

## Migration, ethnicity and health

Statement drafted by the Section for Migration, Ethnicity and Health  
of the European Public Health Association (EUPHA)

9<sup>th</sup> May 2018 (revised 11<sup>th</sup> October 2018 to take account of newly released data)

### Summary

Migrants and ethnic minorities (MEM) often face serious inequities<sup>1</sup> concerning both their state of health and their access to good quality health services. These inequities are increasingly being brought to light by public health researchers, but action to tackle them has lagged behind. To ensure that adequate attention is paid to the determinants of MEM health and the problems of service delivery that can confront these groups, health systems need to become more inclusive.

The rising tide of populism and nationalism in European politics has created a hostile environment for such reforms. Nevertheless, a new willingness to stand up for migrants' rights is emerging at the level of international organisations. Member organisations such as the IOM, WHO, ILO and UNHCR have succeeded in placing migration centre stage at the United Nations, where 'Global Compacts' on migrants and refugees are currently being drafted.<sup>2</sup> These are linked to the Sustainable Development Goals (SDGs) that define the UN's development programme for 2015-2030. The SDG's, with their maxim of 'leaving no-one behind' and their emphasis on equity in all countries (not just 'developing' ones), provide welcome and explicit support for efforts to combat inequities in MEM health.

For those who are unwilling to see research on MEM health limited to a purely academic enterprise, these are encouraging moves. However, policies can only be as good as the data they are based on. EUPHA is therefore issuing this call to reduce the gap between researchers and policy-makers, in particular those responsible for setting research priorities and implementing findings. The statement addresses the following key issues, which are discussed in more detail in the Explanatory Memorandum (click on the headings for links):

1. **[The need for evidence-based policies on MEM health.](#)** How can the evidence base for policy reforms be strengthened?

#### ***a. Fundamental concepts and data collection***

The need for more and better data should be the first priority in MEM health. Because of the failure of research funding bodies and health system managers to recognise the importance of a strong evidence base, researchers and service providers alike suffer from a shortage of crucial data. Progress is also hampered by the lack of harmonisation of fundamental concepts.

#### ***b. MEMs' state of health and its determinants***

Epidemiological evidence, based on population-based rather than clinical data, is badly lacking on many topics. On the principle "no smoke without fire", it is often

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<sup>1</sup> WHO defines inequities in health as "unnecessary and avoidable as well as unjust and unfair" inequalities:  
<http://www.who.int/hia/about/glos/en/index1.html>

<sup>2</sup> <https://refugeesmigrants.un.org/migration-compact>

assumed that migrants' main health problems are those on which most research has been carried out. However, priorities are often defined by myths rather than realities.

***c. Issues concerning service delivery***

The interaction between health services and their MEM users, including issues of access, quality, utilization and communication, has become a major field of research within EUPHA. Not enough attention is paid to the need to adapt health services to the needs of migrant and minority users. Quite independently of their particular vulnerabilities, MEMs have the right to affordable and effective health services of all kinds and at all times, not only in emergencies. Considerations of immigration policy should never be allowed to stand between them and the help they need.

2. **The target group.** Whereas most international organizations tend to confine their attention to migrants, the position of EUPHA has always been that ethnic minorities need to be considered as well. These include the descendants of migrants as well as indigenous minorities. Such groups may experience inequities at least as great as those affecting migrants, and often similar in nature. This has implications for data collection: both ethnicity and migrant status need to be taken into account.
3. **The diversity of MEM groups.** Over-generalising approaches that fail to acknowledge diversity within groups need to be replaced by 'intersectional' analyses that examine simultaneously the effects of socioeconomic position, sex/gender, age and many other variables, as well as their interactions. Instead of being targeted at monolithic categories such as 'migrants', 'refugees' or 'minorities', policies should focus on within-group differences and real need. A 'grapeshot' approach encourages stereotyping and inaccurate targeting. Neither migrants, refugees nor ethnic minorities should be labelled in their entirety as 'vulnerable groups': to do so is to stigmatise them and underestimate their strength and resilience. In service delivery, 'diversity sensitivity' is to be preferred to a narrow emphasis on 'cultural competence'.
4. **The need to return to a broader framing of migration.** The influx of unauthorised entrants to the EU in 2015-2016 (the so-called 'migrant crisis') has led to a one-sided focus on the needs of forced and irregular migrants – ignoring the 'routine'<sup>3</sup> migration that is in no way a 'crisis'. Moreover, whereas the response of policy-makers to the 2015-2016 influx focused mainly on asylum seekers and refugees, many of the newcomers have joined the EU's existing population of migrants in irregular situations; this group is all too often neglected in both research and policy-making.
5. **Combating the fragmentation of MEM health policy in Europe.** Much duplication of effort and 'reinventing the wheel' results from insufficient coordination within and between responsible agencies. In addition to the intrinsic divisions between European countries and language communities, regional and international organisations often

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<sup>3</sup> The word 'routine' is preferred to 'regular', in order to emphasize the fact that asylum seekers, despite often entering without authorisation, regularise themselves by making an asylum application. However, we do not wish to classify asylum-seeking as 'routine'. The distinction 'forced/unforced' is also avoided, because research has shown that it is impossible to regard these as mutually exclusive categories.

compete with each other instead of cooperating, which leads to wasted effort and lost opportunities to create synergies. Priorities should be based on the latest insights into public health and the position of MEM in today's Europe.

6. **More attention in EU research programmes for MEM health.** MEM health was a central topic in the First and Second Programmes of the European Commission (EC), but apart from a sudden surge in financing for projects on asylum seekers and refugees, it has been seriously neglected so far in the Third Health Programme. EUPHA is concerned about the lack of attention in this programme for health inequities in general, and those affecting MEMs in particular.
7. **Better provision of education and training on MEM health.** Although this Statement is primarily concerned with the links between research and policy-making on MEM health, capacity building in both areas has to be supported by education and training directed at health workers of all kinds, researchers, managers and policy makers. This should not only be provided in optional additional courses, but as part of basic curricula.

## **APPENDIX: STATISTICAL SUPPLEMENT ON MIGRATION TO THE EU/EEA**

The Appendix presents new analyses of data on migration to the EU, focusing on two topics about which misconceptions often dominate.

1. **How large was the recent influx of unauthorized entrants to the EU/EEA in comparison with regular migration?**

Even at its peak in 2015-2016, the number of those seeking international protection in Europe was lower than that of 'routine' entrants for purposes such as work, family and study. Moreover, in terms of migrant stock, all the unauthorised landings in 2015 and 2016 added only 4% to the total of third-country nationals already residing in the EU/EEA. In relation to the total population, this percentage was a mere 0.3%. Exaggerating the size of the influx only encourages the backlash against migration that it provoked.

