The Social Determinants of Migrant Health: A Framework to Integrate Migrant Health into Strategies to Reduce Health Inequalities

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ABSTRACT

Health is determined to a large extent by social, economic and environmental conditions. The same factors are strong drivers for migration patterns. Migrant numbers have increased markedly in recent years. However, migrants often experience worse living and working conditions in comparison to the host population. In recognising the challenge to bridge this divide, our approach is to apply a framework of action developed to tackle health inequalities through action on the social determinants of health to promote policies to address inequalities affecting migrants. It is not possible to define a unique profile of migrant health because each community shows particular health outcomes, but some health effects are common among migrants, and they follow the life course. Being a migrant and having a different cultural background are specific determinants of health, having a particular causation pathway interacting with socioeconomic position.

In this context, migration could also represent one of the "causes of the causes" of health outcomes. Policies play a key role in tackling inequities in migrant health at global, national and local level. Using a Global Systems Science approach, it is possible to develop a strategic approach that supports improvements in health and social outcomes for migrants. Within this, policies have to be culturally oriented and intersectoral, and action needs to be at a scale and intensity that is proportionate to need.

INTRODUCTION

Health equity and migrant health have become increasingly relevant issues in global health. This is particularly evident since 2008, when the World Health Organization (WHO) published the Commission on Social Determinants of Health report and adopted the first Resolution to promote migrant health.

At the same time, intensification of the migration flow has been recorded globally, reaching a peak in 2015, when 244 million migrants were counted in the world. Over time both topics have become a priority in the public health agenda at international level: in 2013 the WHO European office adopted the Review of social determinants and the health divide in the WHO European Region[1] and in 2017 the WHO called for a global action plan on migrant health (WHA 61.17)[2 3].

In this context, the paper aims to show how policies to improve migrant health could be integrated into policies for health equity. In order to do this, the paper will discuss the migration phenomenon from a public health perspective, following the evidence on migrant health and the

role of migrant health policies, and then look at how to close the gap between evidence and policy.

MIGRATION AND PUBLIC HEALTH

Migration is a complex multi-causal phenomenon involving millions of people around the world moving for different reasons: economic, environmental and war (push factors) in order to find a job, education, safety, health care, and in general better quality of life (pull factors). Thus, social, environmental, economic and political aspects are at the same time, push and pull factors of migration trends.

As a large-scale movement involving all the continents, migration represents one of the most important challenges for today's health systems, which public health and health systems must consider in terms of societal transformation.

In analysing the phenomenon at international level, migration is defined by the International Organization for Migration (IOM) as the movement of a person or a group of persons from one geographical part to another either across an international border or within a State[4]. It is a population displacement, encompassing any kind of movement of people, whatever its length, composition, and causes, including migration of refugees, displaced persons, economic migrants, and persons moving for other purposes, including family reunification, and excluding short-term travel abroad for purposes of recreation, holiday, business, medical treatment or religious pilgrimage, because there is no change in the usual country of residence.[5]

Considering the UN data and the analysis conducted by the International Organization for Migration (IOM)[6] in 2015 the number of international migrants worldwide was the highest ever recorded, having reached 244 million. At the European level, migration has become one of the most closely examined topics, considering its impact on the economy and on population size in most Member States, due to intensive migration flows over recent decades among European Union (EU) Member States and from outside the EU.[7]

Analysing the migration phenomenon, in 2015 among the EU population of 510.1 million inhabitants (which was 1.8 million more than the previous year), 4.7 million people immigrated to EU Member States, while at least 2.8 million emigrated from EU Member States.[8]

Responding to the needs of the migration phenomenon, and in particular from its global commitment to the health of migrants, refugees and asylum seekers, the WHO European office

adopted the "Strategy and action plan for refugee and migrant health in the WHO European Region" during the sixty-sixth Regional Committee for Europe, held in Copenhagen in September 2016.[9]

WHO Euro's Plan affirms the need to develop resilience to sustained migration, especially after the migration crisis of 2015 and emphasises the phenomenon as "an opportunity not only to deal with short-term needs but also to strengthen public health and health systems in the longer term" [10] It is, therefore, designed to respond to the health needs associated with the migration process, namely, the need to ensure the availability, accessibility, acceptability, affordability, and quality of essential services in transit and host environments, including health and social services

With the objective of preventing disease and premature death due to migration, the Plan provides the following strategic priority areas and action reporting specific objective and actions for both Members States and WHO Regional Office:

- Establishing a framework for collaborative action
- Advocating for the right to health of refugees, asylum seekers, and migrants
- Addressing the social determinants of health
- Achieving public health preparedness and ensuring an effective response
- Strengthening health systems and their resilience
- Preventing communicable diseases
- Preventing and reducing the risks posed by noncommunicable diseases
- Ensuring ethical and effective health screening and assessment

