma, migrants tend to delay seeking medical help. In the case of undocumented migrants, the fear of deportation can be tied to avoiding help seeking at any official institution, among them health services. We know from dozens of studies that avoidance of preventative care in favor of emergency interventions is more costly and less efficient.[4,5] Migrants also make up a high proportion of the health workforce, serving as care workers and home aides, performing necessary tasks in this field, as in every other industry, that other workers scorn. Services upon which majority population members rely would short circuit without the often invisible labor of our migrant communities. With culturally-

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[3] The Lancet. "Harmful, unfounded myths about migration and health have become accepted, used to justify policies of exclusion." *ScienceDaily*, 2018.

[4] Musich, Shirley, et al. "The impact of personalized preventive care on health care quality, utilization, and expenditures." *Population health management* 19.6 (2016): 389-397.

[5] Wilson, Amy R., et al. "More preventive care, and fewer emergency room visits and prescription drugs: health care utilization in a consumer-driven health plan." *Benefits quarterly* 24.1 (2008): 46.

sensitive, strategically targeted and compassionate policies, barriers to access can be broken down, bridges built.

Firstly, migrants must be informed about their health rights and which services are available to them. Once migrants find their way into the health system, we have to make sure that they are treated adequately, with culturally-sensitive services with sufficient capacity. Studies also show that when people face discrimination in healthcare settings, they tend to put off doctor's visits indefinitely until problems become so severe that they can no longer bear the discomfort. By that point, expensive emergency care is the only option. Movsisyan & Matuchova, in their paper *Informing the development of a pilot intervention to improve migrants' healthcare assess in Brno, Czech Republic,* suggested different strategies to make this information more accessible to increase migrant's 'health literacy' and self-efficacy[6], including the provision of trainings for patients, employment of bilingual health staff or integration mediators and counselors, the sharing of multilingual information using technologies such as apps, and assurance that migrants have access to health insurance no matter their residential status.

In 2018, the Migration Policy Group of the European Commission recommended a number of institutional practices to make healthcare more migrant-sensitive. These included the integration of intercultural mediators (Belgium is currently the only member state with guaranteed provision of this service) as well as free interpretation services such as on-demand skype interpreters, and translation of information about respective health systems, online or in person. Our policy agenda must include the adoption of these top-down recommendations as national policies of European member states to achieve sustainable health equity. Cross-national exchange of lessons-learned and best practices is essential in order to reach this goal.

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[6] Movsisyan, N. K., and E. Matuchova. "Informing the development of a pilot intervention to improve migrants' healthcare assess in Brno, Czech Republic: Narine Movsisyan." *European Journal of Public Health* 29.Supplement_4 (2019).

| Mental health of migrants

"There is no health without mental health."

- Dr. Brock Chisholm, director of WHO 1948-1953

Liisa-Maria Voipio-Pulkki of Finland's Ministry of Social Affairs and Health deployed this succinct and timely quote from Dr. Chisolm in one of the conference's plenary sessions on the future of Europe's Public Health. Pre-, peri-, and post-migration stressors, such as exposure to trauma, poor living conditions, economic difficulties, unemployment (and lack of work permits), unclear states of residency, separation from friends and family members, language barriers, cultural and administrative hurdles to integration, lack of entitlement for benefits, and health services are among many factors that can make migrants and asylum seekers prone to mental health issues (see *Fig. 2*).

Compounding this difficult combination of factors, a mental health issue itself and the stigma that surrounds it can serve as an additional barrier for migrants who would otherwise seek help. Stigma, shame, language barriers, confidentiality concerns and cultural beliefs that differ from etiology as well as treatment concepts of the host country's mental health services provided pose major barriers to access, diagnose and treatment.

On an EU policy level, Anne Bucher, DG Santé, pointed out that mental health is under-prioritized, not only financially, but often in research agenda-setting. As health systems are nationally coordinated, mainstreaming prevention approaches into mental health care services, for example, must first happen on the national level before multilateral approaches to standardization and regulation are accepted by state lawmakers. So far, we have the data, and we have guides on best practices, for example WHO's *Mental health promotion and mental health care in refugees and migrants* (2018)[7].