2. **How evenly are asylum seekers and other migrants distributed over EU Member States?**

The uneven distribution of different categories of migrants in the EU/EEA means that 'one-size-fits-all' policies on MEM health are in fact likely to fit none. To begin with, there are extreme differences between EU15 and EU13 countries in the numbers of asylum seekers and other migrants they take in. In addition, migrants are not scattered randomly over different Member States; there are strong bilateral corridors connecting (for example) India with the UK, the Ukraine with Poland, the Maghreb with France, and Turkey with Germany, the Netherlands and Belgium. Likewise, because of the unwillingness of EU Member States to share each others' burdens, acute problems due to migratory pressures are confined to a handful of countries. Of particular concern at the moment are Italy and Greece, where large numbers of newcomers are trapped, often in subhuman conditions, with little prospect of relief.

# **Explanatory memorandum on migration, ethnicity and health**

## **Background to this document**

In July 2017, a draft submission on Migrant Health to the EU Health Platform, written by the NGOs PICUM and ICRT, was sent to EUPHA for comment. At the same time the Association was asked to consider adding its name to the list of signatories to this document. Members of the Board of the Migrant and Ethnic Minority Health Section sent back comments on the document, most of which were taken into account in subsequent revisions. Following this, it was decided to work on a broader statement to be submitted to EUPHA's Governing Board for endorsement.

## **Purpose**

The statement is intended to bring concerns of Section members to the attention of a wider public – in particular, to policy-makers dealing with issues of MEM health. Policy-makers frame problems and set important parameters for research such as funding and topics; they also influence whether and how research findings are implemented in practice. Policies relevant to MEM health are made at several levels: by local, regional and national governments, as well as by intergovernmental organisations (IGOs) such as the European Commission, Council of Europe and organisations belonging to the United Nations system (in particular WHO, IOM, ILO and UNHCR). Since EUPHA is a European association, its primary policy-making counterparts are the European Commission, Council of Europe, WHO Europe and the IOM Regional Office Brussels.

## **Main themes**

In recent years, migration has become an increasingly controversial topic. Support for migration and the rights of migrants has been undermined by the rise of anti-migrant and nationalistic movements. Migrants themselves are to a large extent disenfranchised, and those who are able to vote are usually greatly outnumbered. Despite all this, surveys among the general public have revealed a more complex picture; attitudes towards migration have not become more negative in all social groups and all European countries (Czaika & de Lillo 2017), though overall they are more negative in Europe than in other world regions (IOM 2013).

Against this background, advocating for migrants' rights to health and access to quality health services has become uphill work. There is a persistent shortage of research funding, as well as a widening gap between research and policy. Policy-making is often dominated by rhetoric and prejudice, rather than research findings. This is a symptom of the rise of 'fact-free politics' on both sides of the Atlantic, i.e. increasing disregard for empirical evidence and contempt for the views of 'experts'.

The main thrust of this Statement is that the gap between research and policy must be narrowed; policies need to become more 'evidence-based'. Researchers also need to become more 'policy-oriented', in the sense of actively reaching out to policy-makers and trying to help them solve problems of implementation, rather than simply waiting passively for research findings to be noticed and put into practice. The bodies that finance research and

determine priorities need to take more notice of the rapidly changing ‘state of the art’ in the field. This concerns not only the problems selected for attention, but also the choice of approaches for tackling them. All too often, the priorities reflected in research programming seem uninformed by developments in current thinking about Public Health in general and MEM health in particular.

## **1. Towards an evidence-based MEM health policy agenda**

Traditionally, the main issues in this field have been the state of health of migrants and ethnic minorities, as well as health service provision for them. Research on the first topic has increasingly focused on ‘upstream’ determinants of health, i.e. living and working conditions that create the main threats to MEM health. These can only be tackled by going beyond the boundaries of the health system itself to promote intersectoral action within the framework of ‘Health in All Policies’ (HiAP, see WHO 2014). To underpin work on all these issues, a robust data base is needed.

### **a. Fundamental concepts and data collection**

‘No data no progress’ is a favourite slogan of those working on Roma issues, which applies equally well to the rest of MEM health. More effort must be devoted to collecting and analysing data at European level. It is particularly troubling that ten years later, there have been no successors to the projects MEHO (Monitoring the health status of migrants within Europe, 2007-2010), and CLANDESTINO (Trends across Europe in undocumented migration, 2007-2009).

Fundamental debates must also continue on the conceptual frameworks to be used in studying MEM health. Ideas about migration and ethnicity are constantly evolving, and no conceptual system can claim to be fixed for all time. ‘Cutting-edge’ scientific approaches are insufficiently encouraged by current research funding opportunities.

At present the concept of ‘vulnerable groups’ plays a large role in EC policies on MEM health. There is little discussion of what exactly is meant by ‘vulnerability’ and whether a generic approach is the best way of targeting interventions, as opposed to one that recognises diversity within groups. At worst, a generic approach can lead to stereotyping, overgeneralisation and stigmatising of the groups in question.

### **b. MEMs’ state of health and its determinants**

Once again it is important that policy-making should be data-driven, not simply a response to political or media concerns. There is far more research on post-traumatic stress disorder (PTSD) among refugees than on common mental disorders such as depression and anxiety, despite the fact that the latter are more widespread than the former. Similarly, for a long time it was assumed that migrants are mainly affected by infectious diseases, whereas in reality non-communicable diseases form a greater burden. In relation to MEM health it is also important to remember that some groups may actually enjoy health *advantages* over the majority population (although this only applies to their state of health, not to the accessibility and quality of health services for them).

Research on the prevalence of health issues and risk factors should inform policies on service delivery, but not in the sense that entitlement should depend on prevalence. Failing to provide adequate services when a group is known to be at high risk of a certain condition is especially deplorable, but it is not only high-risk groups that have the right to good health care. Most health problems of MEM are ones that everybody can suffer from, simply by virtue of being a human being. The main value of epidemiological work is for identifying the root causes of illness. What are the threats and how can they be tackled? How can health be enhanced, as opposed to simply reducing illness?

In the category of social determinants of health a special place should be reserved for **discrimination** of all kinds – direct and indirect, individual and institutional. This requires collaboration with social scientists working on policies and attitudes to migrants and ethnic minorities.

### c. Service delivery

In Europe as well as world-wide, there has been a steady increase in scientific attention for issues of access and quality in health service provision. The study of service delivery requires the contribution of many different disciplines (anthropology, sociology, health economics, demography, political science, genetics, etc.) In particular, collaboration with the field of Migration Studies is essential – though at present, regrettably, few who work in that field seem to be interested in health issues.

