Inequalities in Health – The Issue of Migration

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WONCA EUROPE 18th June 2016, Copenhagen

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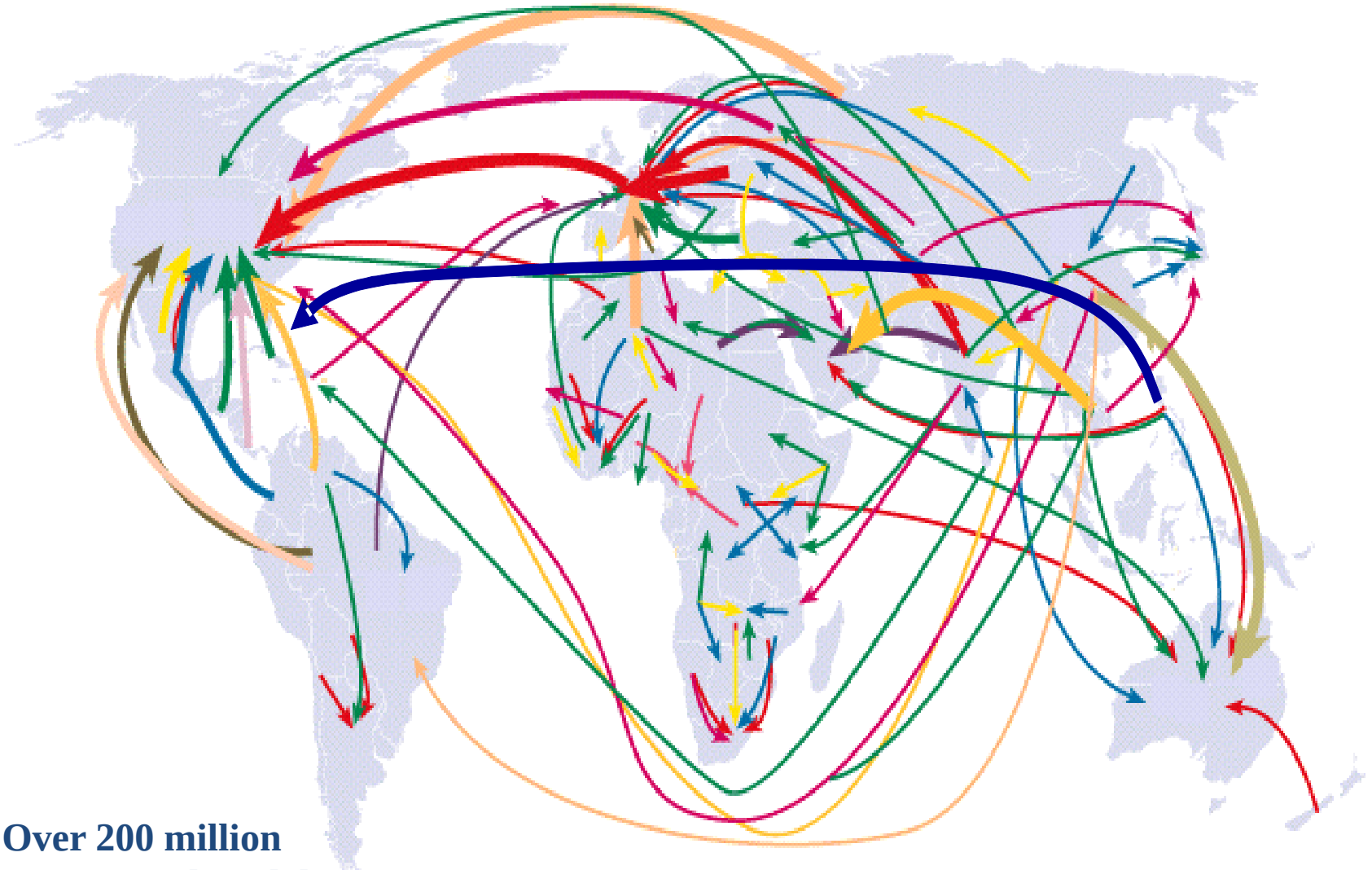
Overview of the Presentation

- Equity and Migration – Concepts, Terminology, Relevance and Context
- Framework for Migration and Health in Europe – Policies
- Migration and Health – Determinants and understanding of differences
- Ethnic Differences in Health – Cases from General Practice
- Adapting Health Care to Diversity – Challenges and Opportunities

The Scope of Migration



- Over 200 million
- 230 m. predicted by 2050
- 9.4% foreign born residents in the EU

Source : IOM

MIGRATION

Migration: Geographic movement, which is either permanent or semi-permanent in nature

- **Forced migration:** encompasses refugees and human trafficking
- **Voluntary migration:** refers to migrant workers, students and family union.

Kilde: Brochmann 2006, Kjeldstadli 2001, og SSB/innvandring

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MIGRANTS -WHO ARE THEY?

- **Refugees**
- **Resettlement Refugees**
- **Asylum seekers**
- **Internally Displaced**
- **Migrant Workers**
- **International Students**
- **Au pairs**
- **Family Reunifications**
- **Tourist**
- **Granted Settlement on Humanitarian grounds**
- **Those who cannot be return**
- **Irregular migrants**