We also heard at the conference from inspiring coordinators of grass-root projects that put those guidelines into practice on a national level. Maryam Gardisi of the German-based Ipso Care Center urged mental health policy makers to think outside of the box and create inclusive long-term solutions, highlighting non-

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[7] Mental health promotion and mental health care in refugees and migrants. Copenhagen: *WHO Regional Office for Europe* (2018).

pathologizing approaches and preventative care as key principles. To tackle both access barriers and lack of sufficient preventative care in the migrant mental health sector, Ipso Care Center trained young community guides and counselling personnel from migrant communities, along the lines of a psychosocial peer counselling concept. For those in need of more intense care, trained peer counsellors can refer patients to psychiatric wards. **In general, intercultural staff and staff from the migrant community are able to provide cultural mediation, preventative low-threshold counselling and information on mental health services available and how to access them.** Ipso Care Center showed that chronification rates of Post-Traumatic Stress Disorders (PTSD) and other mental health conditions dropped in their sample.
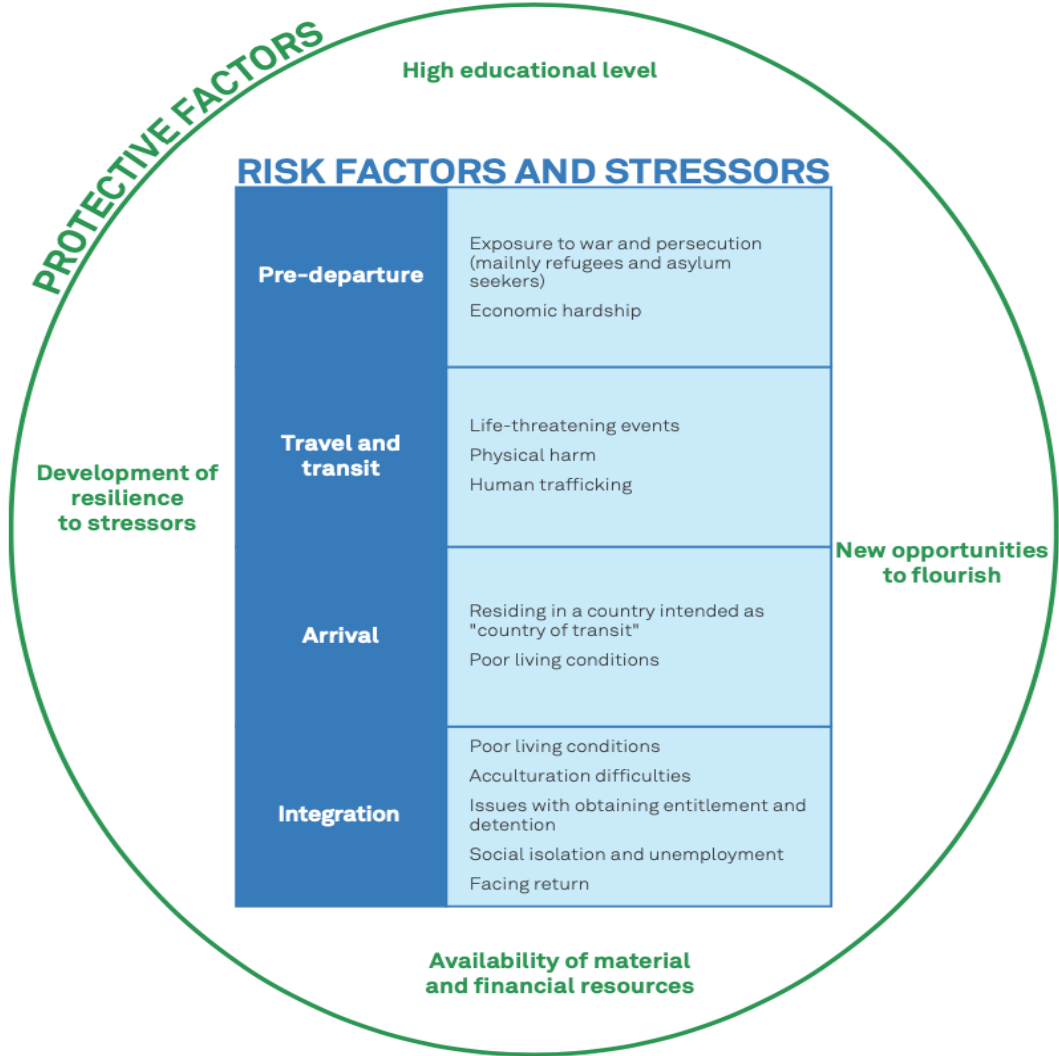

Figure 1. Risk factors & protective factors for mental health conditions in migrants[7]

Migrant mental health, as with health in general, must be approached holistically. WHO Europe suggests to "coordinate mental and physical care with social

services"[7] (also refugee camp staff, volunteer, and grass-root organisations). We know that the interaction of risk factors is complex; the treatment must be designed in a similarly integrated manner. Mental health factors may be intertwined with poor housing conditions or conflicts in a refugee camp, and patients often expect both these issues to be addressed by a mental health care provider and are distressed when they are told half their problem may be outside their health provider's purview.