In work on service delivery, migrants and ethnic minorities should be seen as a *resource*, not a liability: they should be involved in and consulted on health service provision, rather than being treated as passive and ignorant (as implied by terms such as ‘low health literacy’). How to promote their participation is still a major challenge, and the EU should focus more on supporting European research, policy and practice to cope with this challenge (De Freitas & Martin 2015).

One important new scientific development in the field of migration studies is the notion of ‘multilevel governance’, i.e. the recognition that a simple top-down model does not adequately describe the governance of health systems in the EU. Within the same country, different levels of government (national, regional, local and municipal) often have different priorities, and may even conflict with each other. The way in which cities in Europe deal with their (frequently large) MEM populations is particularly important. It is at city level that the most innovative health service provisions can often be found (Perna 2018).

## 2. The target group

One issue that our Section is well placed to address is how the target group should be defined. There are good reasons why the EUPHA section concerns itself with ‘migration, ethnicity and health’, rather than simply ‘migrant health’.

- a) WHO and EC policy tends to focus on ‘first-generation’ migrants alone, with some attention for indigenous minorities such as Roma or Sami. This overlooks the offspring of migrants born in the receiving country, who are classified as part of the



majority population – as if being born in a country guarantees perfect integration. However, the descendants of migrants often confront challenges similar to, or even worse than, those faced by the first generation. Most of these do not result from cultural or genetic factors, but from the degree of acceptance of this group by the ‘host’ society, which is strongly influenced by ethnicity or national origin. For example, unemployment among second-generation youth (especially those of North African or Sub-Saharan origin) tends to be higher than among majority youth (Froy & Pine 2011).

A group requiring urgent attention are the descendants of ‘guest workers’ who migrated to North-West Europe and Austria between the 1950s and early 1970s. The OECD has devoted much attention to the educational and employment level of this group, which is often seriously marginalised; however, very little attention has been paid to their health, either by researchers or policy-makers. (The exceptions tend to be found in countries where researchers can identify nationals with a migration background, such as the UK, Belgium, the Netherlands and Nordic countries.)

- b) Even among ‘first-generation’ migrants, their ethnicity is highly relevant for health researchers. The importance of retaining both perspectives is that each one can yield important insights for policy-makers. There is controversy over how ‘ethnic minorities’ should be defined and categorised, but however it is done, differences emerge that are often relatively independent of migrant status. Using a different lens will render different phenomena visible; ideally, both perspectives should be considered simultaneously.
- c) The term ‘ethnic minorities’ also includes sedentary *indigenous* minorities. These groups fall outside the topic of migration and health, but they may be subject to similar health risks and inequities in service delivery. Research on these groups should be carried out by, or in close collaboration with, researchers on MEM health.

### **3. The diversity of migrants and ethnic groups**

An issue that has come to the fore among researchers in the last 15-20 years, but has been inadequately recognised by policy-makers, is that of the diversity within MEM groups. The tendency to treat all members of a given group as similar, and to project certain stereotypical characteristics on to them, has been challenged by increasing evidence of the heterogeneity of groups. Statistically speaking, the main effect of group membership can be smaller than its interactions with other factors. As yet, this shift has had little impact on policy-makers, who usually seek to base policies only on main effects.

Often, a list of effects found only in particular subgroups is given and ascribed to the group collectively. In this way, migrants as a whole are said to suffer from increased rates of maternal and child mortality, infectious disease, non-communicable disease, PTSD and so on, giving the impression of a disease-ridden population. Underlying this tendency is the assumption that special attention for migrant health would only be justified if the group *as a whole* could be shown to have increased needs. Ignoring the diversity of illness profiles, however, masks the fact that some MEM groups are actually healthier than the native

population (Gruer et al. 2016). Asylum seekers are routinely labelled a ‘vulnerable group’, whereas in relation to the extreme stresses they may have had to endure, their level of physical and mental resilience may be exceptionally high.

The previous section mentioned the importance of distinguishing between migrants with different origins, as well as between members of ethnic groups with differing migrant status. Other dimensions of difference should also be systematically taken into account: not only age and sex/gender, but also socioeconomic status. Doing so reveals that there is great diversity within groups of migrants and ethnic minorities, which calls in question the strategy of targeting policies at groups as a whole. An ‘intersectional’ approach examines the effects of several dimensions of diversity simultaneously (Palència et al. 2014).

Policies, too, need to incorporate an intersectional approach. Rather than considering each dimension of difference separately and making separate policies for each category (e.g. migrant/native, minority/majority, old/young, male/female, rich/poor and so on), there is a need for policies that take account of diversity within each of these dimensions. Labelling our topic in general terms like ‘diversity’ or ‘health equity’ allows simultaneous consideration of many types of difference and is becoming increasingly the norm in both the USA and Europe. This applies not only to health status, but to service delivery as well. For example, the notion of ‘cultural competence’, traditionally associated only with ethnicity and migrant status, is giving way to a broader emphasis on ‘sensitivity to diversity’ (Cattacin et al. 2016).

Although we have stressed that health problems affecting migrants tend to be specific to particular groups, there is one respect in which migrants tend to have a problem in common – not a health problem as such, but a structural form of social disadvantage. This is the gap between universal human rights and the rights accorded to people who are not citizens of the countries they live in. Treating nationals better than foreigners is a defining feature of the nation state; it inevitably affects the living and working conditions of all but the most privileged of migrants.<sup>4</sup> Very often, migrants work under conditions (e.g. pay, safety, status) that nationals are reluctant to accept. This is not in itself a health problem, but it can create a wide range of health risks, including the denial of health care coverage to many legally resident migrants (IOM 2016).

#### **4. The need to return to a broader framing of migration**

One of the negative consequences of the ‘migrant crisis’ in Europe is that it led to a disproportionate emphasis on unplanned and unauthorised immigration, so that migration became framed only as a problem. A study of media representations (EJN 2016) concluded that

.....the media’s reporting on migration focussed almost exclusively on the thousands of people fleeing their home countries as a result of conflict or other contextual factors and the effects of these flows of people on transit and destination countries; as a result, the media also contributed to the perception that migration was “a problem” rather than a

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<sup>4</sup> In theory this ‘rights gap’ should disappear as soon as a migrant is able to acquire citizenship of the receiving country (naturalisation), but many disadvantages may remain because the migrant’s foreign origin may still be visible and audible, as well as being suggested by their name. This is one reason why we argue for studying ethnicity as well as migrant status.



multi-faceted global phenomenon with a variety of permutations, challenges and opportunities. (EJN 2017: 3)

Unfortunately, policy-making at European level contributed to this shift. Migrant health was reframed in terms of ‘preparedness for emergencies’, using concepts and tools from disaster medicine, rather than being seen as a permanent feature of the European social landscape. Long-standing migrants and their dependents dropped out of the picture altogether, despite the fact that ‘routine’ migration for family, work and study reasons far outnumbered unauthorised arrivals. The Appendix shows that even in 2015-16, the majority of newcomers to the EU were in the former category.