Kilde: www.udi.no

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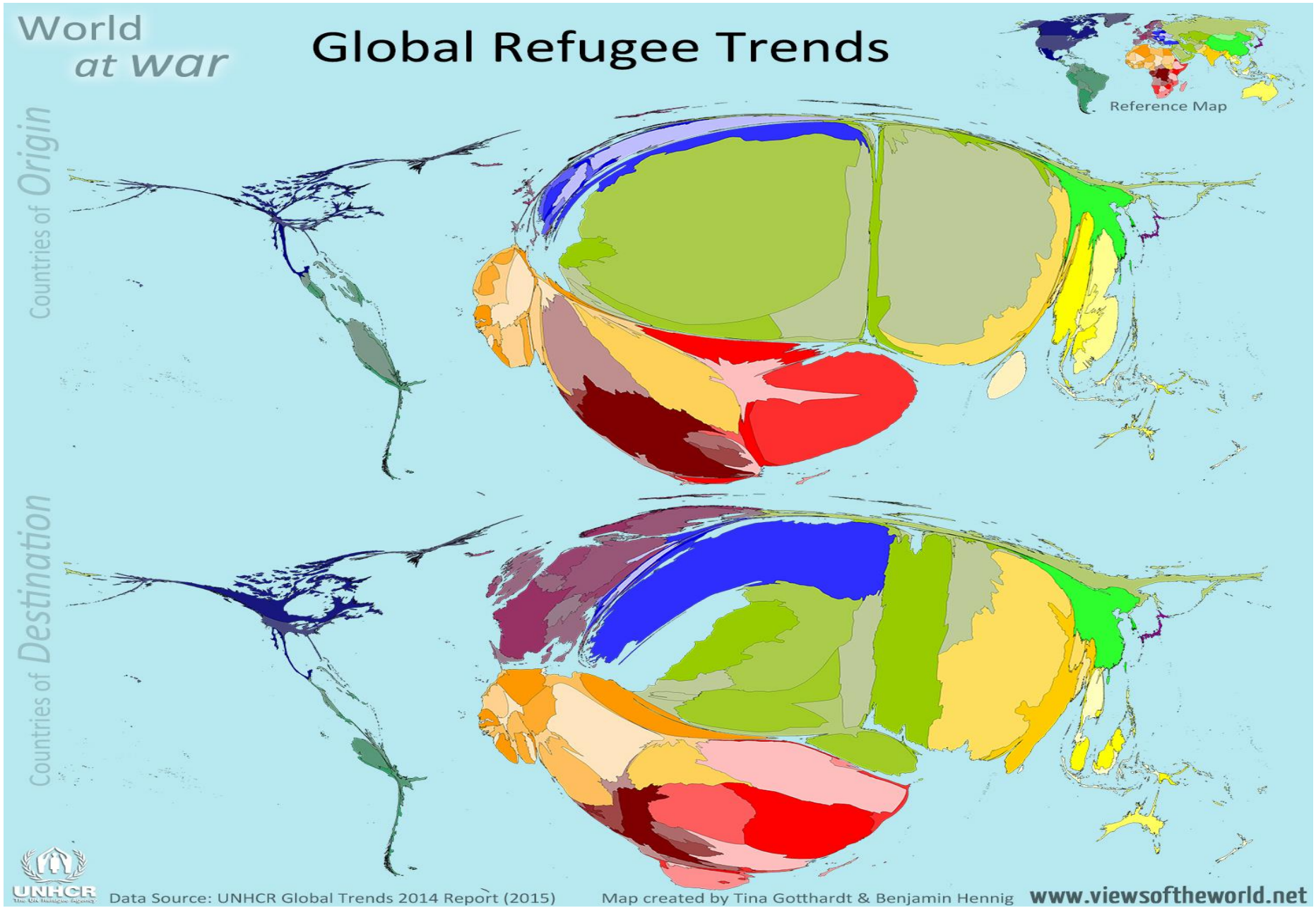
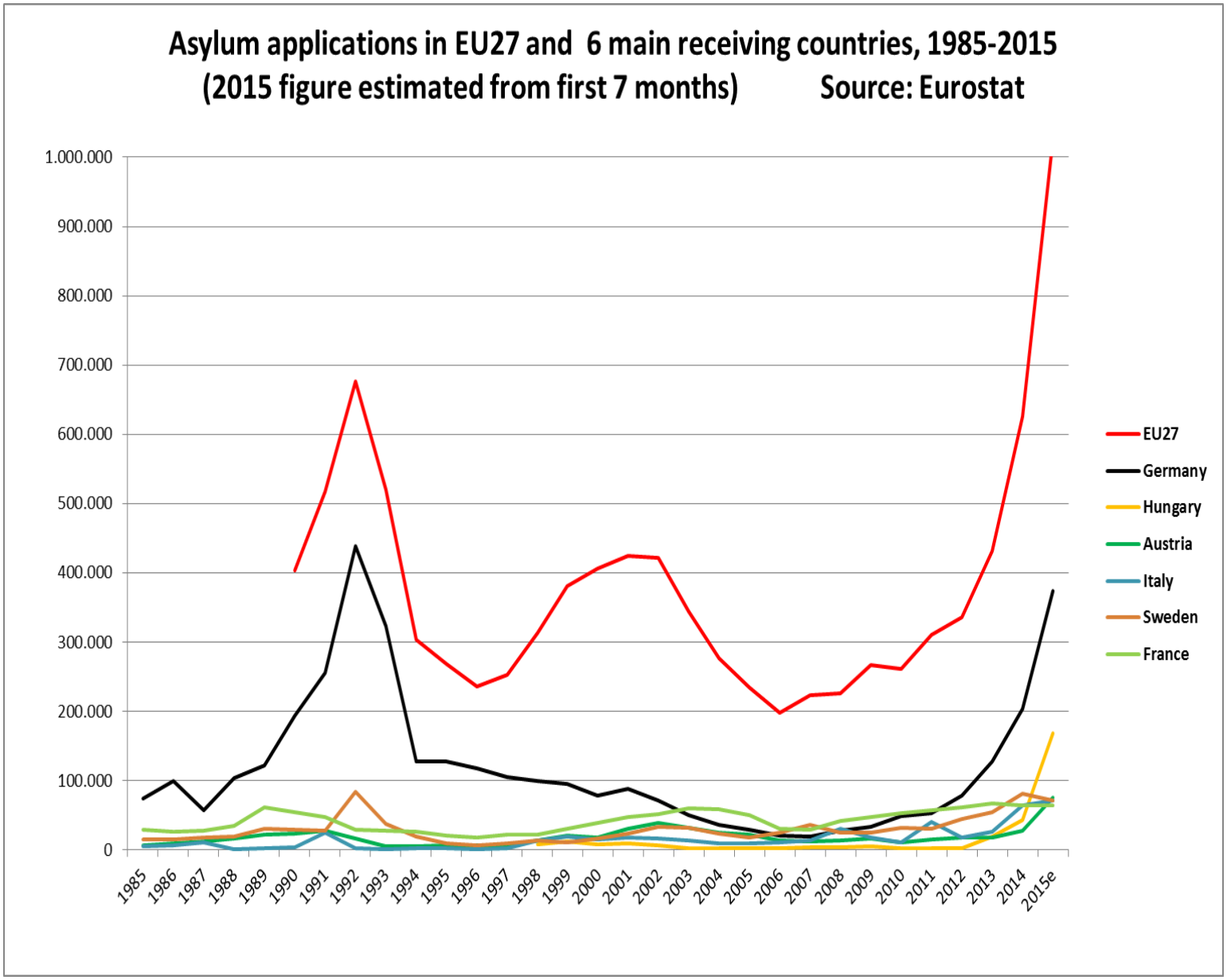
"Il avait un nom : Aylan Kurdi"

