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# Migrants and healthcare within the European Union

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**Abstract:** The investigation of migration can help us understand how the types of migration interact with each other as well as with the various local/national 'immobilities'. Migrants pose special challenges to healthcare systems, in their origin as well as destination countries. Available data on this topic, following EU interests and policies, focuses on health problems of vulnerable migrant groups, often directed exclusively to issues that can affect the local population. This paper aims to set some explanatory contexts when it comes to the relationship between migration and healthcare within the European context.

**Keywords:** *healthcare, migration, infectious diseases, access, Europe*

## Introduction

Migration and health are interconnected in many ways. The investigation of both migration and health forces us to recognise that the types of migration (international, internal, seasonal, circular, etc.) interact with each other as well as other population parameters. The existence of a health perspective in migration research can be an improvement over traditional approaches. In other words, health issues help migration to be regarded as a human process rather than a discrete event, and accordingly, it becomes less important to categorize the event and more important to describe the individual's involvement with human networks and the institutions sustaining them.

Working on European healthcare topics for the last four years, I have always been surprised that when it comes to migrants, data is scarce or selectively collected. The only time I encountered solid healthcare data about migrants was in a report about AIDS, almost obviously put together to justify the high prevalence in the

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EU countries where migration is very present.

Without any specific ambitions, this paper focuses on health problems of vulnerable migrant groups and the explanatory contexts when it comes to the relationship within migration and healthcare in a European context. Drawing on library-based research, this paper is structured as follows. The first section gives some general data about migration, moving to more specific healthcare concerns. Since the European policies seem to be privileging them, infectious diseases take the lion's share. A last section includes migrants' access to healthcare services and data collection issues. Some room is finally left for conclusions.

*Some useful data about migration*

Patterns of migration and population movement are affected by geographical and historical factors as well as by economics, conflict, environmental and political crises. Poverty and the desire for a better life are significant drivers. Seasonal labour is an increasing phenomenon. Refugees, internally displaced people and asylum seekers constitute a significant proportion of mobile populations.

In Europe, the fall of the Berlin wall has had a major impact on migration within the continent. There has been a recent additional dynamic - the accession of ten more states to the EU in 2004 and two more in 2007. However, migrants to the EU are diverse in terms of their country of origin, and the number of migrants from (Latin) America, Asia and Africa is constantly growing.

The following list (Eurostat, 2008) can give us a general idea of where the migrants come from and where they tend to go in Europe:

- Morocco - most likely to migrate to Spain, Belgium, France and Italy;
- Ukraine - most likely to migrate to Czech Republic, Spain and Portugal;
- China - most likely to migrate to Spain and the United Kingdom;
- India - most likely to migrate to the United Kingdom;
- Bolivia - most likely to migrate to Spain;
- Albania - most likely to migrate to neighbouring countries such as Greece and Italy;
- America (United States);
- Turkey - most likely to migrate to Germany and Austria but also France and the Netherlands;
- Brazil - most likely to migrate to Spain;
- Russia - the largest group of migrants to Finland and Latvia;
- Romania - most likely to migrate to Italy and Spain.

The greatest problem in tackling the analysis of the relationship between migrants and receiving countries' policies regarding them is the diversity of the matter. In each country of the EU, two things are critical for this relationship: the legal status of the migrant and the country's reimbursement system. Other than the well-known rights of EU migrants, there are mechanisms more or less related to the welfare state from which migrants may benefit, including education, social security, healthcare services. Baldwin-Edwards (1997) put up a rough guide for the situation of migrants in the European Union which hasn't changed much in the last twenty years:

**Table 1.** *Synthetic image of migrants in Europe*

| | Education | Healthcare | Social security | Public housing |
|---|---|---|---|---|
| Undocumented | Y | ? | N | N |
| Workers | Y | ? | ? | ? |
| Permanent residents | Y | Y | Y | Y |
| Refugees | Y | Y | ? | ? |

Source: Baldwin-Edwards(1997). Legend: Y = generally available, ? = wide variation and / or doubt, N= generally not available. As it can be observed in this table, worse than education but better than social security or public housing, healthcare services for migrants can vary from one country to another when it comes to availability. But in order to understand this availability it is worth looking at the special issues and challenges that migration brings to healthcare.