It is of course commendable that substantial resources were devoted to the health challenges created by the 2015-2016 influx. However, this seems to have been at the expense of funding for research on other MEM groups. The balance needs urgently to be restored – not only in terms of research funding, but also in terms of the way we talk about MEM health.

Another issue illustrated in the Appendix concerns the great differences between European countries in the distribution of migrants and asylum seekers. Even at the height of the ‘migration crisis’, sudden changes in demand for health services were experienced only in a small number of countries. EU Member States responded with alacrity to the new situation – but mainly by taking urgent steps to ensure that the influx passed them by. Because of the failure of the EU’s ‘burden-sharing’ policies, the main task of hosting asylum seekers and integrating refugees has fallen to Greece, Italy, Sweden and above all Germany, which received more asylum seekers than the rest of the EU/EEA put together. Localised problems require localised solutions: a standardised approach to MEM health in the EU is not an effective way of distributing resources and influencing national governments.

## **5. Combating the fragmentation of MEM health policy in Europe**

As we saw earlier, efforts at the United Nations to tackle migration issues in the framework of the Global Compacts and the SDGs show an impressive degree of cooperation between these bodies. Unfortunately, this has not been the norm up to now: efforts have often been fragmented and uncoordinated. A ‘joined-up’ approach is needed, in three main ways.

### **a. Better internal coordination of EC activities on MEM health**

Within the EC, the diverse initiatives undertaken by various DGs on MEM health often seem haphazard and show little sign of coordination. At least seven DGs are active in this area and there is frequent overlap between their activities, as well as with those of EC-supported bodies such as PICUM, WHO Euro and IOM Brussels RO.

A major weakness of the Commission’s approach to health concerns the application of the ‘health in all policies’ principle (HiAP). On its website,<sup>5</sup> DG SANCO claims that “All EU policies are required by the EU treaty to follow [the] ‘Health in All Policies’ (HiAP) approach”: however, this requirement seems more honoured in the breach than in the

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<sup>5</sup> [https://ec.europa.eu/health/health\\_policies/policy\\_en](https://ec.europa.eu/health/health_policies/policy_en)

observance. The health impact of EU policies is hardly ever monitored, let alone allowed to influence policy-making (Ståhl 2010). This applies particularly to policies affecting MEM health.

Instead of acting as a kind of NGO, trying to plug gaps in countries' health systems, the Commission needs to put more emphasis on influencing the policies of Member States. Of course, the principle of subsidiarity prevents it almost entirely from doing this by legal coercion: but this is no excuse for not making full use of all the instruments it has at its disposal within the 'open method of coordination' – influencing policies by dialogue and friendly persuasion.

#### **b. The need for collaborations outside the EU/EEA**

MEM health is a global concern. Obviously there are limits to the amount of European taxpayers' money that can be spent outside Europe, but collaborations with other countries working on MEM health, as well as with countries from which migrants originate, can yield many benefits to the EU/EEA in return. Closer to home, although Switzerland does not belong to the EU/EEA, it has played a pioneering role in developing expertise on migrant health and should be encouraged to participate in EU activities – rather than being, as at present, systematically excluded.

#### **c. More collaboration with other high-level organisations**

As well as the EC, organisations such as IOM, WHO, UNHCR, ILO, Council of Europe and OECD are all active in the field of MEM health, as are several international NGOs. The Commission maintains a certain number of active collaborations, but there is also much duplication of effort and 'reinventing the wheel', while many opportunities for creating synergies are lost. It is also regrettable that since the closure of its Health Division, the Council of Europe has discontinued its valuable activities on MEM health.

### **6. More attention in EU research programmes for MEM Health**

In the first and second EU Health Programmes (2003-2013), work on 'health inequalities' was a separate and explicit theme. The overview published by Chafea (2014) gives details of all 64 projects on this theme, two-thirds of which were carried out between 2006 and 2010. Target groups, methodology and health issues fell into two main clusters, one focusing on 'the social gradient' and the other on 'vulnerable groups'. The latter comprised migrants and ethnic minorities, as well as certain high-risk social groups such as drug users or sex workers.

While work on the social gradient was characterised by a long-term perspective and the need for structural change through intersectoral action on the social determinants of health, using the principle of 'Health in all Policies' (HiAP), that on vulnerable groups focused on immediate, localised action ('first aid'), similar to that which NGOs undertake. Indeed, NGOs often carried out these projects. Work on MEM health aimed at tackling 'upstream' health risks was generally lacking. This split between work on socioeconomic differences on the one hand, and work on migration and ethnicity on the other, runs deep: until December 2011, the section of the WHO Euro website currently entitled 'Social determinants' was actually labelled 'Socioeconomic determinants'.

In the Third EU Health Programme (2014-2020), ‘reducing health inequalities’ was included as a *general* objective, but without any *specific* programming.<sup>6</sup> At the start of the programme, the theme of health equity was much less visible than it had been in the First and Second Programmes. However, the sudden influx of unauthorised entrants in 2015 led to a sudden change. Eight Chafea projects have now focused on migrant health, five of them (including four launched in 2016) targeted at refugees and asylum seekers.<sup>7</sup> Inevitably, most of these projects came too late to be able to benefit the 2015-2016 wave of entrants; they aimed at strengthening preparedness for possible crises in the future, which up to now have not materialised, although of course they could do so at any time.

Though commendable, this programming also lacked an emphasis on social determinants. Firstly, it focused on treating health issues that had affected refugees and asylum seekers in the past (for example the effects of ‘trauma’), rather than considering how post-migration health threats can be avoided. Reception conditions for asylum seekers (which were deliberately downgraded in some countries in an attempt to discourage asylum seekers) were hardly addressed. Neither was the issue of integrating refugees into mainstream society, known to be crucial for the health and well-being of those granted asylum (Hjern 2013; Priebe et al. 2016).

## **7. Better provision of education and training on MEM health**

In this Statement we have argued for policies and practices on MEM health that are firmly based on research and evidence. However, to train the researchers, health workers, managers and policy makers whose efforts are essential for improving the ‘state of the art’ in this field, educational programmes are required that provide adequate attention to MEM health. Such education should not only be provided in the form of one-off trainings and refresher courses, but should be integrated in the basic curriculum of all the disciplines involved. EU agencies are already active in supporting Europe-wide training and educational initiatives in this area; these efforts need to be intensified and harmonised with each other.