Manuel Valls tweete la photo de l'enfant Syrien mort sur une plage

40% migrants move to a neighboring country



50% of refugees are children


Asylum applications in EU27 and 6 main receiving countries, 1985-2015
(2015 figure estimated from first 7 months) Source: Eurostat
1.000.000
900.000
800.000
700.000
600.000
500.000
400.000
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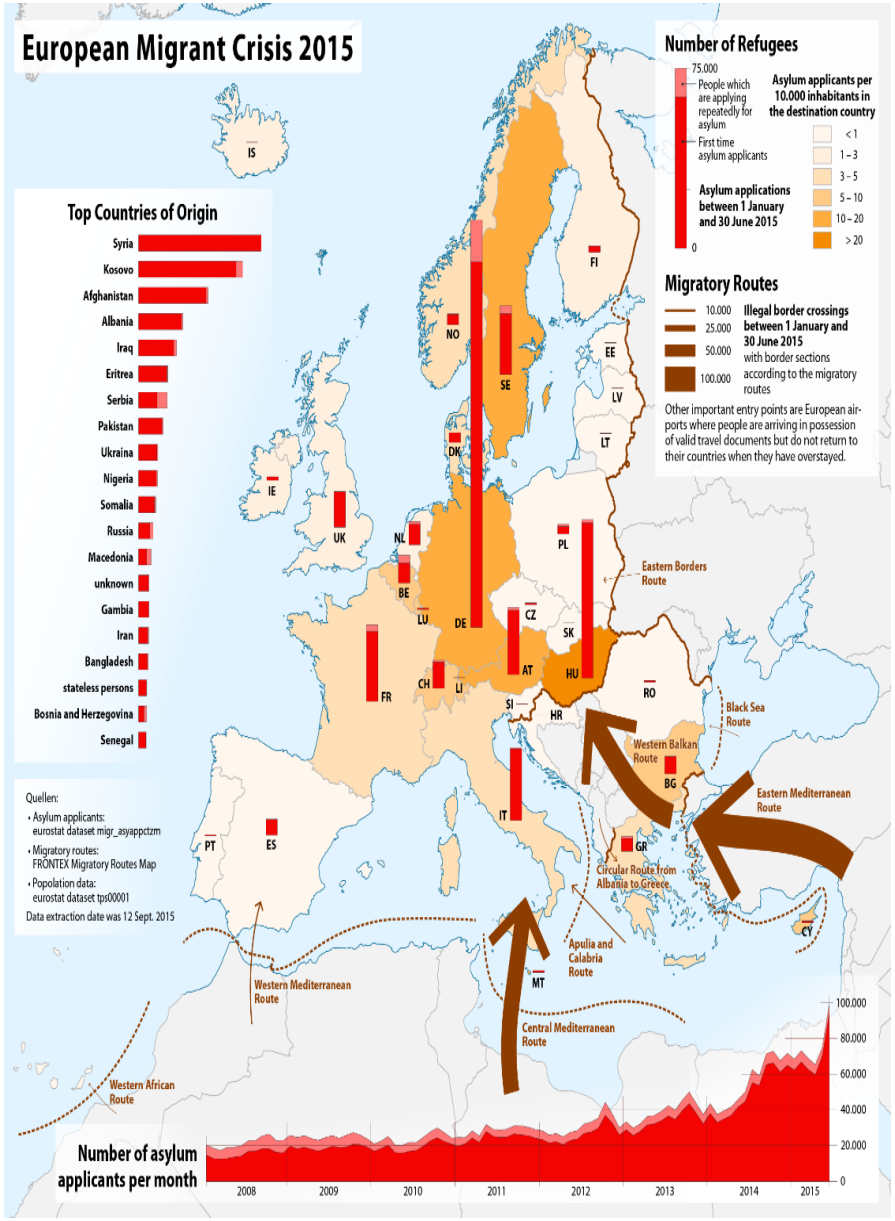
Hungary
Austria
Italy
Sweden
France


European Migrant Crisis 2015
Number of Refugees
75.000
People which are applying repeatedly for asylum
First time asylum applicants
0
Asylum applications between 1 January and 30 June 2015
Asylum applicants per 10.000 inhabitants in the destination country
< 1
1 – 3
3 – 5
5 – 10
10 – 20
> 20
Migratory Routes
10.000
25.000
50.000
100.000
Illegal border crossings between 1 January and 30 June 2015 with border sections according to the migratory routes
Other important entry points are European airports where people are arriving in possession of valid travel documents but do not return to their countries when they have overstayed.
Top Countries of Origin
Syria
Kosovo
Afghanistan
Albania
Iraq
Eritrea
Serbia
Pakistan
Ukraina
Nigeria
Somalia
Russia
Macedonia
unknown
Gambia
Iran
Bangladesh
stateless persons
Bosnia and Herzegovina
Senegal
Quellen:
• Asylum applicants: eurostat dataset migr_asyappctzm
• Migratory routes: FRONTEX Migratory Routes Map
• Popolation data: eurostat dataset tps00001
Data extraction date was 12 Sept. 2015
IS
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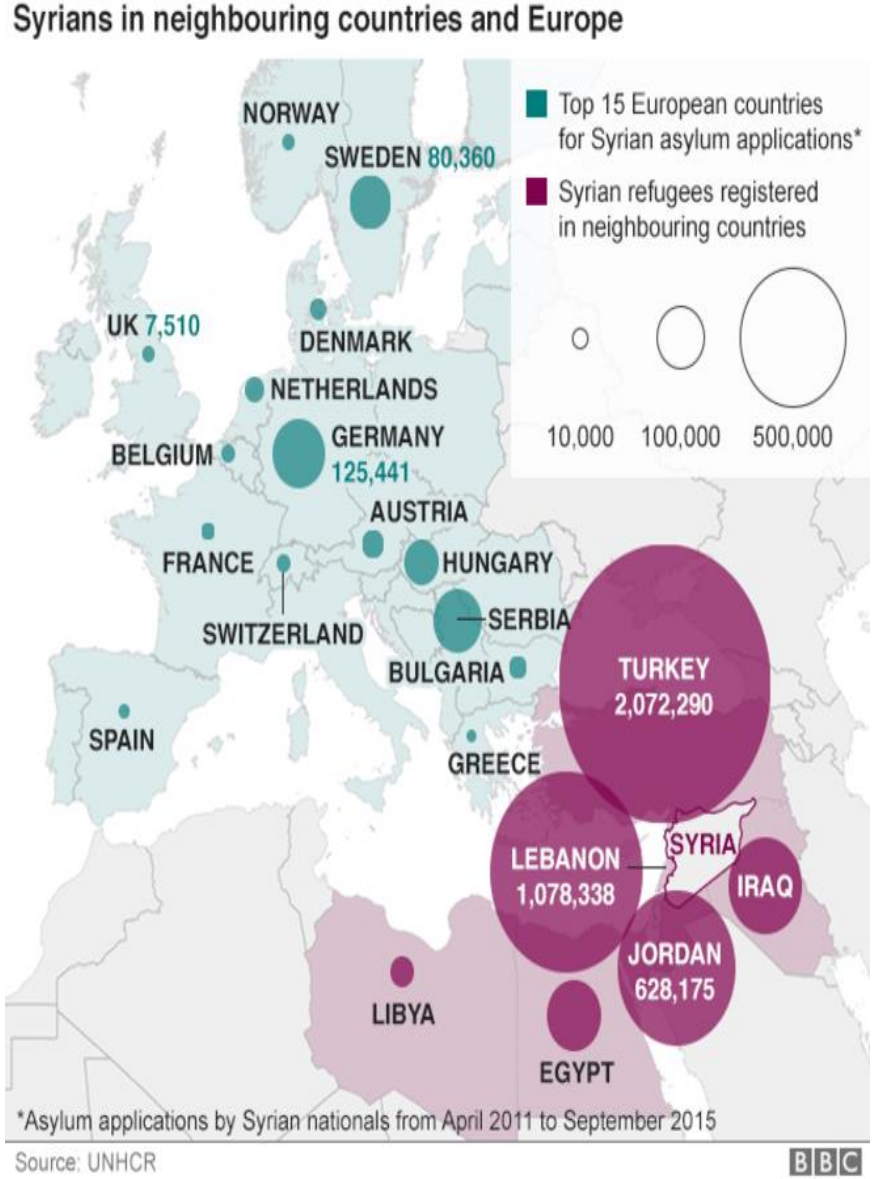
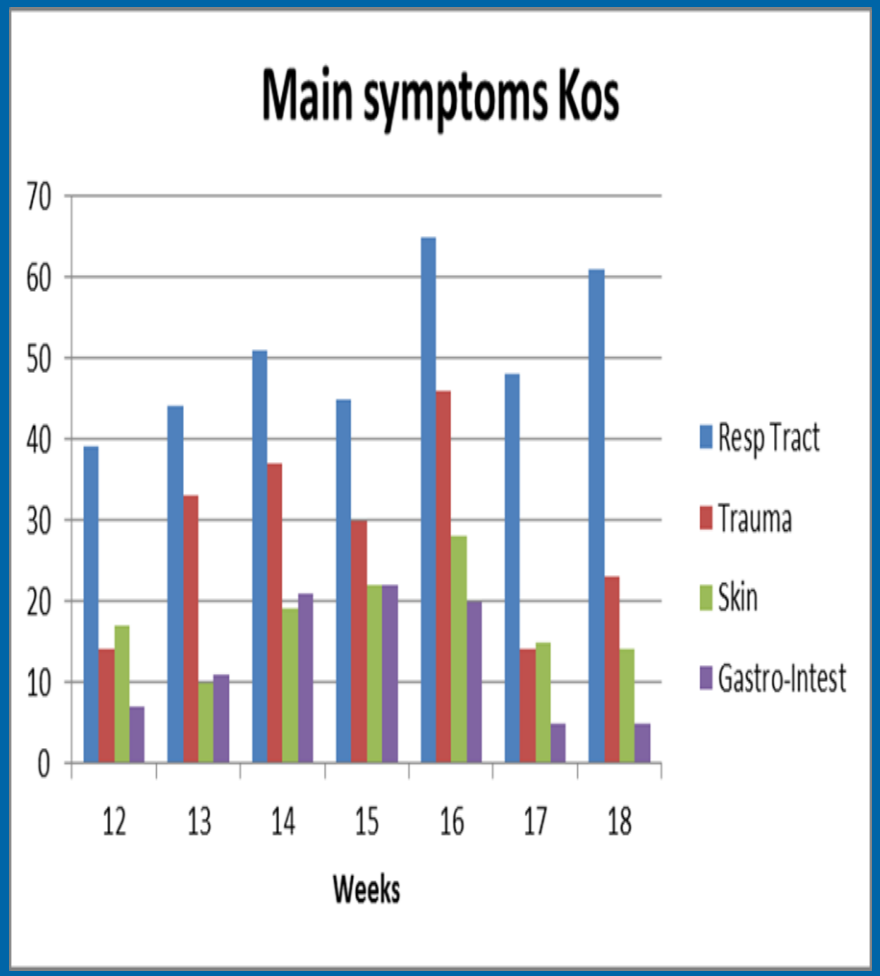
IT
PT
ES
GR
MT
CY
Eastern Borders Route
Black Sea Route
Western Balkan Route
Eastern Mediterranean Route
Circular Route from Albania to Greece
Apulia and Calabria Route
Central Mediterranean Route
Western Mediterranean Route
Western African Route
Number of asylum applicants per month
100.000
80.000
60.000
40.000
20.000
0
2008
2009
2010
2011
2012
2013
2014
2015

