Migrant health in the EU

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Summary: Across European Union countries, attempts to incorporate the needs of migrants into health systems have remained uncoordinated. The limited available data suggest that infections, accidents, injuries, musculoskeletal disorders and violence disproportionately affect certain migrant groups compared to long settled populations in the European Union. However, low birth-weight and some chronic diseases are relatively less prevalent in some migrant groups, known as the ‘healthy migrant effect’. This advantage may diminish in subsequent generations. Legal barriers, communication, lack of information and mistrust are some obstacles to providing good quality care for migrants. Several research topics and policy considerations merit greater attention to address these inequalities.

Keywords: migrants, immigrants, inequalities.

The thirty-five to forty million foreign-born people in Europe continue to face difficulties in becoming a full part of the economic, cultural, social, and political lives of their adopted societies.1 This situation is undesirable both from the perspective of European integration and human rights. The right to health obliges governments to ensure that “health facilities, goods and services are accessible to all, especially the most vulnerable or marginalised sections of the population, in law and in fact, without discrimination on any of the prohibited grounds”2.

Migrant health trends
Unlike Australia, Canada and the United States, European countries rarely collect health data by ethnicity (the UK, Sweden and the Netherlands being exceptions). One difficulty in studying migrant health is defining the subject. At least five sub-categories of ‘migrants’ have been be identified: students; economic migrants; asylum seekers; irregular or undocumented migrants; and displaced persons.3 However, it is still unclear how long before a group of people thought of as ‘migrants’ begin to simply constitute a socially or culturally distinct or ethnic group of residents;4 there are different understandings of what it means to be a ‘migrant’ across Europe.

Another difficulty is a lack of data. The data that are available give rise to a complex and dynamic picture. A review of the literature suggests that infectious diseases (including sexually transmitted infections), accidents, injuries, musculoskeletal disorders, violence and drug abuse all appear to disproportionately affect certain migrant groups compared to what are referred to technically as the ‘autochthonous’ or long-standing resident European populations. These patterns are likely to be linked to increased exposure to risk factors, either in the country of origin and/or in European countries where migrants are forced to live and work in poor conditions.

Migrants are not necessarily disadvantaged in all areas of health though. Relatively low rates of low birth-weight infants have long been observed in migrant groups in the US and Europe. Many studies have shown that chronic diseases are less prevalent in some, though by no means all, migrant groups compared to indigenous European (and North American) populations. This is known as the ‘healthy migrant effect’. It has been suggested that (self-) selective migration may play a role; such findings may also be explained by a difference in timing between the health benefits and the health risks of migration.5

However, this relative advantage does not translate across all countries and across all migrant groups. Also, research suggests that the advantage may diminish over time (length of stay) or in subsequent generations. In short, a review of the literature suggests that it is not useful to make generalisations about the health of migrants, since mortality and morbidity patterns vary across space, time, age, gender, disease, different countries of origin and type of migration. Disaggregating mortality and morbidity data by cause, and by country of origin, is crucial.

Five explanations for the differences in health between ethnic groups have been identified6,7 genetic differences; cultural differences; socioeconomic position; short-term migration history; and ethnic identity. In terms of more proximal determinants, varying patterns in risk factor prevalence (smoking, inactivity; alcohol consumption and so on) account in part for the differences in health between migrants and the indigenous populations. Additionally, it seems that access to and utilisation of health services also plays a role. Findings that some immigrants are comparatively healthy and under utilise health services refute the simplistic assumption that immigrants represent a disproportionate burden on European health care systems.

Health care access and utilisation
Most countries grant full equality of treatment to third country nationals after awarding them long-term or permanent residence status. So is access to health care still an issue? Data on this topic are relatively sparse, but several studies suggest...
migrants do experience unequal access to health care. One issue is that requirements for permanent status vary across Europe and obtaining this status may take several years. Secondly, undocumented migrants in many countries are not granted equality of treatment. Besides the legal barriers, migrants also face other specific difficulties in accessing health care. In clinical encounters, language and literacy are the most obvious cultural obstacles to providing good quality care. In addition, miscommunication and dissatisfaction stemming from cultural differences and expectations can also contribute to suboptimal care. Categories and concepts used by migrants to explain health problems may differ significantly from Western understandings, as the field of medical anthropology has long demonstrated. This suggests there is a major role for user involvement in the design of effective services for migrants.