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<sup>6</sup> [https://ec.europa.eu/health/programme/policy\\_en](https://ec.europa.eu/health/programme/policy_en)

<sup>7</sup> [https://webgate.ec.europa.eu/chafea\\_pdb/health](https://webgate.ec.europa.eu/chafea_pdb/health)

## Appendix: Statistical supplement on migration to the EU/EEA

Research and policy-making on migration and health need to be based on up-to-date, complete and accurate figures about actual numbers of migrants and their descendants in each country. This Appendix examines some issues on which misconceptions often dominate. It does not consider migration between EU Member States, which in any case is difficult to quantify because official statistics on migration only include those staying (or intending to stay) for a year or more – ‘long-term migrants’ in UN terminology. Using this criterion, EU migrants are approximately half as numerous as those from third countries: however, the relatively short distances and lack of border restrictions for EU migrants encourage temporary and circular migration involving stays of less than a year. This is not visible in the statistics, making it likely that the number of EU migrants is much higher than reported.

### 1. How large was the recent influx of unauthorized entrants to the EU/EEA in comparison with ‘routine’ migration?

In December 2015, media sources all over the world carried the report (quoted inaccurately by Reuters from an IOM/UNHCR press release) that “one million migrants and refugees arrived in Europe in 2015” – strongly suggesting that the ‘boat people’ arriving on Europe’s southern shores were the only migrants to Europe. The much larger volume of ‘routine’ migration for purposes of work, education, family etc. was ignored. Regrettably, many statements by the EC, including some by DG SANCO, created the same impression. The routine arrivals continued, yet nobody seemed to be talking about them. What was the real situation?

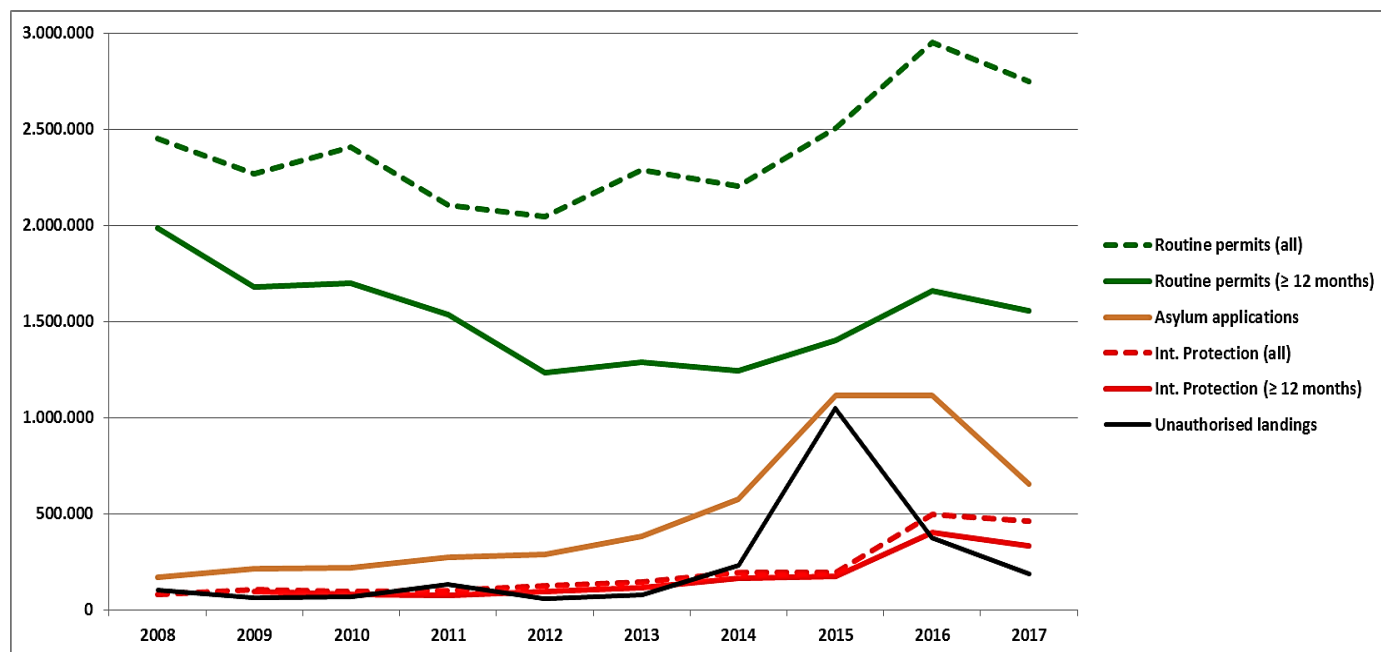
Although Eurostat data on asylum seekers and decisions made on them are very complete and up-to-date, the same cannot be said for ‘routine’ migration. Datasets on immigration (**migr\_imm1ctz** and **migr\_imm3ctb**) may or may not include refugees and asylum seekers, depending on the country, but the metadata which should tell us whether or not they do so is inaccurate and incomplete. Non-EU citizens are only disaggregated from 2013 onwards, while the data are published 15 months or more after the end of the year in question.

Luckily, other databases (**migr\_resfirst** and **migr\_resother**) report totals of first-time residence permits issued to non-EU immigrants, disaggregated by reason and period of validity (3-5, 6-11 and 12+ months). Permits for reasons of international protection can thus be distinguished from those for all other reasons. Although in principle only permits issued for 12 months or more qualify the holder as a ‘migrant’, some people may enter on a short-term permit and convert it to a long-term one (for example when they acquire a secure job or get married). Some migrants will also enter on a permit which is not their first. The figure for long-term permits thus represents a lower bound for the number of migrants entering Europe. Asylum seekers do not automatically count as migrants, because they may receive a rejection within less than 12 months; moreover, in 2015 and 2016 many of them made an application in more than one country.

It is thus difficult to be sure one is comparing like with like when one sets ‘routine’ and ‘non-routine’ immigration flows alongside each other. However, it is clear from the following

graph that the former type has always been more common than the latter – even at the height of the ‘migration crisis’. Fig. 1 shows the yearly totals of first-time ‘routine’ residence permits (issued for family, work, study, residence only or other reasons not specified); (first-time) asylum applications;<sup>8</sup> permits issued for reasons of international protection (‘Geneva’ refugee status, subsidiary and humanitarian protection); and unauthorised arrivals.