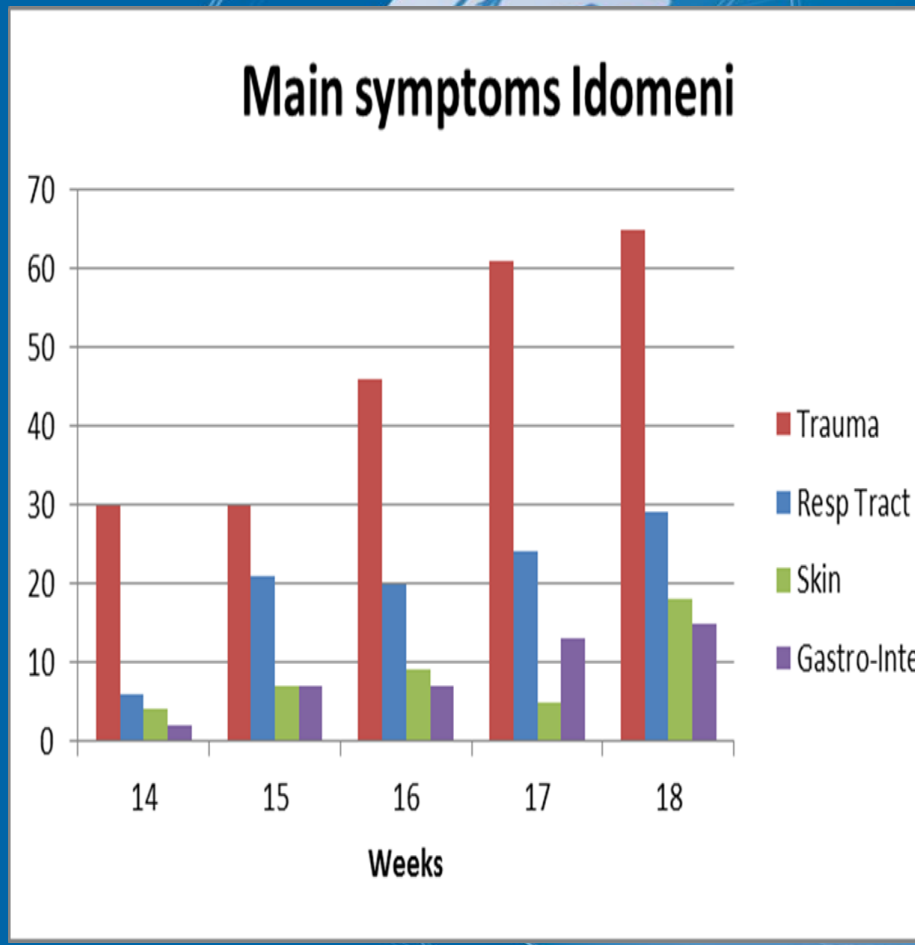

Syrians in neighbouring countries and Europe
Top 15 European countries for Syrian asylum applications*
Syrian refugees registered in neighbouring countries
10,000
100,000
500,000
NORWAY
SWEDEN 80,360
UK 7,510
DENMARK
NETHERLANDS
BELGIUM
GERMANY 125,441
AUSTRIA
FRANCE
HUNGARY
SWITZERLAND
SERBIA
BULGARIA
TURKEY 2,072,290
SPAIN
GREECE
LEBANON 1,078,338
SYRIA
IRAQ
JORDAN 628,175
LIBYA
EGYPT
*Asylum applications by Syrian nationals from April 2011 to September 2015
Source: UNHCR
BBC

Migrant Health…?