A lack of knowledge about the health care system may also be a serious obstacle to access, sometimes even despite tailored publications and orientation services. Mistrust of service providers may be an important issue for some, particularly undocumented migrants fearing detection. In countries with complex registration systems for social health insurance, administration and bureaucracy is a major barrier. Barriers to health care may result in worse health outcomes, as is suggested by the relatively high rate of avoidable mortality found among migrants in some studies, resulting in health inequalities. They also may result in increased consumption of more expensive emergency treatments.

Certainly, migrants are likely to face different barriers/inequalities in different European countries. There are also difficulties with measuring utilisation. Also, immigration may not always be the primary explanatory factor for differences in health care utilisation, with income being an important confounding variable. Nevertheless, in countries with immigrant populations, it does seem that language-adapted and culture-sensitive programmes are needed to decrease inequality in access for ethnic minority groups.

**Measurement and indicators**

Measurement of migrant health and health care utilisation is challenging for a variety of technical and political reasons. Medical research favours homogeneous samples, resulting in ignorance about the effectiveness of treatments on ethnic minorities, while recording ethnicity in clinical records can be perceived as discriminatory. Ethnic minorities often have low response rates in epidemiological surveys, in part because monitoring undocumented immigrants is difficult and information cannot easily be validated. Moreover, immigrant mortality in the population may be underestimated in register-based studies because sizeable numbers of immigrants who subsequently leave their new homeland (the host country) fail to register this fact with the national registration authorities.

Several techniques have been developed to counter a lack of data on migrant health, for example linking datasets and developing algorithms to identify persons of ethnic origin by surname in registries. If surveys do include migration variables, they mostly depend on a broad ‘social science’ definition of immigrant status, employing country of birth, parental country of birth and length of stay in the host country as indicators to identify this population. Conceptually, there are two main problems with this. Firstly, the paradigm incorporates important subcategories of persons, such as refugees, who may experience specific non-random patterns of health and health care that differ to those of non-refugee immigrants. Secondly, the paradigm does not capture legal status which may affect access to and utilisation of health services, which in turn may also affect patterns of disease in a non-random manner. To make these indicators relevant to health research, an understanding of the way in which immigration law relates to eligibility in accessing public services is important. This may become complex when legal criteria on the eligibility of immigration subcategories change over time.

Reflecting both these technical difficulties, but also political concerns, there are very few, if any, national or European surveys currently available to measure the health of first and second generation migrants relative to the health of the native population. There are also generally low levels of reporting on migrant health. Exceptions include the Netherlands and to some extent Sweden and the UK. Countries such as Belgium, Spain and Germany have only very recently started to introduce questions on migration into health surveys. New Member States, reflecting their relatively low levels of immigration, rarely include indicators of immigration in health surveys, but this may change in the future as the numbers of immigrants to these countries are also increasing.

**Migrants and health policy**

Across EU countries, attempts to incorporate the needs of migrants, in particular from non-EU countries (so-called third-country nationals), into welfare systems have remained scattered and uncoordinated. In terms of Europe’s policy response, it seems there is an increasing effort at the supra-nationalisation of migration policy. This has affected the upgrading of many national anti-discrimination policies, but at the same time there is a concern that the focus of EC policy on the flexibility of the labour market may take precedence over concerns with social citizenship and the protections afforded by the welfare state.

To some extent, however, diversity in policy is to be expected, since the way migrant health is approached to some extent depends on the type of immigration affecting the country. A country’s approach to migrant health issues will also depend on its welfare regime, with different nations responding to similar political challenges in idiosyncratic ways. Furthermore, where migrant health policy is elaborated, implementation may not necessarily reflect this on the ground.

