

Migrants' access to healthcare

– secondary publication

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ABSTRACT

Migration means that both locally and globally our world is getting more and more multicultural. From 1975 up to the year 2000, the number of migrants in the world doubled to 175 million, which is 3% of the world's population – half of them living in low-income countries [1]. This figure includes labour migrants, permanent migrants, refugees, and asylum seekers, while undocumented migrants and people who migrate from rural to urban areas are not included. The increasing diversity of the population means new challenges for our societies, including our health services. The aim of this article is to outline a general framework for understanding the access that migrants have to healthcare and the factors that can affect that access.

EQUAL ACCESS TO HEALTHCARE

According to the UN Universal Declaration of Human Rights, "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care ..." [2]. The declaration asserts that access to healthcare is a human right. In line with this, WHO's 1978 Alma Ata Convention has "universal access to healthcare" as its goal. However, a number of factors can affect people's access to healthcare. These factors are often divided into predisposing factors, enabling factors and needs. Predisposing factors include socio-demographic factors such as ethnic background. Enabling factors are a matter of the individual's ability to pay including insurance cover, and needs are about how ill a person is and how likely to recover.

Access is often bound up with principles of equity. Equal access is about maximising a fair and even access to healthcare and minimising differences in health [3]. Equal access is seen when need decides the allocation of resources, independent of "irrelevant" factors such as ethnic background.

THE SIGNIFICANCE OF ETHNIC BACKGROUND AND MIGRATION

By migrants we mean people who have moved to and settled in a country, but have a different ethnic background from the majority. Migrants usually belong to one or more heterogeneous groups. Nevertheless, a series of common denominators can be identified on the basis of ethnic background and migration.

Ethnic background can be defined as membership of a social group on the basis of common culture, which could include elements of a common history, geographical origin, religion, language, diet, etc. [4]. Ethnic background is a complex and dynamic concept, constantly changing both for the individual and for the group – not least when meeting new cultures and new conditions. The determination of ethnic background is often based on country of birth, religion, language or self-identification. It is controversial, because it

can give rise to assumptions about homogeneous groups and cultural stereotypes [5].

Migration can be seen as a process of social change whereby a person moves from one cultural context to another and settles down either for a lengthy period or permanently. Migration is an ongoing process and to understand its consequences for the individual person, we need to take into account circumstances before, during, and after arrival in the country of destination. Moreover, there is no clear definition of when a person stops being a migrant and becomes a part of the majority population instead. Factors related to migration can give a disposition to illness. These factors are again related to circumstances before, during, and after the migration. It might have been preceded by torture, serious illness, or poor access to health services. The journey itself might have been dangerous, if for example it took place under conditions of avoiding the authorities (illegal trafficking) or with poor access to healthcare. And in the country of destination, a series of formal or informal barriers to access to the health services could contribute to the worsening of the health of migrants. This latter is the particular focus of this article

MEASURING MIGRANTS' ACCESS TO HEALTHCARE

Access to the health services can be measured in several ways. Effective access to healthcare can be investigated both in terms of clinical measurements, such as levels of ill-health and mortality, and by examining patterns of use, such as the length of hospital stays and the kinds of treatment chosen. In the latter case, low consumption of healthcare services may reflect less ill-health or more barriers in access to healthcare. Research into migrants' access to healthcare should take account of socio-demographic factors and be capable of revealing any inequality that might exist. A migrant's use of healthcare services may also change with time, so how long he/she has been in the country is often also relevant.

BARRIERS TO ACCESS

Migrants' access to healthcare services in the destination country can be affected by a series of factors, which can be basically divided into formal and informal barriers. Formal barriers include the way the health services are organised, such as user charges. In countries where patients pay for treatment, this can impede migrants' access to the optimal healthcare, because migrants will often have poorer socio-economic conditions than the majority population.

Formal barriers also include legal restrictions that affect migrants' access. According to the law in ten of the 25 EU-countries, for example, asylum seekers only have access to acute treatment [6]. Women and children, however, are excepted from this limitation in several countries. Access for refused asylum seekers is limited to acute help in even more countries. Restricted access to healthcare is increasingly used as a means of applying political pressure to get people to leave the country of destination [6]. The special situation of people who are undocumented migrants is discussed elsewhere in this issue. Here, we will just point out that this group has no formal right to healthcare in most Western countries.