As we try to bridge public mental health in the future, technology-based interpretation and treatment tools should be always included, as they make mental health services even more accessible. Among best practices are tele-psychiatry concepts and the use of translation software to ensure the use of appropriate language so that patients understand the purpose of diagnostic measures and interventions, in order to increase comfort and compliance. Implementing holistic migrant mental health concepts across all member states is a daunting task, but successful examples from various case studies show that it is worth the investment.

| Economic arguments for universal health coverage schemes

"High costs are often cited by governments as the main reason to not include migrants in health systems. Meanwhile, migrants contribute more in taxes than they receive in benefits, send remittances to home communities and fill labour market gaps in host societies. Equitable access for migrants to low cost primary health care can reduce health expenditures, improve social cohesion and enable migrants to contribute substantially towards the development."

- Jacqueline Weekers, Migration Health Division Director of International Organizations for Migration

Study after study have demonstrated that states' investments in universal health coverage pay off. Human rights arguments aside, providing migrants with primary care and giving them alternatives to emergency response systems simply makes sense, and for those to whom the human rights case carries little weight, the economic argument may yet be convincing. By providing migrants access to regular healthcare, covered by statutory insurance, a state can ensure that all residents address health concerns quickly and efficiently, before they turn into a chronic or emergency issue, which is by far more costly in the long term. In keeping with global commitments to the Sustainable Development Goals (SDGs), countries have agreed to strive for universal health coverage (UHC) which must, by any reasonable definition or human rights standard, include migrants. The point of universal health coverage is the recognition of the fact that the poorest and most vulnerable in society often experience the worst health conditions and outcomes (discussed in depth in the *Social Determinants of Health* section). UHC imagines another type of society, where consumers are not expected to pay out of pocket for treatment. Where medical care is prioritized for funding and made accessible to every individual in a society, not only are human rights better observed, but state coffers remain fuller. The evidence could not be clearer: the human rights and economic cases for UHC go hand in hand.

| Gaps in policy between the countries in Europe

"International and European frameworks pave the way for health equity but no equal access to health care is possible without national commitments."[8]

As health systems are nationally coordinated, it has so far been nearly impossible to implement EU wide policies. Anne Bucher (DG Santé) elaborated on the topic, explaining how although most member states recognize the need for specific migrant health policy, and although helpful tools (such as cultural mediators) have started to mainstream into national health policies, we are still waiting on the implementation of holistic concepts in most countries.

Strong	NO	Many	Few
EU legal framework	targeted national policies	tools implemented nationally	evaluations conducted

Figure 2. Key results from "Migrant health across Europe", a study by the European Commission (2018)[8]

Regulation mechanisms are also still lacking to hold member states accountable for the implementation of and compliance with quality standards. European policies can provide recommendations, but these remaining challenges must be tackled primarily at the national level. It is the responsibility of public health advocates to remind our national governments and health departments to comply with European standards. By sharing best practices at venues such as the European Public Health Conference we make sure that we agree on scientifically proven concepts that we know work. EU-wide adoption should be the aim of our advocacy.

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[8] Migrant health across Europe: Little structural policies, many encouraging practices. *European Commission* (2018). https://ec.europa.eu/migrant-integration/feature/migrant- health-across-europe

| Methods for monitoring migrant health: Visibility towards equality

"Migrants are very heterogeneous in terms of reasons for migration, region of origin and chances in the countries of destination and thus, differ greatly in regards to health resources and risks. It is crucial to gain valid data on migrant health status to inform policy makers in order to plan, implement and adjust health interventions and services."[9]

Migrant health monitoring and surveillance is key in order to generate data that properly visualizes the true diversity of Europe and maintains the visibility of hard-to-reach sub-populations. We also have to take into consideration that migrant populations themselves are highly heterogeneous and must be received, diagnosed, and treated as such.

Shadia Rask from THL, Finnish Institute for Health and Welfare, shared important lessons learned.[10] Flexible sampling approaches, adaptive data collection with multimodal interviewing (phone, face-to-face, paper-and-pencil), and creative solutions bridging language barriers served as core principles. These methods enable researchers to see migrants or other hard-to-reach populations and objects but rather as actors in developing survey material, in data collection, and analysis.

Methods for approaching target groups are crucial. Snowball sampling was a useful tool for Finland's Roma population as they often can't be detected by census. THL, and also another German health monitoring project, IMIRA from the Robert Koch Institute,[9] both found that eliminating government seals and logos from the documents increased participation rates. They hypothesized that these images provoked fear and anxiety in recipients and decreased willingness to participate, an important cultural contrast to majority populations who tended to respond positively to official government documents, sensing increased legitimacy and feeling a sense of obligation. Training research staff on cultural sensitivity ensures that appropriate language is used, for example, and that interviewers always take into consideration that participants do not necessarily identify as migrants.