- Entry to Greece \



- Exit out of Greece \



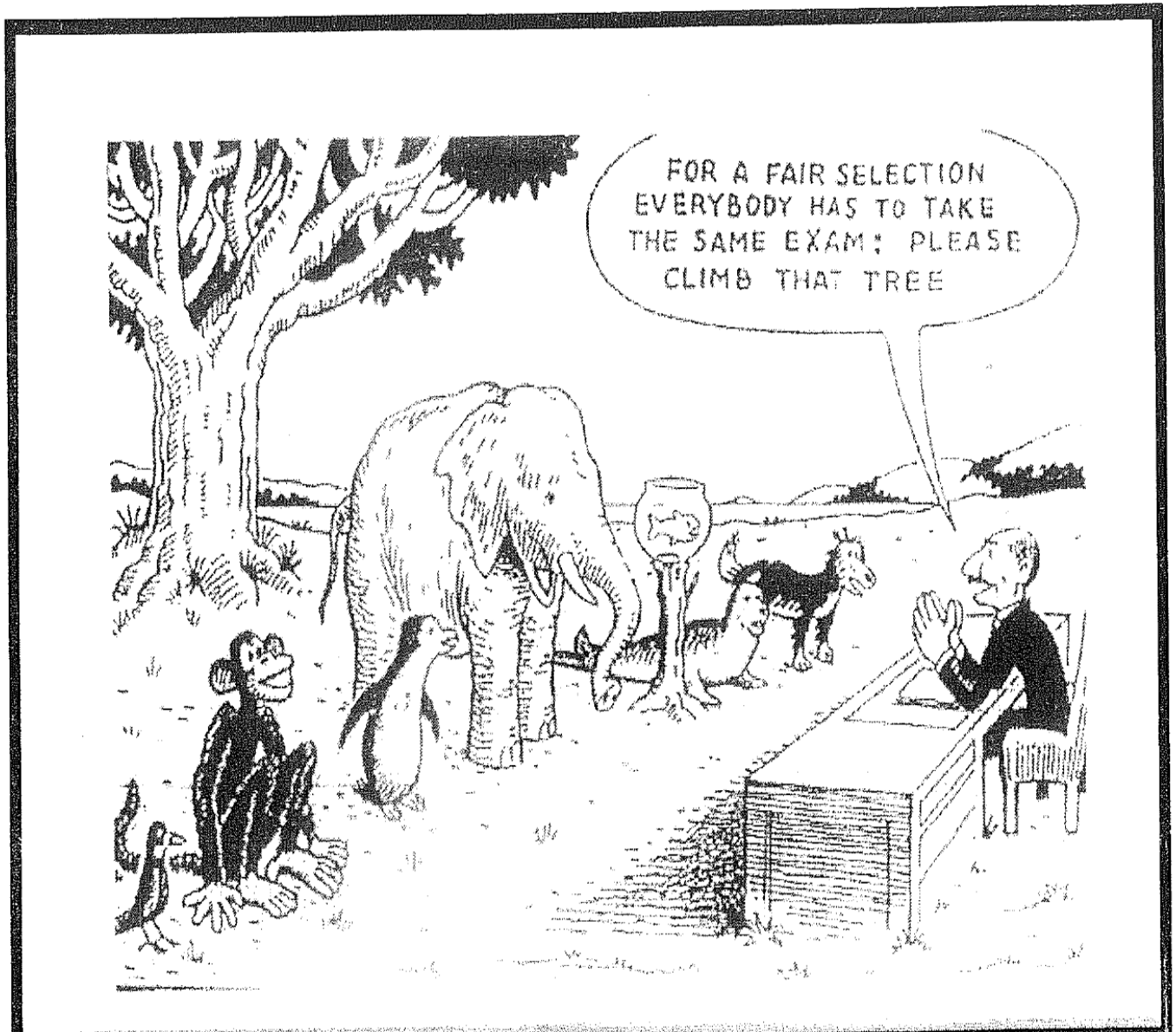
SOURCE: MÉDECINS SANS FRONTIÈRES, GREECE

“Butterflies have always had wings; people have always had legs.
While history is marked by the hybridity of human societies & the desire for movement,
the reality of most of migration today reveals the unequal relations between rich & poor, between North and South, between whiteness and its others.”
— Harsha Walia, Undoing Border Imperialism

Are inequities killing people on grand scale ??

- ***In Oslo Norway's capital if you live in the Eastern part of the City your life expectancy will be 9 years shorter than the West part of the City!!***
- ***A child born in a Glasgow, Scotland suburb can expect alife 28 years shorter than another living only 13 kilometres away.***
- ***A girl in Lesotho is likely to live 42 years less than another in Japan.***
- ***In Sweden, the risk of a woman dying during pregnancy and childbirth is 1 in 17 400; in Afghanistan, the odds are 1 in 8.***
- ***Biology does not explain any of this. Instead, the differences between - and within - countries result from the social environment where people are born, live, grow, work and age.***

Is being treated the same fair?



Equity in Health

- **Equity in Health**: Creating equal opportunities for health and bringing health differentials down to the lowest possible. (M. Whitehead, 2000)
- **Equity in Health Care**: is defined as equal access to available care for equal need; equal utilization for equal need; equal quality of care for all. (M. Whitehead, 2000)

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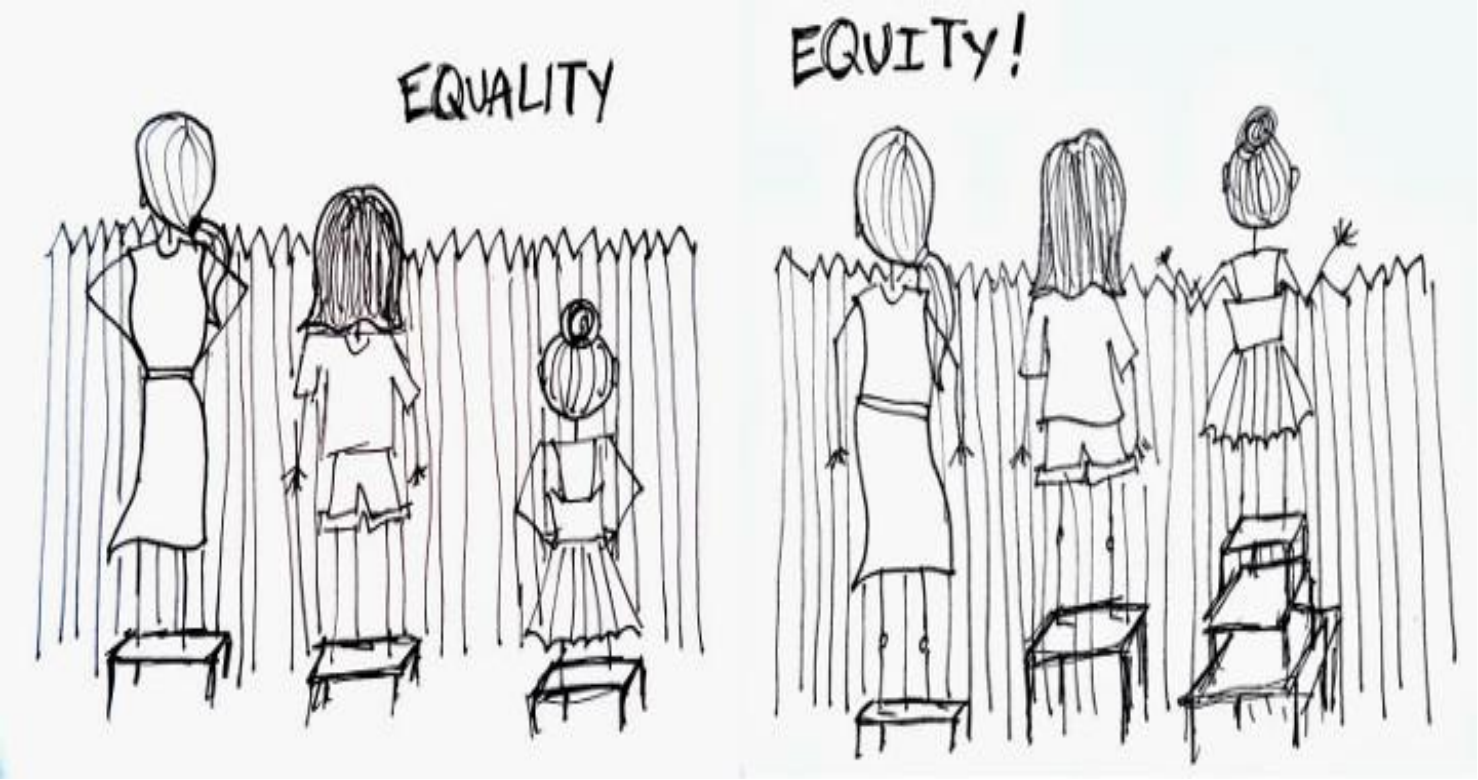
Equity in Health Care