**Figure 1. Annual arrivals of different categories of migrant to the EU/EEA, 2008-2017**  
(data from Eurostat, IOM and Frontex)



- Between 2008 and 2012, ‘routine’ migration to the EU (green lines) declined as a result of the financial crisis and the resulting depression, but after 2012-13 it started to pick up again. The peak in 2016 is probably due to unauthorised entrants who were granted a ‘routine’ permit.
- The large influx of unauthorised arrivals (black line) in 2015 can be clearly seen in the above graph; however, annual totals were always far lower than those for ‘routine’ migration. The ratio of ‘routine’ permits to unauthorised landings was 2.4:1 in 2015, 8:1 in 2016, and 15:1 in 2017.
- Many of the unauthorised entrants in 2015 did not make an asylum application until 2016: the number of international protection permits issued in 2015 remained close to the number in 2014. In 2016 the number of unauthorised landings fell off steeply, but the number of asylum applications remained about the same.
- The graph also shows that the build-up of asylum applications was well under way before 2015.
- Finally, it can be assumed that about half of the rejected asylum seekers will stay to become irregular migrants (European Parliament, 2017).

<sup>8</sup> In 2015-2016 many migrants made an asylum application in a ‘transit’ country but moved on to make another one elsewhere. This was particularly common in Greece, Bulgaria, Hungary and Poland. Using Eurostat data, we have estimated their numbers conservatively at 175,960 in 2015 and 98,505 in 2016 and removed them from the total of asylum seekers.

## 2. How evenly are asylum seekers and migrants distributed over EU Member States?

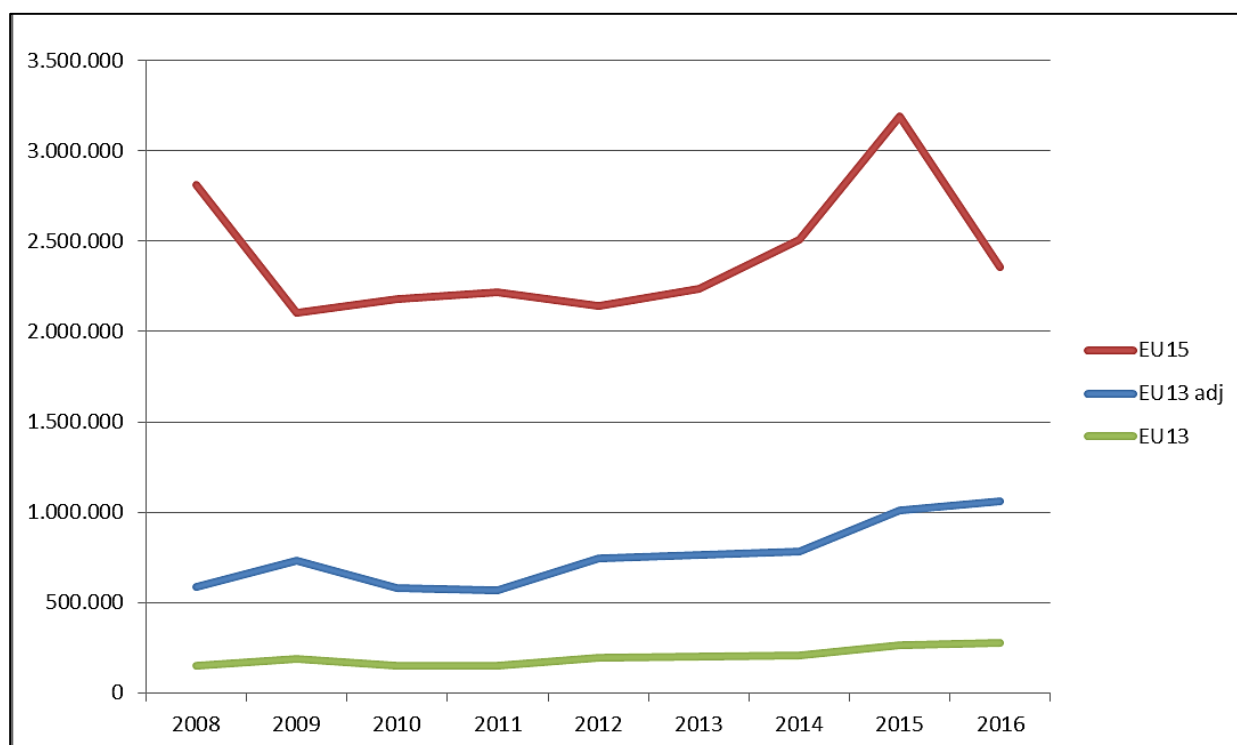
The above analyses were carried out on figures for the whole EU28/EEA. There are however great variations between EU Member States: this sets limits on the possibility of standardising policies on migration and health.

### a. There are major differences between EU15 and EU13 countries (i.e. those that joined the EU before or after 2004) in levels of migration

Figure 2 shows that between 2008 and 2016, the numbers of migrants entering the EU15 (brown line) were much higher than the numbers entering the EU13 (green line). Note that these numbers refer to all migrants, including EU nationals (source: Eurostat **migr\_imm1ctz**); separate figures for EU and non-EU migrants are only available for 2013-2017. Returning nationals have been excluded from these figures: some countries (particularly in the EU15) include refugees and even asylum-seekers.

To allow for the fact that the EU15's population is about four times greater than that of the EU13, the blue line shows the levels of immigration to the EU13 when this difference is compensated for. Even after this adjustment, EU15 countries received between 2008 and 2016 3.2 times more migrants per head of population than EU13 countries. This cannot be entirely explained in terms of the lower GDP per capita in the EU13; it also seems to be connected with a feature of the policy climate in those countries (IOM 2016:90).

**Figure 2. Annual immigration to EU15 and EU13 countries, 2003 - 2016**





- b. There is a strong clustering of migrants from certain sender countries in certain receiving countries <sup>9</sup>