Moving in the same direction, the WHO Regional Committee for the Americas adopted Resolution CD 55 R13 "Health of migrants."[11] The resolution mentions the WHO effort for migrant health, recognizing the four strategic lines of action defined within the regional Strategy for Universal Access to Health and Universal Health Coverage[12] as the framework for the health system's actions to protect the health and well-being of migrants. In particular, the actions are:

- Expanding equitable access to comprehensive, quality, people and community-centred health services
- Strengthening stewardship and governance
- Increasing and improving financing, with equity and efficiency, and advancing toward the elimination of direct payment that constitutes a barrier to access at the point of service

• Strengthening intersectoral action to address the social determinants of health

Most recently, following the 1st Global Consultation on Migrant Health, the 2nd Global Consultation on Migrant Health: Resetting the Agenda in 2017 was held in Colombo, Sri Lanka. The meeting was organized by IOM, WHO and the Government of the Democratic Socialist Republic of Sri Lanka, with the aim of offering Member States and partners a platform for multisectoral dialogue and political commitment to enhance the health of migrants.

At the end of the High-level meeting, the participants adopted the "Colombo Statement" as a Political Statement, which deliberated on how to enhance the health of migrants globally, declaring the guiding principles.[13] Among them, "the enjoyment of the highest attainable standard of physical, mental, and social well-being is a fundamental right of every human being" and "the importance of multisectoral coordination and inter-country engagement and partnership in enhancing the means of addressing health aspects of migration."

Given the global recognition of the issue of migrant health, it is timely to consider the issue within the paradigm of the social determinants of health.

MIGRANT HEALTH ACROSS LIFE COURSE

Considering migration as a substantial heterogenic phenomenon, defining a complete migrant health profile proves extremely difficult. However, it is possible to draw a general picture based on available evidence, taking into account the action of the selective pushes at the beginning and end of the migration path, and other elements that influence the general condition of migrant health, such as the quality of the relationship with health services, inaccessibility, and the effectiveness of the integration processes. Health and quality of the life of migrants are influenced by their foreign status, legal status, employment status and socioeconomic position. Having the right to access health care does not necessarily mean equality of access.

Regarding the life course approach, when analysing migrant health at the different stages of an individual's life, there is not a unique migrant health profile, but international literature recognizes different effects. Both traditional health beliefs and the process of acculturation play a fundamental role in the health and well-being of migrants.[14 15 16]

As shown in Figure 1, adapting the life course figure of the Marmot review,[17] the Strategic Review of Health Inequalities in England, the accumulation process of positive and negative effects on health and well-being are clearly represented during migrants' lives. Therefore, all these

life phases are areas of action to address health inequalities.