## Specific healthcare concerns related to migration

Besides the 'usual' healthcare matters that apply for migrants as well as for local population, special challenges to the healthcare system and policy are driven by this mobility status, in the origin as well as destination country:

*Age*. The new arriving migrants are a young majority and demand a set of health services focused on other matters than the population at large. In 2006 for instance, 1.8 million people from outside the EU settled in a new country of residence in the EU; of these, more than half were less than 30 years old. Confronted more and more with ageing populations, the EU healthcare policies tend to focus less on youth.

On the other hand, the ageing population challenges may also arise when it comes to migrants, but for their countries of origin. For the settled migrants from previous migration waves (60s, 70s, etc.) or for the seasonal / circular ones, a crucial variable is return migration. For those who want to go back to their country of origin, it is an open question whether they will have contributed enough in taxes to pay for their demands on the public health system (as well as social security system, etc.) upon their return.

*Concentration.* The fact that migrants tend to be geographically clustered implies that medical capabilities could be very stressed in areas subject to high rates of migration, especially for publically supported institutions. Hospitals in some neighbourhoods of main cities and town around Europe, similarly to schools, are confronted with a majority of patients of foreign origin. The staff and infrastructure are often overwhelmed by this situation.

Also, concentration in the sense that migrants often live in overcrowded housing leads to spreading of infections or high rates of domestic accidents (e.g. lead poisoning has been recorded among migrant children living in poor quality housing - de Jong & Wesenbeek, 1997).

*Occupational accidents.* Migrants tend to do jobs in higher risk occupational sectors. The incidence of occupational accidents and diseases in construction and agriculture is higher than in other sectors (Bollini & Siem, 1995). Also

and maybe due to language issues, migrants may be unfamiliar with safe use of equipment and often receive inadequate training, supervision and protection. Occupational accidents due to lack of legal contracts and acceptation of hard working conditions are a bigger healthcare burden for migrants than for the local population.

*Infectious diseases and vaccination.* In population terms, migrants bear a disproportionate burden of infectious disease. Coverage with childhood vaccination programmes in countries of origin is sometimes lower and there are still outbreaks of childhood diseases that have been largely controlled in the EU. The infectious disease area is given special attention and we shall come to this subject later.

*Women and maternity care.* Despite the awareness related to the feminisation of migration and the policies implemented by the EU, a large number of migrant women are marginalised, facing many forms of double discrimination: from an economic point of view as well as being frequent victims of abuses, on grounds of gender and ethnic origin, in the host society and in the migrant community in which they live.

Many authors find that migrant women's maternity needs are being exploited or not enough respected and the ways in which these needs are met differ considering the perspective of migrant women or health providers (Phillimore, 2007). Key problems concern the integration of female spouses of migrants (family reunion), most of them being disempowered when it comes to child benefit, social welfare, health and other services. Social isolation is enhanced because many migrant women do not have family networks to help them with childcare and other support.

Prevention and control programmes have paid insufficient attention to differences in vulnerability in women and children, sexual and reproductive health, access to family planning education and maternity services. Other areas of concern include women migrants who are victims of violence or victims of the sex trade.

*Mental health.* Psychological health may be affected by the process of leaving family and home country, coping with time-related insecurity (migrants tend to project themselves in a temporary situation; even when settled, most of them think of spending retiring years in their home country), administrative and legal issues, unfamiliar language and culture.

Additional stress and anxiety than faced in a non-migrant situation can result in more serious psychological problems. Poorer access to health services results in higher levels of preventable illness and poor social integration often provokes mental health problems.

Infectious and child diseases seem to be the biggest challenge and focus for the EU healthcare policies regarding migrants, for reasons related to the possible contamination of the local population. Prevention and control of infectious diseases among migrant populations has planning and budgeting implications for host healthcare systems. Therefore we will dedicate more space to the overview of infectious diseases.

*Mortality and 'salmon bias' in return migration.* The selective return of less-healthy migrants to their country of birth hypothesis is often referred to as the 'salmon bias' effect, a phrase coined by Pablo-Mendez (1994). It posits that, in contrast to the healthy in-migrant hypothesis, foreign-born persons who have lived in the United States for some time return to their countries of origin in significant numbers when their health deteriorates. This type of selective migration results in mortality for the migrant population that is lower than if the mortality experience of the return migrants had not been omitted. A second mechanism related to return migration that can affect estimates of migrant mortality concerns prospective mortality in follow-up studies. That is, when survey data are prospectively linked to death registration records, deaths of individuals who migrated during the follow-up period will be missed. The resulting downward bias in mortality due to this omission will be greatest for subgroups most likely to migrate, notably the foreign-born (Palloni & Arias, 2004). This type of error, in contrast to the salmon bias effect, occurs even when migration is not selective of unhealthy individuals.