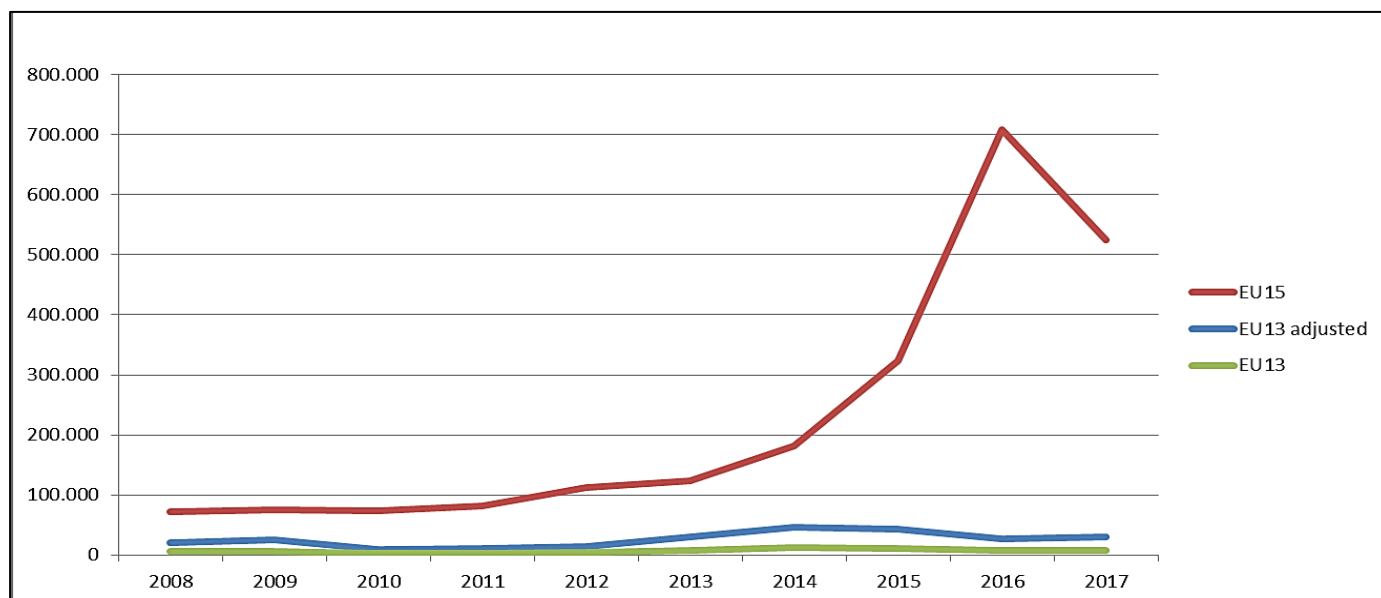
**Table 1. Main EU28 Member States issuing permits to certain nationalities in 2015**

Country of citizenship	Permits	Main EU-28 Member states issuing permits					
		Rank 1	#	(%)	Rank 2	#	(%)
Ukraine	499 992	PL	430 081	86.0	CZ	23 207	4.6
United States	261 760	UK	201 040	76.8	IT	8 714	3.3
China (*)	167 118	UK	80 724	48.3	FR	15 005	9.0
India	135 514	UK	71 651	52.9	IT	11 585	8.5
Syria	104 134	SE	29 316	28.2	DE	26 383	25.3
Morocco	96 099	ES	37 184	38.7	FR	26 544	27.6
Belarus	82 024	PL	75 394	91.9	CZ	1 148	1.4
Russia	73 528	CZ	11 289	15.4	DE	9 054	12.3
Turkey	58 131	DE	18 599	32.0	UK	6 069	10.4
Brazil	57 027	IE	10 955	19.2	UK	10 519	18.4

Poland harboured 92 % of all nationals from Belarus in the EU, as well as 86% of those from the Ukraine (who totalled half a million). Over half of all Syrians in the EU live in Germany or Sweden; nearly one-third of migrants from Turkey also live in Germany. US citizens go mainly to the UK (77%), as do roughly half of all Indians and Chinese in the EU. These figures indicate a ‘funnelling’ of certain nationalities into a small number of corridors, rather than a ‘fanning-out’ to a large number. This means that average figures for Europe may be an unreliable guide to local situations.

- a) Between 2008 and 2017 the EU15 accepted far more refugees than the EU13, as measured by the total number of positive asylum decisions <sup>10</sup>

**Figure 3. Refugees accepted annually by EU15 and EU13 countries 2008-2017**



<sup>9</sup> Adapted from [http://ec.europa.eu/eurostat/statistics-explained/index.php/Residence\\_permits\\_statistics](http://ec.europa.eu/eurostat/statistics-explained/index.php/Residence_permits_statistics)

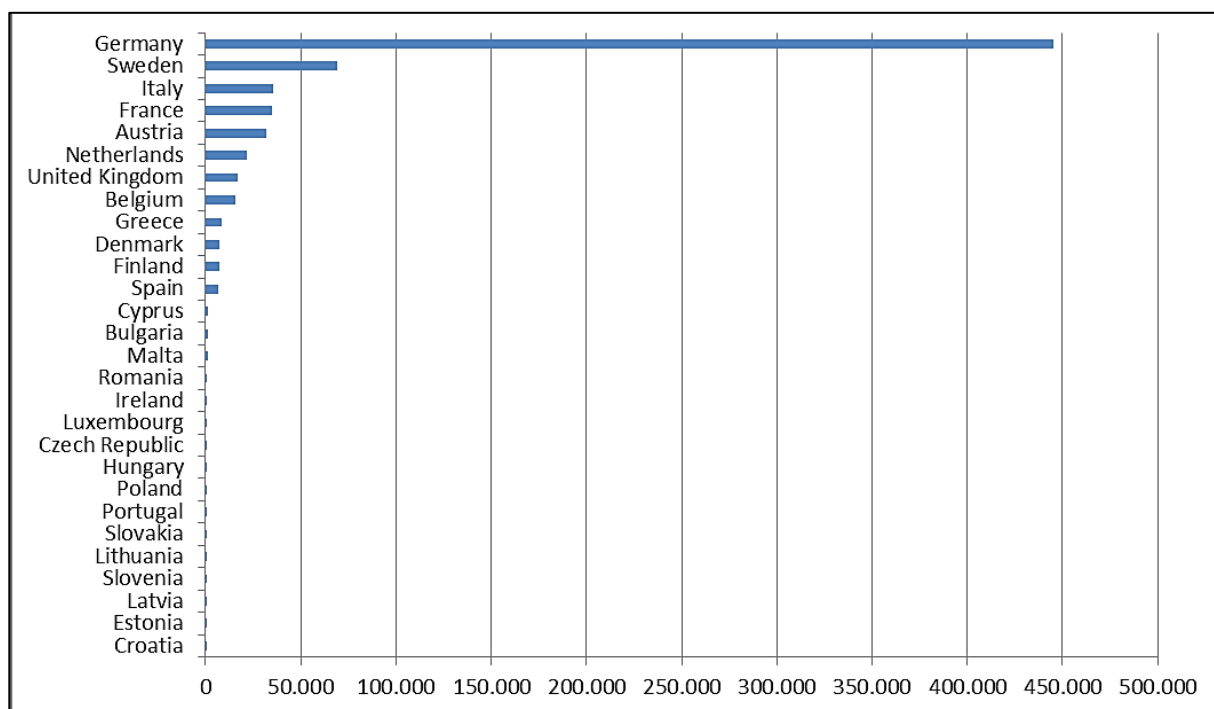
<sup>10</sup> These figures take no account of asylum seekers relocated under the EC’s ‘Emergency Relocation Scheme’, only of annual positive decisions. However, of the 160,000 migrants the Commission intended in September 2015 to relocate, only about 30,000 had actually moved when the scheme ended in September 2017.