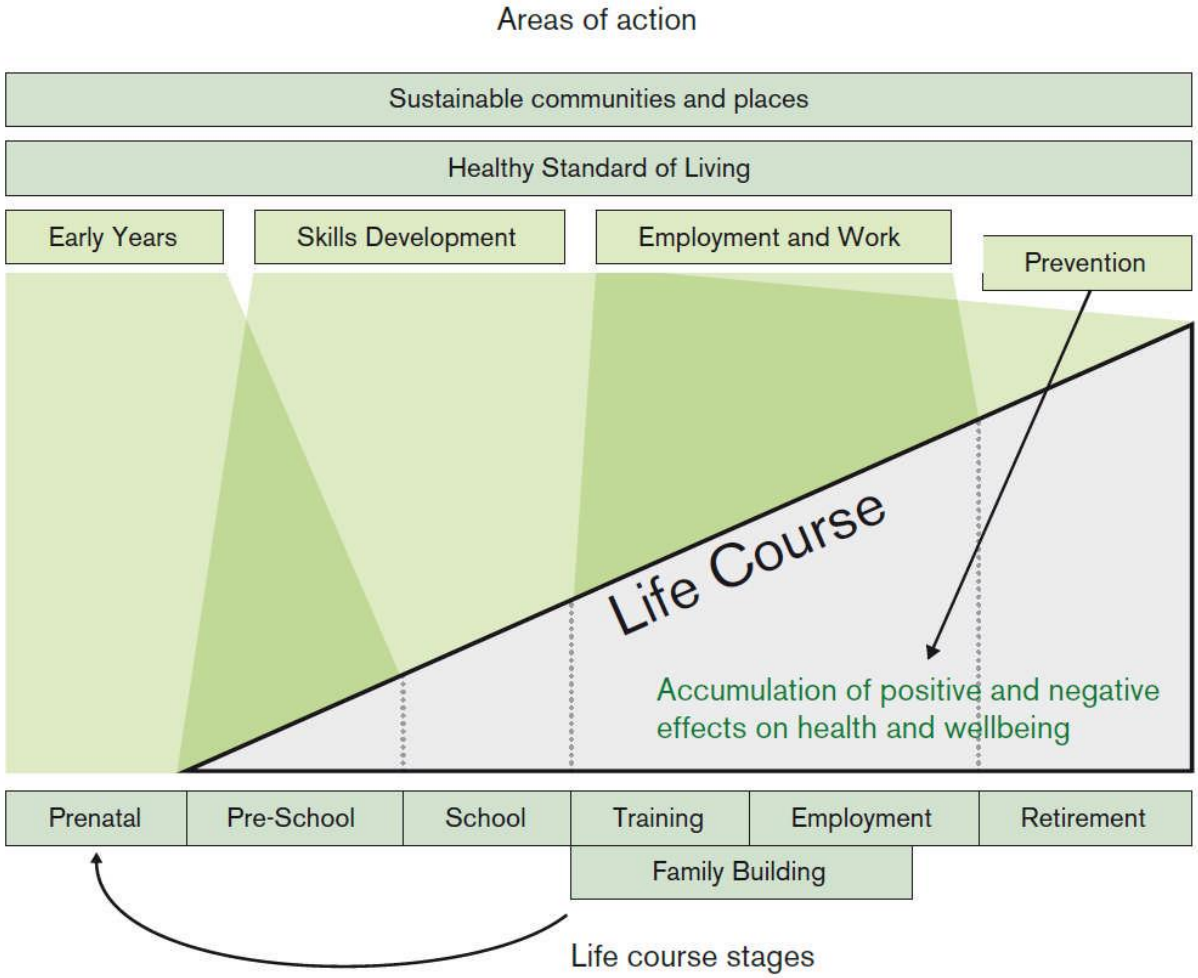

Figure 1 Migrant Health Across Life Course

By adjusting the process for migrant, it is possible to follow the migration process: the first three stages usually are in the country of origin, training, and employment in the country of destination and again the retirement period in the country of origin.

By looking at the inequalities in migrant health across the life course, some health-related effects are common among migrants. The "healthy migrant" effect is widely described in the literature regarding the first-generation immigrants who are often healthier than country-born residents with similar ethnic or racial backgrounds.[18] The migrant descendants, if well integrated into the host population, could reflect more the health profile of the host population,[19] considering that they may not receive the culture-specific behaviours from their forefathers.[20] In particular, the healthy migrant effect is mainly explained with self-selection at migration-level, where healthier

and wealthier people tend to be migrants: those who decide to emigrate are, in fact, mainly individuals in good health.[21] This effect is particularly common in worker migrants, and it is recognized in occupational epidemiology as the "healthy worker effect," describing subjects which are typically hired as generally in good health or without pathological conditions and disability.

From the host population's point of view, this kind of effect is widely unrecognized and underestimated by the media and public opinion. This explains the Italian myth of the 'migrante untore'[22] ("migrant as disease-bearer"), designating the migrant as a disease bearer using the word attributed to the people who were suspected of spreading the plague contagion during the well-known Milan plague in 1630.

Remaining in the Italian context, this kind of myth is closely linked to the 'Salgari syndrome,'[23] which refers to the imaginative expectations of finding foreign people with tropical morbidities without any experience and scientific evidence for this. The term comes from the name of an Italian novelist who, despite never travelling out of Italy, had described in detail faraway countries, not always painting the inhabitants of these imagined lands in a favourable light.

In accordance with the 'healthy migrant' and the 'migrant hope' effects, which reflect lower initial rates of morbidity and mortality than the native population,[24] the 'socioeconomic mortality paradox' is recognised as describing low migrant mortality compared to the host population despite poor socioeconomic status[25] [26]This is explained by the speed of the health transition, which precedes the gradual, cumulative effect of poor socioeconomic status-ill health.[27]

Indeed, analysing the migrant life course, it emerges that foreign people become more vulnerable to illness and disease as a result of poor living and working conditions in the host country. Arriving in a new country, migrants can experience adverse socioeconomic conditions[28] and in continuing to spend time in these circumstances increases disease risk by process of accumulation.[29]This kind of phenomenon has a vital role in the social determinants of health approach, and it is described in different ways at international level.

In particular, it is named the 'exhausted migrant' effect,[30]explaining the major migrant exposure to risk factors in the hosting country. Over time the migrant health advantage can diminish dramatically according to the success or failure of the migration project and the living conditions. Thus, even migrants' children could have considerably worse health over their lives than their counterparts in the national population.[31]This effect is closely connected to the

'weathering hypothesis. 'described in the literature whereby the health of African-American women may begin to deteriorate in early adulthood as a physical consequence of cumulative socioeconomic disadvantage.[32]

This effect is also linked with the 'double jeopardy' hypothesis, suggested in the 1970s to describe the intersection of age and ethnicity in leading to poorer health when it was noted that Black Americans experienced poorer health relative to White Americans as they age, and this was attributed to the effects of a lifetime of racial discrimination interacting with ageism[33].