**Infectious diseases**

The Council of the EU, via its draft Conclusion regarding the health of migrants, is openly focusing on infectious diseases. First of all, the different stages of migration present different challenges when it comes to infectious diseases. There is a pre-entry phase, where a migrant's health reflects the disease profile of his or her country of origin. There is a transitional phase, where the process of moving, sometimes through intermediate countries, can influence a migrant's health (Ho, 2003). Finally, there is a post-entry phase, shorter or longer, depending on the migrant, where the working and living conditions in the host country can also influence a migrant's health.

*Tuberculosis* (TB)

The last 50 years have seen a decline in TB in most of what were the original EU countries. However, this decline has not been consistent across Europe and TB remains a challenge in some countries. The downward trend has also been interrupted by the re-emergence of TB among vulnerable populations including cases in migrants from countries where TB is less well controlled, which represent an increasing proportion of new cases (Falzon & van Cauetern, 2008; Jakubowiak et al., 2007).

In 2007, 21% of reported TB cases were of foreign origin. There is evidence that TB among migrants is occurring in younger age groups and is also associated with higher treatment default rates and poor outcomes (Falzon & van Cauetern, 2007; Jakubowiak et al., 2007). Although this suggests that imported TB is the main problem, the situation is more complex. Material deprivation appears to be far more of a determinant than country of origin. Many migrants develop TB as a consequence of their socio-economic status in the host country. Migrants who had arrived with a history of TB may be at risk of reactivated TB infection long after they have settled because of overcrowded

and poorly ventilated living conditions or inadequate nutrition (Ho, 2003; Gagliotti et al., 2006).

Limited access to healthcare prevents migrant populations from accessing information that would enable them to avoid TB and to obtain early diagnosis and treatment of new or re-activated TB infection.

*AIDS / HIV*

In 1987, the main public health issue was a disease thought to be related to migration (including patterns of internal migration and residential mobility). AIDS turned out to be a critical factor regulating migration and healthcare and illustrates how these two fields interrelate.

HIV is a significant health issue in some EU countries, while in others prevalence and incidence are comparatively low. But as a general trend, HIV infection keeps growing in Europe. 'While the number of People Living With HIV (PLWH) increases in every member state of the EU, budgets in several countries are reduced. Sexual risk behaviour is becoming more and more a regular practice. Criminalization of HIV is a problem in many countries, and HIV-specific legislation still exists in some countries; people can get prosecuted for unintentionally and unknowingly transmitting the virus. Discrimination and stigma against PLWH is frequent at work and in schools. Harm reduction strategies in prisons are still weakly implemented, especially in the Eastern European countries. There is a general lack of leadership in HIV management. Alarmingly enough, no government seems to know the true number of HIV-infected inhabitants. The main conclusion of this EU HIV Index is that there is still a lot to do.' (Cebolla & Bjornberg, 2009)

Migration is considered a factor influencing the epidemiology of HIV in Europe. In 2005, 45% of all cases of heterosexually acquired HIV infection in Western Europe involved migrants from high prevalence countries (EuroHIV, 2006).

In the UK, approximately 70% of newly diagnosed cases of tuberculosis and HIV were in people born outside the UK and most HIV cases reported between 2004 and 2006 involved migrants from Sub-Saharan Africa who were infected prior to leaving their country of origin (HPA, 2006).

In Spain, increased HIV among migrant women involved in sex work is changing the epidemiological profile of the disease (Belza, 2004). In Belgium, migrants account for more than 50% of all reported HIV cases since the epidemic began (EuroHIV, 2006). In France, reported AIDS cases among migrants increased by 20% between 1999 and 2004. Migrants are disproportionately represented in HIV statistics in the Netherlands, Germany, Sweden, Ireland, Spain and Italy.

*Hepatitis A and B*

Hepatitis A is mainly transmitted through contaminated food and water, but infection can also occur through injecting drug use and sexual contact. Hepatitis A is endemic in countries with overcrowded living conditions, poor hygiene and limited access to clean water and sanitation but also occurs in parts of South-Eastern and Southern Europe.