Without adjustment for population size, the ratio of all total positive decisions in the EU15 to those in the EU13 between 2008 and 2017 was 40:1; after adjustment this becomes 10:1. (It is important to note that the number of positive asylum decisions in a given year may diverge from the number of residence permits issued for international protection. ‘Humanitarian’ permits can be issued even in the absence of a positive asylum decision; moreover, a residence permit may be issued some time after a positive asylum decision was made.)

Particularly striking is that the recent ‘migrant crisis’ resulted in a *decrease*, not an increase, in the numbers of positive decisions awarded by EU13 countries. Migrants in transit seem to have moved on from these countries as fast as they could, no doubt encouraged by the apparent breakdown of the Dublin system. They evidently had no desire to become refugees in the EU13, and if they applied for asylum it was probably mainly because the authorities compelled them to do so (as in Hungary) under threat of being deported back over the border.

**b) There are wide variations between EU Member States in the numbers of positive decisions and the backlog of asylum applications**

**Figure 4. Positive decisions in 2016 (EU total = 710,400)**



The main source of variation in these numbers is not so much the probability of an application being accepted (which depends on the strictness of policies and the country of origin), but the volume of asylum applications received. Above we see that Germany gave international protection to far more people (445,000) than any other country in 2016. Indeed, this figure was more than the total for all other countries combined (265,000). The backlog of asylum seekers in procedure at the end of 2016 in each country (see Eurostat **migr\_asypencztm**) was strongly associated with the numbers of positive decisions shown above.

Summing up, these analyses show that **migratory pressures in the EU are highly localised**. Large groups of migrants trekking across EU countries have not been seen since 2015;

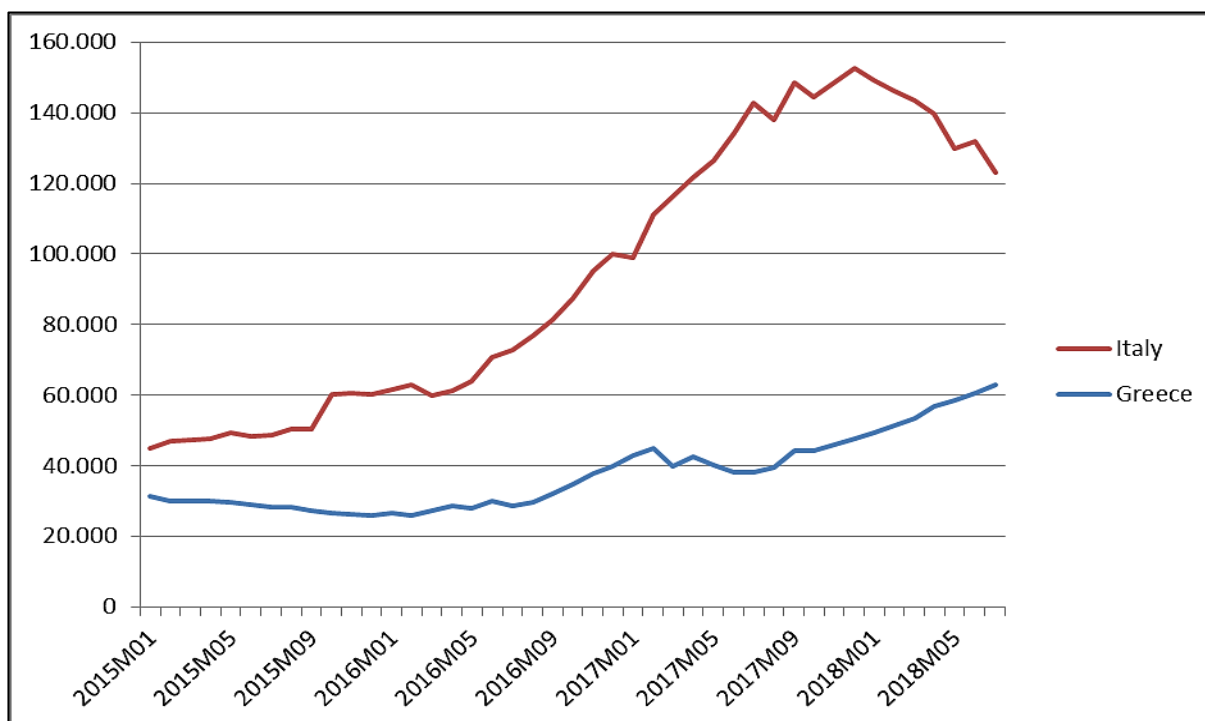
physical and administrative barriers now ensure that such transit migration takes place clandestinely.

## Hotspots

Italy and Greece have been singled out for further analysis of their backlog of asylum seekers, because they were chosen by the EC in 2016 to host ‘hotspots’ (reception and identification centres or RICs). The backlog of asylum applicants is affected by three main factors: how easily those seeking asylum can reach a country, how easily they can leave it, and how rapidly asylum procedures are completed.

Despite the large numbers of arrivals in **Greece** in 2015, its backlog actually declined in that year as increasing numbers left the country to travel northwards (see Figure 5). Greece’s backlog increased from the moment the EU-Turkey deal was implemented in March 2016; this discouraged new arrivals, but at the same time it became harder to leave the country, so the backlog has increased steadily to its present level of over 60.000. Although the ‘hotspot’ plan provided for redistribution to other EU member states, little of this has taken place. Less than 20% of the asylum seekers that the EC intended to relocate in its plan for September 2015-September 2017 had actually moved by the time the scheme ended.<sup>11</sup> Although relocations are still taking place, overcrowded and inhumane conditions at the RIC Moria on Lesbos led to international protests in 2018.<sup>12</sup> Slow processing of asylum applications appears to be a major cause of the backlog.

**Figure 5. Backlog of asylum applicants in Greece and Italy, January 2015 – July 2018**



<sup>11</sup> <http://www.unhcr.org/news/press/2017/9/59ca64354/unhcr-calls-eu-relocation-scheme-continue.html>

<sup>12</sup> <https://bit.ly/2wvwAB7>

Discouraging crossings to Greece led to more crossings to **Italy** (which carried an increased risk of drowning at sea).<sup>13</sup> Although (as in Greece) many migrants were not registered and left the country, Italy's northern neighbours have stepped up their border controls. Discontent about the increasing numbers of asylum seekers and irregular migrants in the country contributed to the fall of the Italian government in March 2018.

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<sup>13</sup> <https://missingmigrants.iom.int/>

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