A consultation with country experts in health policy revealed that in France, social analyses by ethnic origin are not routinely carried out both for cultural and administrative reasons and migrant health policy has mainly focused on preventing the spread of infectious diseases. In Germany and Ireland, at the national level, the issue of migrant health and access to health care has also not yet been developed as a specific policy issue, though there is an increasing interest in tackling health inequalities. Politically, migration itself was a widely neglected policy area in Germany until very recently. In Italy, on the other hand, policy regarding the health of migrants is relatively developed, though how successful the government has been at implementation is not clear. At the central level, immigrant related health policy targets have been set since the 1990s.

As early as 1997, the Netherlands Organisation for Scientific Research (NWO) set up a working party on culture and health, and a programme to stimulate research and care innovations in this area was launched. Indeed, the Netherlands stands out in Europe for its sustained and systematic attention to the problems of migrant
health, although a closer look at the current situation suggests there is a danger of these initiatives stagnating. In Spain, migrant health and health care issues have recently started to feature in national and regional plans for the integration of immigrants. The general Swedish national health policy aims to create social conditions that will ensure good health, on equal terms, for the entire population with a special emphasis on vulnerable groups such as immigrants. The government has thus developed a multi-sectoral approach to coordinating services in a way that promotes health among newly arrived individuals.

In the UK, health policy relating to migrants is largely integrated into a policy framework addressing health inequalities in general (dating from the 1980s) and the health inequalities of ‘black and minority ethnic’ (BME) groups specifically. The Department of Health (in England) has commissioned a number of initiatives to generate or collate good practice in “race equality”. However, as in most European countries, the lack of baseline data on ethnicity makes it difficult to evaluate the impact of such projects, which in turn makes it hard to identify good practice.

In light of this variability, there appears to be a significant role for the EU to play in facilitating the development and transfer of evidence and information on immigrant health policy. The upcoming Portuguese presidency, which is focussing on immigration, may be a timely opportunity for further policy development on this issue.

Potential policy considerations

Both this and previous reviews’ throw up a number of concurrent potential policy considerations. The methodological problems associated with migrant health research indicate a need to increase funding and collaboration at the European level between national research centres to develop research techniques. This could include some focus on methodological barriers to the inclusion of data on migrants in national and European health surveys.

Nutritional and psychosocial problems among migrant children and youth signal a need for greater attention paid to multi-sectoral policies, particularly across health and education. While problems relating to sexuality, reproduction and family life, might imply that there should be more attention devoted to the improved planning and provision of targeted preventive and curative sexual health services; ante and post natal care; and social services for vulnerable women. At the other end of the life course, the ageing of migrant populations requires the development of culturally appropriate long term care.

The access of illegal/undocumented migrants to health services remains a major problem, as much political as it is technical. Greater transparency in countries’ approaches to responding to health and health care utilisation inequalities experienced by this population, within the framework of human rights, is merited.

As this review indicates, migrant groups can play an important role in the design and provision of services. This also resonates, and could be integrated, with many countries’ more general attempts to improve empowerment through better access to information, strengthened patient rights and choice and enhanced complaints procedures. Linkages between sender and receiver countries could also be explored to provide insights into health norms, culturally relevant methods of research and treatment, and the expectations and health beliefs of migrants.

Preserving the health ‘advantage’ of some newly arrived migrants could potentially be a very important preventative strategy, particularly in terms of chronic diseases; focusing on healthy diets and other lifestyle related factors through targeted programmes is a possible way forward. Where individuals are at risk, such as in the workplace, multi-sectoral policies need to be developed to address this important area of migrant health. However, this is potentially a political issue since poor working conditions are often related to the exploitation of undocumented migrants. In settings where there is a need to prevent and control tuberculosis and HIV/AIDS among migrants, it may also become apparent with further research that interventions fully mainstreamed within the health care system are more effective both clinically and in terms of cost than vertical programmes (run at ports and borders for example).

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**References**