[cid:265A8902-CAB5-4E29-84AC-3EBFF875DBEA]
Credit: Mary @ Off She Goes<http://offshegoes2013.blogspot.com/2014/06/equity-vs-equality.html

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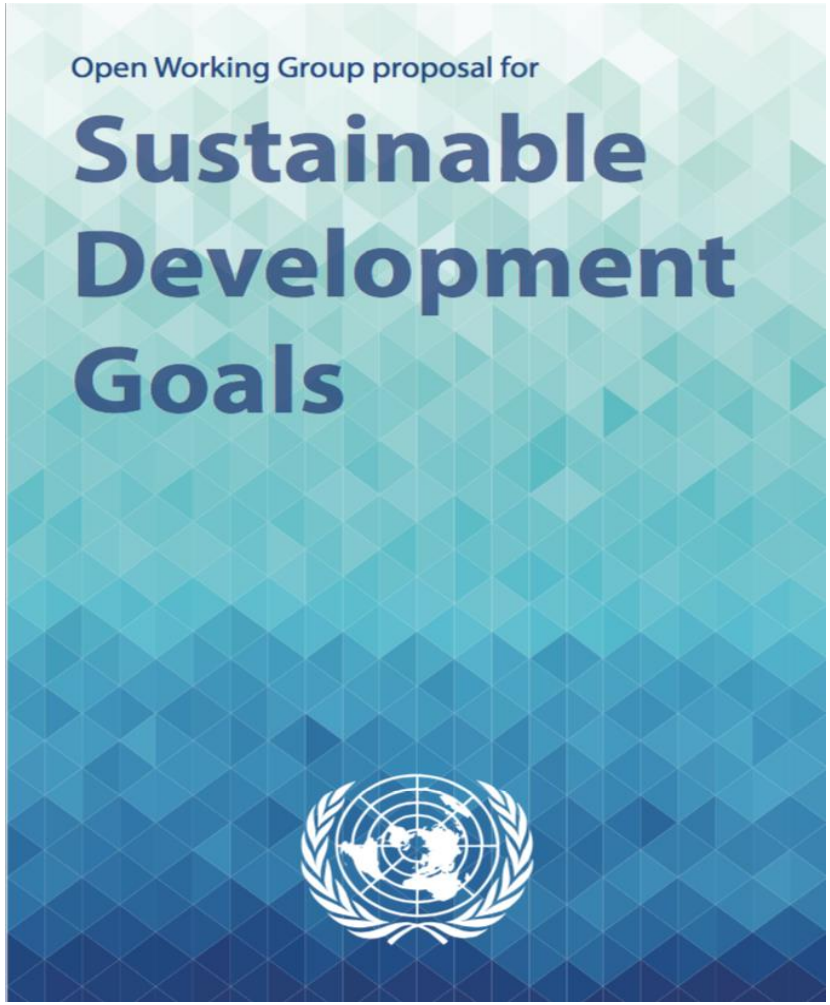
GLOBAL POLICY

GOAL 17

Strengthen the means of implementation and revitalize the global partnership for sustainable development



Data, monitoring and accountability

17.18 By 2020, enhance capacity-building support to developing countries, including for least developed countries and small island developing States, to **increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location** and other characteristics relevant in national contexts

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Recommendation CM/Rec(2011)13
of the Committee of Ministers to member states
on mobility, migration and access to health care

(Adopted by the Committee of Ministers on 16 November 2011
at the 1126th meeting of the Ministers' Deputies)

Preamble

The Committee of Ministers, under the terms of Article 15.*b* of the Statute of the Council of Europe,

Considering that the aim of the Council of Europe is to achieve a greater unity between its members and that this aim may be pursued in particular by the adoption of common rules in the public health field;

Recalling the Action Plan adopted at the Third Summit of Heads of State and Government of the Council of Europe (Warsaw, 2005) wherein it is stated that: "We are aware of the importance of population movements within Europe and from other continents to Europe. Management of this migration is a major challenge to 21st-century Europe";

Recalling also the statement in the Action Plan: "We shall systematically encourage intercultural and interfaith dialogue, based on universal human rights, as a means of promoting awareness, understanding, reconciliation and tolerance, as well as preventing conflicts and ensuring integration and the cohesion of society";

Having regard to the 8th Conference of European Ministers of Health and the Bratislava Declaration on Health, Human Rights and Migration (2007);

Recalling Part I of the European Social Charter (revised) (ETS No. 163) which provides that the Parties thereto accept as the aim of their policy, to be pursued by all appropriate means, both national and international in character, the attainment of conditions in which the right of everyone to benefit from any measures enabling them to enjoy the highest possible standard of health attainable may be effectively realised;

Recalling Article 11 of the European Social Charter (revised) on the right to protection of health and Article 3 of the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicin
Rights and Biomedicine (ETS No. 164) on the equitable access to health care;

- Reduce health risks to which migrants are exposed
- Ensure access to good quality health services
- Some EU countries have dedicated, inter-ministerial Global Health Policy

Bozorgmehr & Razum 2015; Lancet 385: 2147. Brashares et al. 2004; Science 306: 1180-3

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Mapping migrants (asylum seekers) access to health care in Europe: The MIPEX Health Strand

www.mipex.eu

What MIPEX covers

Seven policy areas for immigrants to participate in society:

Labour market mobility

Family reunion

Education

Political Participation

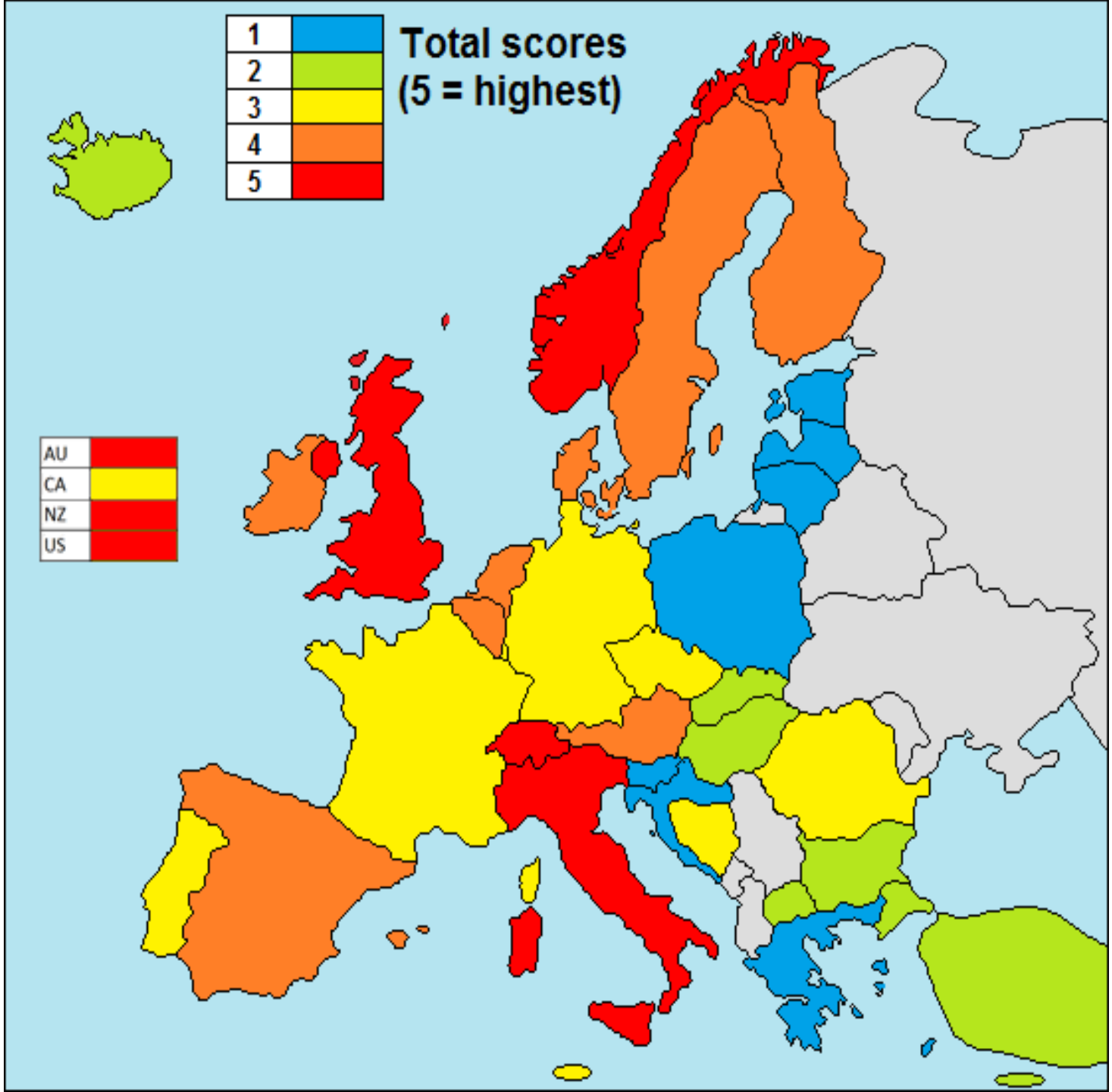
Long-term residence

Access to nationality

Anti-discrimination

In more than 30 countries:

EU Member States + Norway, Switzerland, Canada, United States of America, Australia, Japan, and soon New Zealand, Korea, Turkey, Serbia, Croatia, Kazakhstan, Mexico …..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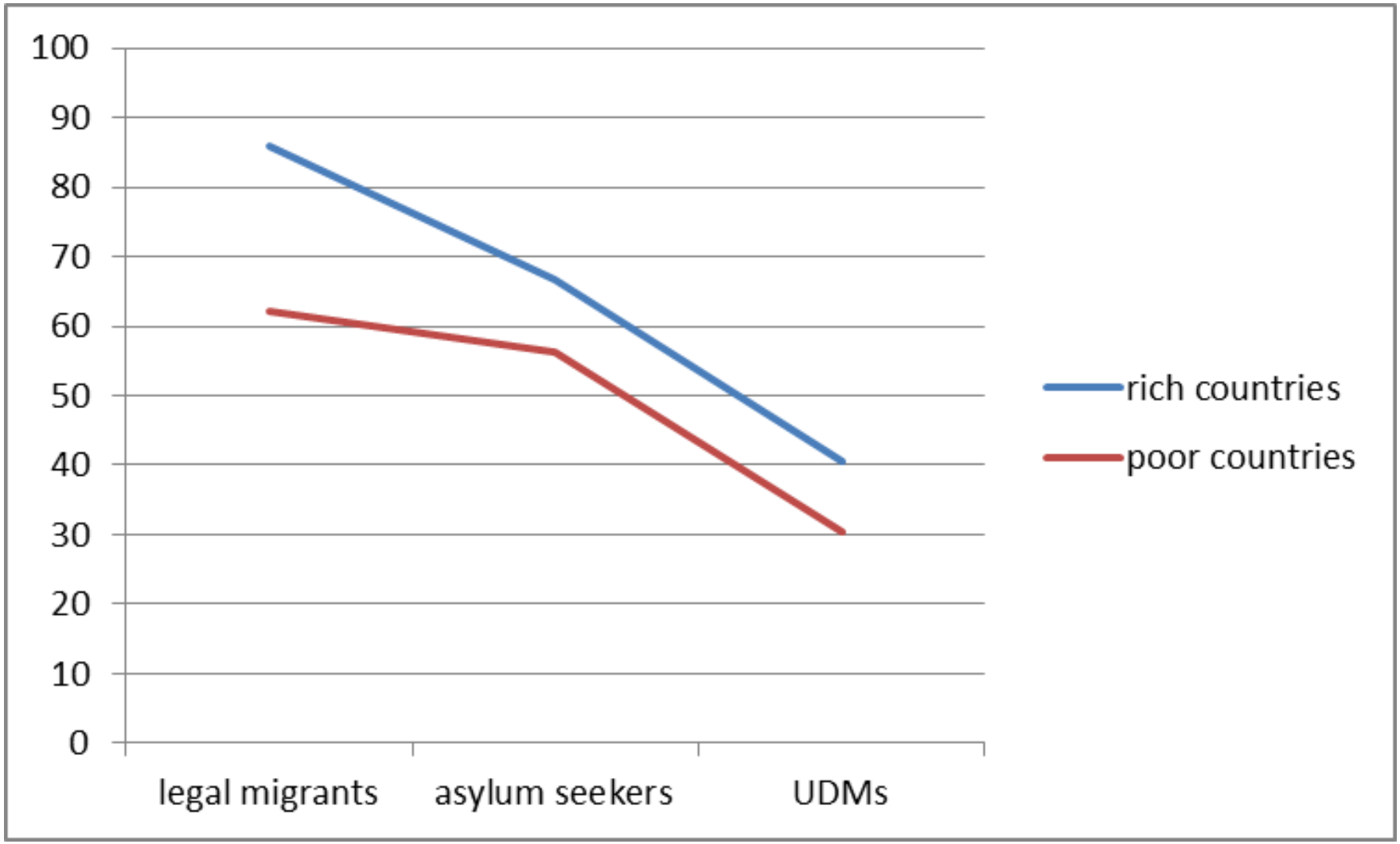
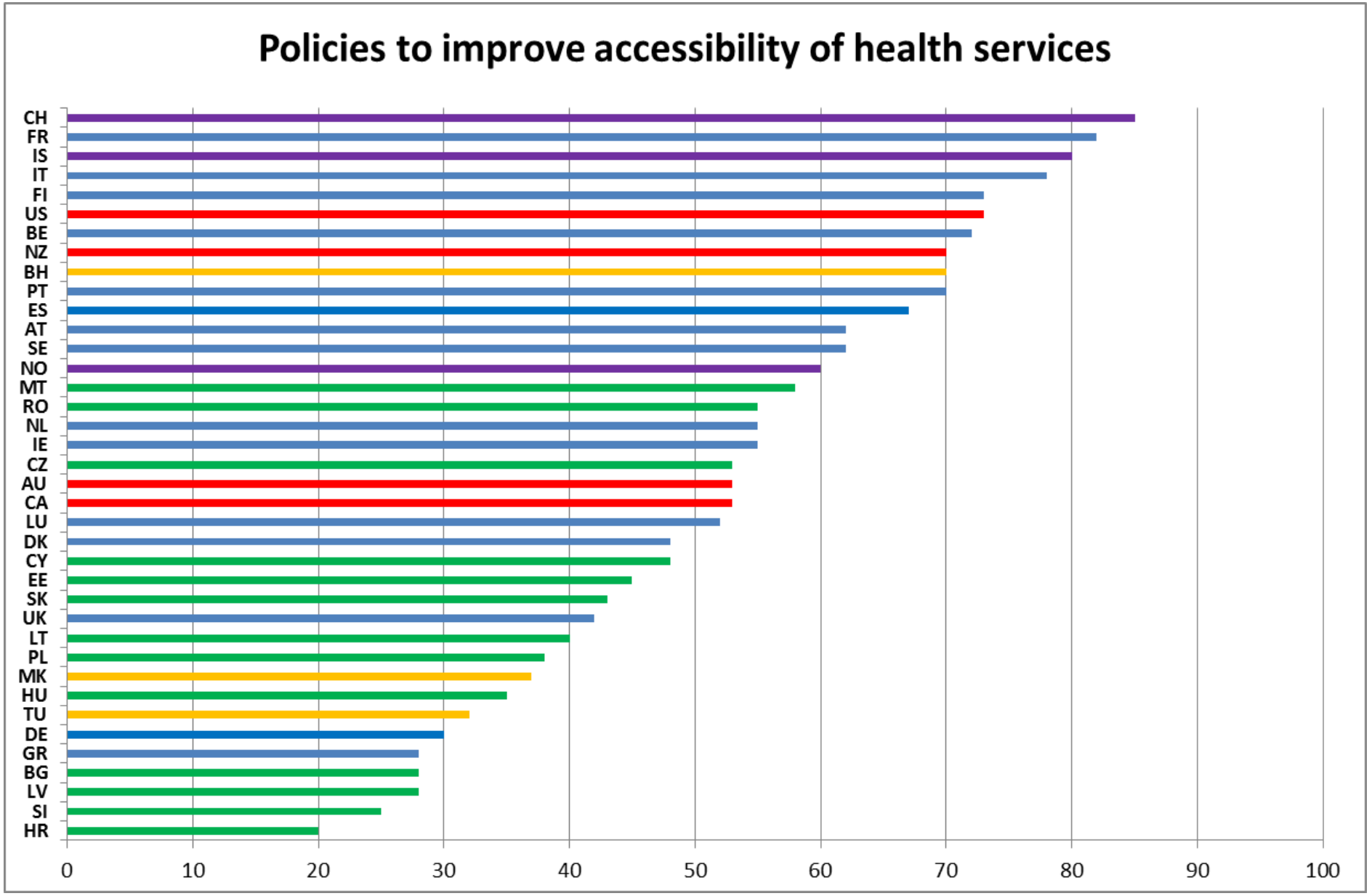
Total scores
(5 = highest)
AU
CA
NZ
US