There have been outbreaks of food contamination related hepatitis A in

countries such as Luxembourg (2000), Italy (2002), the UK (2003), Denmark (2004), and Germany (2004) (HPA, 2006). Outbreaks have also been reported in the EU among injecting drug users and men who have sex with men (Tallo et al., 2003).

There is little evidence to indicate that hepatitis A in Europe is associated with migration, although for example infection in Hungary has been linked to migration from areas of high prevalence in former Yugoslavia and China. Children of migrants who return periodically to their family's country of origin (circular migration) may be exposed to the virus.

Children of migrants in the Netherlands who had visited hepatitis A endemic countries, such as Morocco and Turkey, were found to be among the most vulnerable to hepatitis A (Richardus et al., 2004). Similarly, relatively high rates of infection have also been found among children of migrants in Spain who had returned to Morocco for their annual holidays (Llach-Berne et al., 2006). In countries with universal vaccination programmes and where high-risk groups have been targeted, incidence in children has decreased significantly.

However, in many European countries, migrants from highly endemic regions are many times more frequently affected by hepatitis B than the general population (HPA, 2006). In the general population the prevalence of hepatitis B varies widely between EU countries, with higher rates in Romania (6%), Bulgaria (4%) and Latvia (2%), which are low-receiving countries when it comes to migration, and lower rates in the Netherlands, Slovenia and Norway (all below 0.5%). Due to the large differences that exist in surveillance systems, reporting practices, data collection methods and case definitions across EU countries, the surveillance data are difficult to compare across countries and there is no evidence that hepatitis should be directly linked to migration.

*Childhood diseases*

Coverage of childhood vaccination programmes varies across the EU and coverage rates are lower in some countries, in particular new Member States. Coverage rates in some countries have also declined as some parents choose not to have their children vaccinated because of unsubstantiated concerns about adverse effects. Outbreaks of measles infection in a number of EU countries highlight the fact that vaccination programmes are not reaching all children, irrespective of origin.

There is relatively little data on vaccination coverage of migrant children in the EU, but available information suggests that the situation is variable. In Germany, for example, the vaccination status of migrant children and teenagers depends on the type of the vaccination, country of origin, age and duration of residence. Experience in some countries indicates that there are challenges in reaching the children of migrants with routine vaccination services, because their parents are either unaware of these services or are unwilling to use them for cultural, religious or other reasons (Henderson et al., 2008).

Outbreaks of measles and other infections in the host population in some EU countries may be linked to suboptimal protection in migrant

populations. For example, the persistence of the rubella virus in Switzerland has been partly attributed to migration from Asia, Africa and Central and South America, where the prevalence of rubella antibodies in young adults is low (Matter et al., 1995). The children of migrants who have not been reached by routine vaccination programmes are also at elevated risk of preventable childhood diseases.

Overall, many migrants from outside the EU come from countries where prevention and control of infectious diseases such as TB, HIV and hepatitis is inadequate and the risk of exposure to these diseases is higher than in most EU countries. Coverage with childhood vaccination programmes in these countries is sometimes lower and there are still outbreaks of childhood diseases that have been largely controlled in the EU.

The situation with regard to infectious diseases has improved in Europe, although progress has not been universal. In some European countries, the prevalence of diseases such as TB has remained relatively high. Likewise, the prevalence of hepatitis A and hepatitis B has also remained high. Poor(er) living (overcrowded housing) and working conditions are still critical factors.

Stigma and discrimination associated with TB and with HIV may be exacerbated in the case of migrants, who are already rather isolated socially and fear further stigma, discrimination and marginalisation. This may deter them from seeking screening, counselling or testing.

**Migrants' access to healthcare services**

Beyond the specific challenges brought to healthcare services by migrants (age, concentration, occupational accidents, infectious diseases and vaccination, women and maternity care, mental health and mortality) in theory legally-residing migrants have the same health care access as EU nationals, whilst illegally-residing ones are entitled to emergency health care only. Any public healthcare system in the EU must by law treat sick people, not only sick citizens. All EU Member States have recognised the right of everyone to the 'highest attainable standard of physical and mental health' and to medical care in the event of sickness or pregnancy[1]. The Council adopted in December 2007 a draft Conclusion which highlighted the link between the health of migrants and that of all EU citizens. The Council's Conclusion recommended that the European Commission supports action through the Programme of Community Action in the Field of Health 2008–2013. Member States were invited to integrate migrant health into national policies and requested to facilitate access to healthcare for migrants.