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[9] Santos-Hövener, C., et al. "The IMIRA (Improving Health Monitoring in Migrant Populations)-project in Germany–Lessons learned and implications for health monitoring." *European Journal of Public Health* 29.Supplement_4 (2019): ckz185-010.

[10] Rask, S., et al. "Collecting high-quality survey data on hard-to-reach populations: lessons from Finland: Shadia Rask." *European Journal of Public Health* 29.Supplement_4 (2019): ckz185-009.

For the sake of policy advocacy, it is convenient that economic models support the inclusion of migrants in mainstream medical coverage. But if variables of population size or health needs were to change, experts at the EPHC reminded us, the mandate to provide comprehensive medical care for migrants would nevertheless hold fast, from a pure human rights perspective. It is crucial that we not lose track of this, and that the public health community continue to lift up the voices and care for the bodies of those most vulnerable, not because the bottom line of the budget demands it, but because our humanity does.
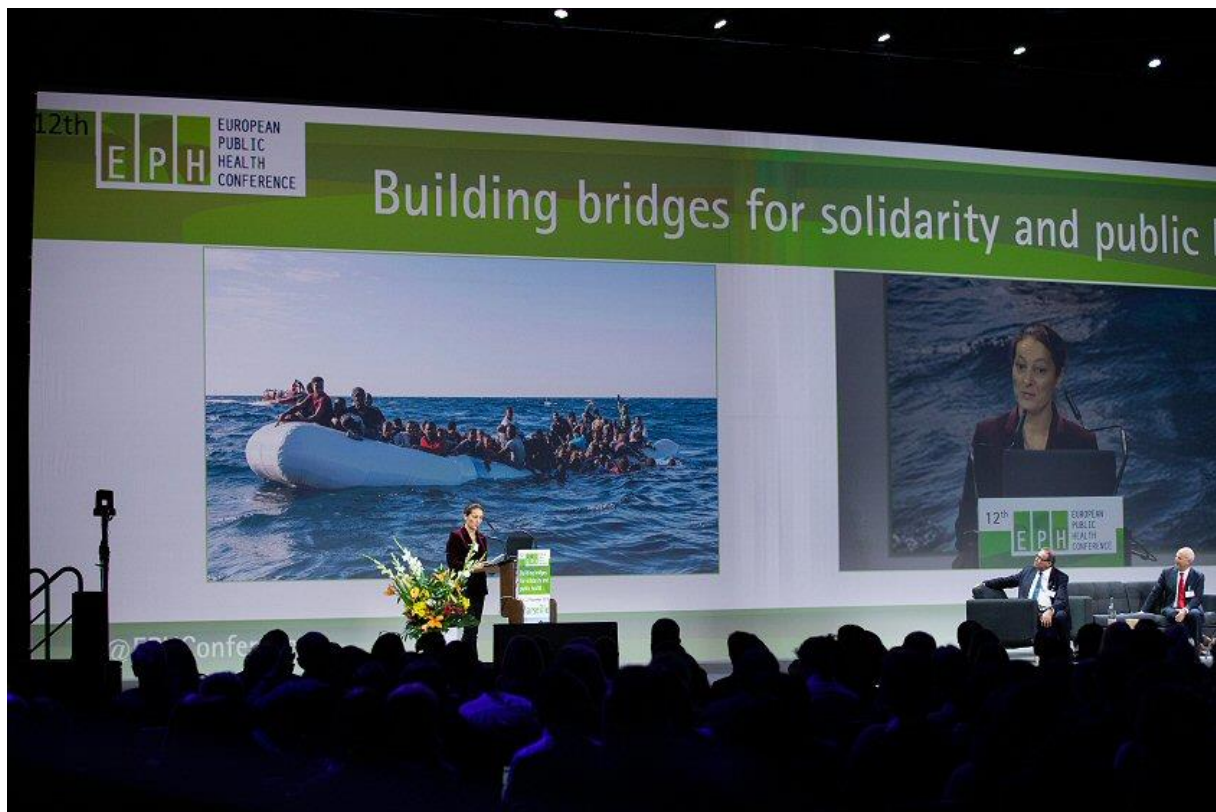
Sophie Beau, Co-founder and General Director of SOS Méditerranee in the opening plenary of the 12th European Public Health Conference in Marseille.

The European Public Health Association, or EUPHA in short, is an umbrella organisation for public health associations in Europe. Our network of national associations of public health represents around 20'000 public health professionals. Our mission is to facilitate and activate a strong voice of the public health network by enhancing visibility of the evidence and by strengthening the capacity of public health professionals. EUPHA contributes to the preservation and improvement of public health in the European region through capacity and knowledge building. We are committed to creating a more inclusive Europe, narrowing all health inequalities among Europeans, by facilitating, activating, and disseminating strong evidence-based voices from the public health community and by strengthening the capacity of public health professionals to achieve evidence-based change.

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