Recently, the 'multiply disadvantaged status'[34] definition has been proposed referring to migrant health, which affirms that holding more than one stigmatised identity is worse for health than experiencing single or no disadvantages. This concept revisits the double jeopardy hypothesis considering whether having an ethnic minority background is linked to living with a severe mental illness, leading to a 'double disadvantage' to confer worse physical health and shorter life expectancy. This shows that it does not mean that disadvantage is automatically assumed with the holding of either identity but that there may be specific issues, in particular relating to experiences of discrimination and stigma, which may have adverse consequences for health.[35]

Some studies that relate this argument about a vulnerability in the period after the immigration process as the result of different factors, such as living in poorer socioeconomic conditions than the national population[36] and tending to assimilate lifestyles of the more socioeconomically disadvantaged population groups.[37]

At the end of the migration pathway, there is a further selective mechanism which is known in international epidemiological literature as the 'salmon effect' or 'salmon bias'[38] as an analogy with the behaviour of this fish which goes back to the river in the place where it was born to deposit eggs and die. The expression, in fact, describes the habit of older immigrants who tend to return to their country of origin, especially if ill.

By examining the causal pathway from political, social, economic environmental and cultural drivers, differential exposures to risk factors and inequities in health outcomes, the health effects described show that in some cases migration determines integration in a specific socioeconomic position, which determines specific exposure to risk factors, which determine health outcomes. On the other hand, in other cases, migration could represent a specific determinant of health.

Thus, following this pathway, although on the one hand, some specific experiences of migrants could be the same for ethnic minorities, such as discrimination and cultural barriers, on the other hand, other aspects could be very far from this, and it could be more appropriate to consider the highly specific aspect of people's migration pathway, such as the consequences of the same migration trip.

Therefore, health inequities affecting migrants can start from two different points: the first regards being a migrant and has specific causes as described above and it could be dealt with by addressing specific migrant needs; the second is related to being a migrant as a component of the most vulnerable part of society, and it could be dealt with by addressing inequities in society as a whole.

BRIDGING THE GAP BETWEEN RESEARCH AND POLICY

The rise of migrant health as a public health priority has led to an increase in the attention of policy makers to this matter, making migrant health an extremely important topic.

In accordance with the Report of the CSDH,[39] implementing policy measures for migrant health also calls for a multisectoral and multi-stakeholder strategy involving national, regional, provincial and municipal authorities, as well as civil society and local communities, businesses, professional, educational and scientific bodies, media and international agencies. Although national governments should play a leading role, the participation of all these agents is essential for achieving change.

Overcoming the common separation between health equity and migrant health matters, understanding the pathway from migration to health outcomes allows us to adapt the social determinants of health approach to specific migrant health needs. The role of intersectoral policies appears fundamental for action on the causal pathway generating inequalities in migrant health.

As defined by WHO,[40] intersectoral action for health refers to the inclusion of several sectors in addition to that of health, during the design and implementation of public policies to improve quality of life. An important objective of the intersectoral action is to achieve greater awareness of health, and the health equity consequences of policy decisions and organizational practice in different sectors and move in the direction of healthy public policy and practice across sectors.

In this regard, one of most significant lessons of the CSDH conceptual framework is that interventions and policies to reduce health inequities must not limit themselves to intermediary determinants of health but must include policies specifically to tackle the social mechanisms that systematically produce an inequitable distribution of the determinants of health among population groups.

Therefore, considering migrants as a specific group, tackling health inequities requires special approaches such as targeted methods of health promotion[41]. The combination of "Health in all policies" (HiAP)[42] and "proportionate universalism"[43] appear adequate to address the mechanisms generating the particular migrant health inequalities. Proportionate universalism means delivering policies that are universal at a scale and intensity proportionate to need.

On the one hand, HiAP can represent a governmental strategy to improve population health by coordinating action across health and non-health sectors, and on the other hand "proportionate universalism" can make it possible to effectively tackle health inequities with universal services responding to the level of need, recognizing the need for greater intensity of action for more disadvantaged groups.

Research and policy must work together to implement an evidence-based approach to improve migrant health.

CONCLUSION

Bridging the gap between research and policy is a challenge in tackling inequities in migrant health. The Marmot review and the WHO documents clearly indicate how it is possible to act on the causal pathway determining inequities in migrant health. Policies can use the evidence to address inequities in migrant health.

In this framework, policies must be: culturally oriented, Intersectoral, following Health in All Policies approach. They must include policies specifically to tackle the social mechanisms that systematically produce an inequitable distribution of the determinants of health among population groups.

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