However, there is a general resistance to recognition or application of these healthcare services to migrants, particularly to undocumented / irregular ones. Despite the availability of necessary or urgent medical treatment to any migrants in principle, problems exist in accessing such treatment in practice. Another particular practical problem is the lack of information about the availability of such healthcare services, both for migrants and those

responsible for their provision.

For example, in Belgium, hospitals often do not know how to deal with migrants (both lawfully resident and irregular migrants) and the government is not always forthcoming with the necessary information. Moreover, general practitioners will frequently refuse to treat migrants and refer them to a specific hospital where such treatment is normally available thus delaying access to important treatment. This problem is also compounded by bureaucratic procedures.

Practical problems exist in Germany (Cholewinski, 2005) where carriers' liability applies to ambulances with the result that they have to pay for transporting uninsured persons.

In the UK, local authorities provide services to vulnerable persons. These services have evolved on the basis of an assessment of the needs of the individual. However, such services have been gradually removed from migrants.

In arguing for equal treatment between nationals and migrants in respect of health care provision, it should also be underlined that in some countries, such as Belgium and Germany, access to comprehensive health care services is not necessarily available to all citizens, which is the position, for example, of self-employed persons. Furthermore, lawfully resident and employed migrants do not always have full access to healthcare provision.

While NGOs also provide social services to irregular migrants, it is strongly arguable that NGOs can only supplement government provision rather than replace it altogether. NGOs are frequently required to operate on a contradictory basis. Governments are willing to praise NGOs for undertaking these activities but obtaining funds for such activities becomes difficult especially since the organisations concerned are hard to 'professionalise'; NGOs are also in a

**Data collection**

Once again, this paper in based on library-based research. Since there is no consistent approach to recording migrants' status in health records, comprehensive and comparable data about the health of migrants is almost not available. Data is drawn from small studies, unrepresentative samples or questions added to other data collection exercises.

EU's various programs focus on new arrivals and a lot of data is available on migration as flow. But data on settled or returning migrants, second and third generation migrants (earlier arrivals) is often mixed within the host country national data. Once 'introduced' in the national healthcare system, the migrant status is lost and data gathering becomes very difficult. The same happens with internal EU migration where healthcare data does not follow the person from one country to another. These shortcomings limit the understanding of migration and health or the (sometimes only) apparent differences between nationals and migrants. Different EU countries use different definitions for data collection and analysis, making comparisons practically impossible.

Despite the considerable amount of research that has been conducted (medical sociology and anthropology), there are also gaps in information

about the impact of culture and religion on health beliefs, attitudes and health-seeking behaviour of migrants, making it difficult to establish a clear picture of the burden of diseases in migrant communities.

Also, although health is in large part defined by social and economic determinants, and for many migrants these tend to be adverse, little research has been conducted to identify the specific determinants of health in different subpopulations of migrants.

## Conclusion

Even though granted in theory, migrants' access to general or specific healthcare remains limited throughout the EU, often due to a mix of legal, administrative, linguistic and cultural factors. Migration brings new challenges to healthcare and specific concerns related to age, concentration, occupational accidents, infectious and child diseases as well as vaccination, women and maternity care, mental health and mortality. The life and work conditions of migrants increase their risk of diseases, from infectious to mental.

Existent data related to migrants and healthcare reflects rather the EU policy interests and focuses on infectious diseases. Stigma and discrimination associated with infectious diseases may be exacerbated in the case of migrants, who are already rather isolated socially and fear further stigma, discrimination and marginalisation.

There is a lack of comprehensive information on migration and related health issues in most EU countries.

Moreover, most data is drawn from secondary questions added to other exercises, either on migration or on healthcare in general. Even though little is known about the situation of migrants living in Europe, one thing is certain: they encounter problems when trying to claim their right to care and to benefit from assistance from the healthcare systems.

## Notes

[1] Article 25 of the Universal Declaration of Human Rights (UN 1948), Article 5 of the International Convention on the Elimination of All Forms of Racial Discrimination (UN 1965), Article 12 of the International Covenant on Economic, Social and Cultural Rights (UN 1966), Article 12 of the Convention on the Elimination of All.

[2] Forms of Discrimination against Women (UN 1979) and Article 24 of the Convention on the Rights of the Child (UN 1989).

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