

Viewpoints

Migrant health: the economic argument

The right to health care is acknowledged in many international declarations—however, often with unclear statements regarding the population groups that should actually be provided with this right and the extent of services that should be included. National legislations of the European countries on the provision of health care are generally restricting entitlements to certain population groups. As a consequence, many migrants enjoy entitlements which are not comparable to those of the citizens of the country—depending of their formal status in the country.¹ Besides, the full enjoyment of health care requires not only formal entitlements, but also the existence of inclusive health services that are able to ensure quality of care when access has actually been obtained. An accumulating body of evidence in the field of health and migration concludes that the specific health needs of migrants and ethnic minorities are often poorly understood, communication between many health care providers and migrant patients remains poor and health systems are not fully equipped to respond adequately. Despite these facts, only a few countries have adopted national policies on migrant and ethnic minority health to meet the challenges. It is also pointed out that the research fields concerned with equity in health, human rights and health and migration are insufficiently connected to each other and therefore miss synergies to support policy change.

In Europe, ageing societies are increasingly dependent on immigration to compensate for low birth rates, meet labour market demands and sustain their welfare models. Health is both a prerequisite and an outcome of successful migration and integration processes. Health systems have to become more responsive to the needs of migrants to reach the goal of equity in health service provision and health outcomes as defined in European normative frameworks. In a press release in May 2015 The European Public Health Association (EUPHA) states that ‘Health systems need to be supported to respond both to (their) immediate health needs due to problems arising from exposure and injury as well as ensuring access to health services in the long term particularly to psychological support services’.

Economics: recent studies on effects of restricted access

Besides the human rights and equity principles the so-called economic arguments have increasingly been subject to discussions in recent years. What are the economic effects of immigrants for society at large and what are the costs and the benefits from ensuring or restricting entitlements, access and quality of care for different groups of migrants? Recent studies have made first attempts to quantify economic losses that may occur due to restricted access to health care for migrants, be it for legislative or practical reasons. Those studies have focussed on the most vulnerable migrant groups: asylum seekers, undocumented migrants and uninsured. Using different methodological approaches and data sources, they come to similar conclusions: it is not cost saving to restrict access to health care.

The European Agency for Fundamental Rights FRA commissioned a study on ‘Costs of Exclusions’, targeting undocumented migrants in three EU member states, using a decision tree model.² A study for Germany of the same year surveyed annual, nation-wide, aggregate data of the German Federal Statistics Office for 1994–2013 to compare incident health expenditures among asylum seekers and refugees with restricted access to those with regular access,

concluding that the cost of exclusion from health care appears ultimately higher than granting regular access to care.³ A vignette study using primary data from health care providers in four EU member states within the framework of the IOM/EC EQUI-HEALTH project ‘Fostering health provision for migrants, the Roma and other vulnerable groups’ demonstrated that in the conditions and settings studied, timely treatment in a primary health care setting is always cost-saving when compared to treatment in a hospital setting. At least 49% and up to 100% of direct medical and non-medical costs of hospitalisation can be saved in such cases, if timely primary health care is provided to those who would otherwise be denied it.⁴

Results from such studies back up the concerns about negative effects of inequalities in access to care as formulated by the Parliamentary Assembly of the Council of Europe (2013): ‘These inequalities lead to a phenomenon of non-recourse or delayed recourse to care, which could have disastrous implications for both individual and public health and lead in the long term to an increase in health expenditure’.⁵

Economic arguments and human rights go hand in hand

The assumption that it is not cost saving to restrict (timely) access to health is thereby closely connected to the acknowledgement of the human right to health as it is enshrined in various international and European documents. An expert consensus paper developed in the course of a series of joint international meetings in 2012–2016 within the framework of the IOM’s EQUI-HEALTH project, in collaboration with COST Action IS1103 ADAPT (Adapting European health systems to diversity), takes this issue further. The first recommendation is that: ‘The principle of universal and equitable health coverage should be applied to all persons residing de facto in a country, regardless of their legal status’.

Equity is defined as the extent to which a system fairly deals with all concerned. It includes the distribution of the burden of paying for health care and the distribution of health care and its benefits among people. This may lead to exclusion of people who did not contribute or did not contribute enough and may also lead to discourses about ‘deservingness’, as a moral assessment whether, to what extent and why a person or group ought/ought not to be granted recourse to public (health) resources. It is a frequently presented claim that certain groups of immigrants such as asylum seekers, undocumented migrants or even newly arrived immigrants with residence permit do not deserve full access to qualified health care at the same level as ‘natives’ because they have not (yet) contributed to the society, financially or in other terms. Another claim with a similar consequence relates to the assumption that generous welfare services like health care attract more migrants to your country. Exclusionary viewpoints on deservingness like the one presented above are clearly in conflict with the general human rights declarations which are not restricted to citizens contributing to society. The second claim on the effect on patterns of migration of the attractiveness of your welfare system is hardly supported by existing evidence at all.