A number of Western countries have legal requirements that all migrants or selected groups of them must be offered medical screening. The aim of screening is partly to protect the host population and partly to help the migrants, but the content and target groups of such screening programmes vary a lot from country to country [6].

Informal barriers to healthcare access can be divided into questions of language, psychology, and socio-cultural factors. Access will often be affected by a complex interaction between all these factors. Language barriers include not being able to communicate, perhaps because of lack of an interpreter. Psychological barriers are about a lack of trust and difficulties in social interaction. Socio-cultural barriers include differences between healthcare professionals and patients in relation to procedures, patterns of communication, roles, and levels of knowledge about illness and about the way the health services are organised.

Fact box

Migrants are a heterogeneous group. By migration, we mean the social and physical process when a group or an individual moves from one place to another for a lengthy period – whether voluntarily or of necessity.

Ethnic background and migration status are important factors in migrant health and access to health services.

Migrants' access to healthcare can be affected by a series of factors, which can basically be divided into formal and informal barriers.

Knowledge and political will are essential at a global and local level, if migrants are to be assured equal access to healthcare.

Refugees and internally displaced persons in Africa and Asia are migrant populations where there are special problems. Poor security and logistical problems often hinder the international community in establishing access to basic healthcare for these populations [7]. Access will also depend on what stage the humanitarian help is in. It has been shown that the state of health in permanent camps can sometimes be better than that of the local population, especially if the camp healthcare is organised by NGOs with plenty of resources [8].

THE SITUATION IN DENMARK

The Danish Red Cross is responsible for the health of asylum seekers, who are offered screening on arrival and can visit general practitioners attached to the asylum centres. Asylum seekers are not covered by the national health insurance scheme, so they only have the right to help in the case of acute illness, unless they are pregnant women or children. But Red Cross doctors can apply to the Danish Immigration Service for approval of expenses for treatment that is "necessary, pain-relieving, or urgent". However, not all such applications are approved, especially not in the case of mental illness. This means there is a formal difference between citizens and asylum seekers in relation to what healthcare they have a right to. The health consequences of this differential treatment have not yet been investigated.

Quota refugees are one of the groups of people who receive asylum. They are flown direct from a refugee camp to a local authority in Denmark where they are given a place to live, a doctor, etc. A recent Danish survey showed that 64% of a group of newly-arrived quota refugees had one or more physical illnesses – mental illness was not registered [9]. Before July 2005, there was no national plan for preventive examination or vaccination for quota refugees. It was up to the individual local authority what they offered. Since July 2005, all quota refugees have received a general medical examination and tests for tuberculosis and HIV in the refugee camps before getting a Danish residence permit. The scheme is new and it is not yet clear how the screening results will be used.

People who come to Denmark to be reunited with their families go straight to their relatives. In January 2006, there was no systematic offer of preventive examination or information for them. This means that a large proportion of the migrants that come to Denmark have not been medically examined and the children have not been through a Danish vaccination programme. So we need a national plan for early screening and treatment of this group, and we need to offer children vaccination.

PUTTING THINGS IN PERSPECTIVE

Political will is essential at both a global and a local level if migrants' health and access to healthcare are to be assured. So it is important that the responsible parties, right from WHO down to local govern-

ments and regions, have worked out guidelines or health plans that include the health of migrants.

But effective political initiatives require knowledge. This research area is still facing a lot of challenges, including questions of method. The development and operationalisation of ethnicity and migration are decisive, as is the establishment of information systems for the collection of nuanced knowledge about ethnic background, health and contact with the health services. In relation to contact with the health services, it is important to research both quantitative patterns of use and the qualitative experience of migrants in using the health services. Furthermore, we also lack knowledge of the options for intervention and its effect among migrants. A special topic, on which we have almost no information, is the way all these things change over time for migrant groups after they have arrived in the new country and for second and third generation migrants in the light of ethnic background, kind of migration, and conditions in the country receiving them [10]. Information on migrants' access to healthcare is generally inadequate in Denmark, but almost totally non-existent in most low and middle income countries. The problems in these countries are on quite a different scale because of the many international and internal migrants, local accumulation in slums and refugee camps, widespread health problems, and strained health systems that were already inadequate for the local population. (Box 1)

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