The economic argument, however, seems increasingly in support of the full provision of services for all immigrants on the level of everyone else in the country—not only in order to fulfil the equity principles and general human rights, but also to avoid future

preventable costs for society. Europe needs immigrants in order to ensure future productivity and welfare—and there are very good reasons to ensure the best possible health of the migrants right from their arrival in Europe.

Competing interests

The authors declare that they have no competing interests.

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Migrant health: putting the economic argument into the context of deservingness debates

The main arguments for improving access to health care for marginalised groups, including migrants and ethnic minorities, have mostly been based on public health considerations, human rights claims and ethical principles of equity. However, the respective political debates often focus on economic arguments such as moral hazard, (presumed) health expenses, and the need to safeguard scarce resources. Acknowledging the role of economic arguments in political decision-making processes, researchers and activists have begun to pay more attention to the fiscal implications of limiting migrants' access to care. As yet, however, empirical evidence on the economic implications of different policy responses to migration is scarce. As pointed out by Trummer and Krasnik,¹ the 'right to health care is acknowledged in many international declarations—however... only a few countries have adopted national policies on migrant and ethnic minority health to meet the challenges.' They also cite several recent studies indicating that restricting access to care for those groups does not help save costs.

While we absolutely support the call for evidence of the economic consequences of exclusionary policies, we also want to point out the need for a better understanding of how economic arguments have been put forward within different contexts, and how such evidence can actually be moved into practice. According to our and others' research,^{2,3} economic arguments are perceived and employed very differently in different contexts and in interrelation with a variety of other rationales.

Considering the central role of economic arguments in political decision-making generally, and considering furthermore the concurrent context of austerity specifically, one would expect that the costs of migrants' exclusion will leave an impact on the political debate—all the more since they are corroborated by empirical evidence. Yet, in our experience economic arguments in support of migrants' greater inclusion gain only scant attention; and suggestions for inclusive policy reforms continue to be regarded as impractical romanticism. More than that, the economic argument that, in an integrated health care scheme, migrants' health needs would become a drain on the system continues to be used to justify exclusionary policies, although no empirical data is produced in order to verify it. In light of the evidence mentioned above the decision to maintain restrictions on migrants' health entitlements seems self-defeating. Why not opt for a more inclusive alternative to resolve

the tensions with international law and agreed-on ethical principles and, in the same breath, enjoy the economic (and public health) benefits of such policy reform? What are the reasons, really, that keep governments around the world from making such change?

In our view, what ultimately tips the scales in decision-making processes on migrants' health entitlements are value-based, rather than evidence-based rationales; namely, discourses of deservingness. '[A]rticulated in a vernacular moral register that is situationally specific and context-dependent'⁴ these discourses demarcate right-holders from non-right-holders. Importantly, 'deservingness debates often have less to do with empirical evidence than with... everyday responses to normative questions. These vernacular responses generally mix subjective attitudes and presumptions with taken-for-granted truths regarded as collective "common sense."' (ibid.) Moreover, these moral discourses are very different from universalistic human rights and public health ethical frameworks in that they absolutely discriminate; e.g. on the basis of national belonging or perceived contribution to society.

Are we arguing that these deservingness discourses are powerful enough to simply override all other factual and ethical arguments for migrants' greater inclusion? Not exactly. The interaction between discourses of deservingness and other rationales is not straightforward in that evidence- and value-based arguments, knowledge and norms, 'facts' and 'politics' are interwoven in dialectic manners: not only do empirical facts influence the formation of normative positions; but also normative positions mold the generation and perception of factual 'knowledge', including in the field of health and evidence-based medicine.⁵ This interaction deserves further research. And more questions remain; e.g. why are discourses of deservingness so rarely invoked to legitimize exclusionary policy choices? What are the reasons that, instead, economic arguments that are unfounded or even belied by evidence are used to uphold exclusionary policies? How can we explain that these arguments persistently dominate the discussions on migrants' access to care? And how can we explain that, by way of comparison, evidence-based arguments in favor of more inclusive policies barely succeed to attract political decision-makers' interest? And finally: what are the consequences for us as researchers, if the influence of scientific evidence on political decision-making processes concerning