Migrants' healthcare entitlements in "rich" and "poor" EU countries




Policies to improve accessibility of health services
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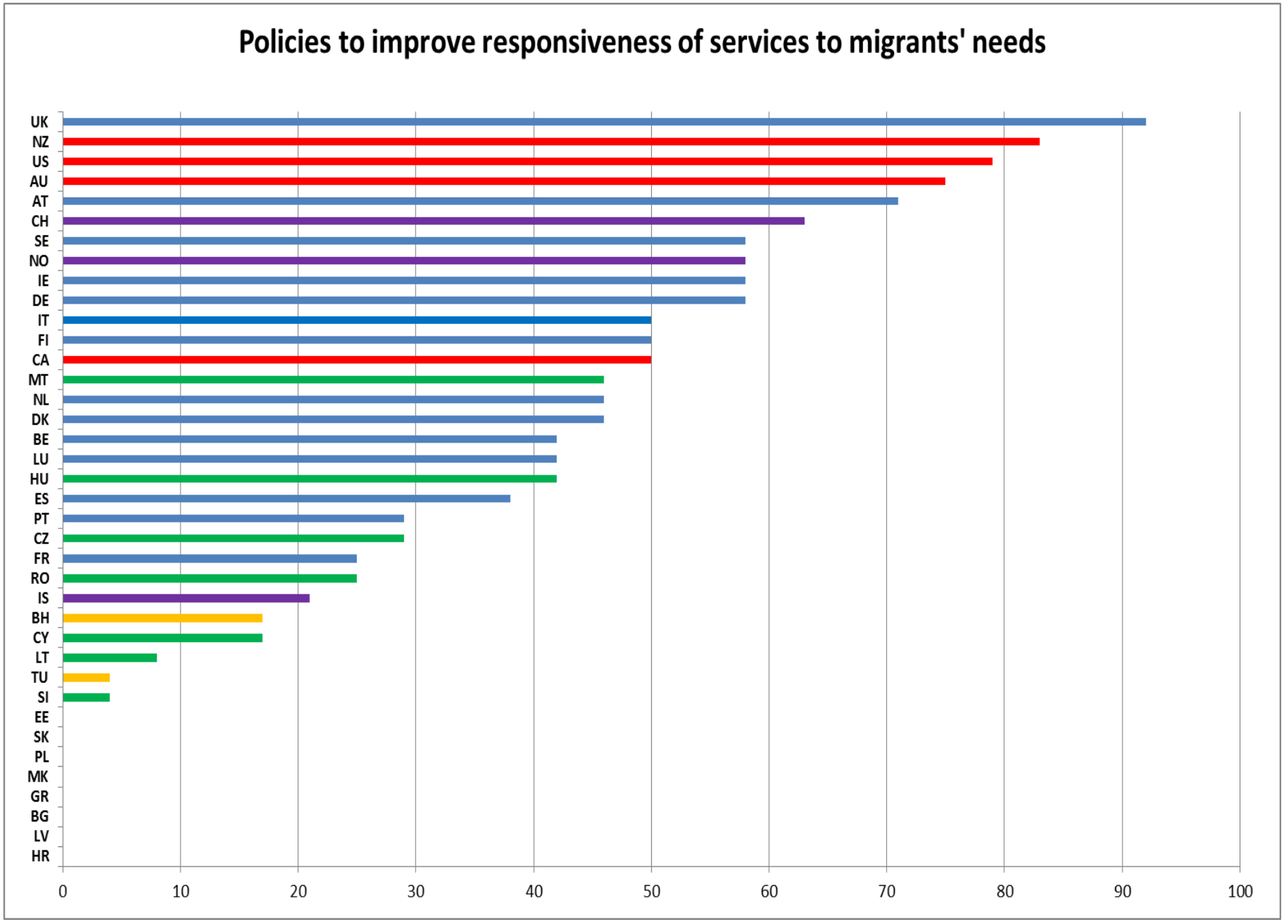
Policies to improve responsiveness of services to migrants' needs
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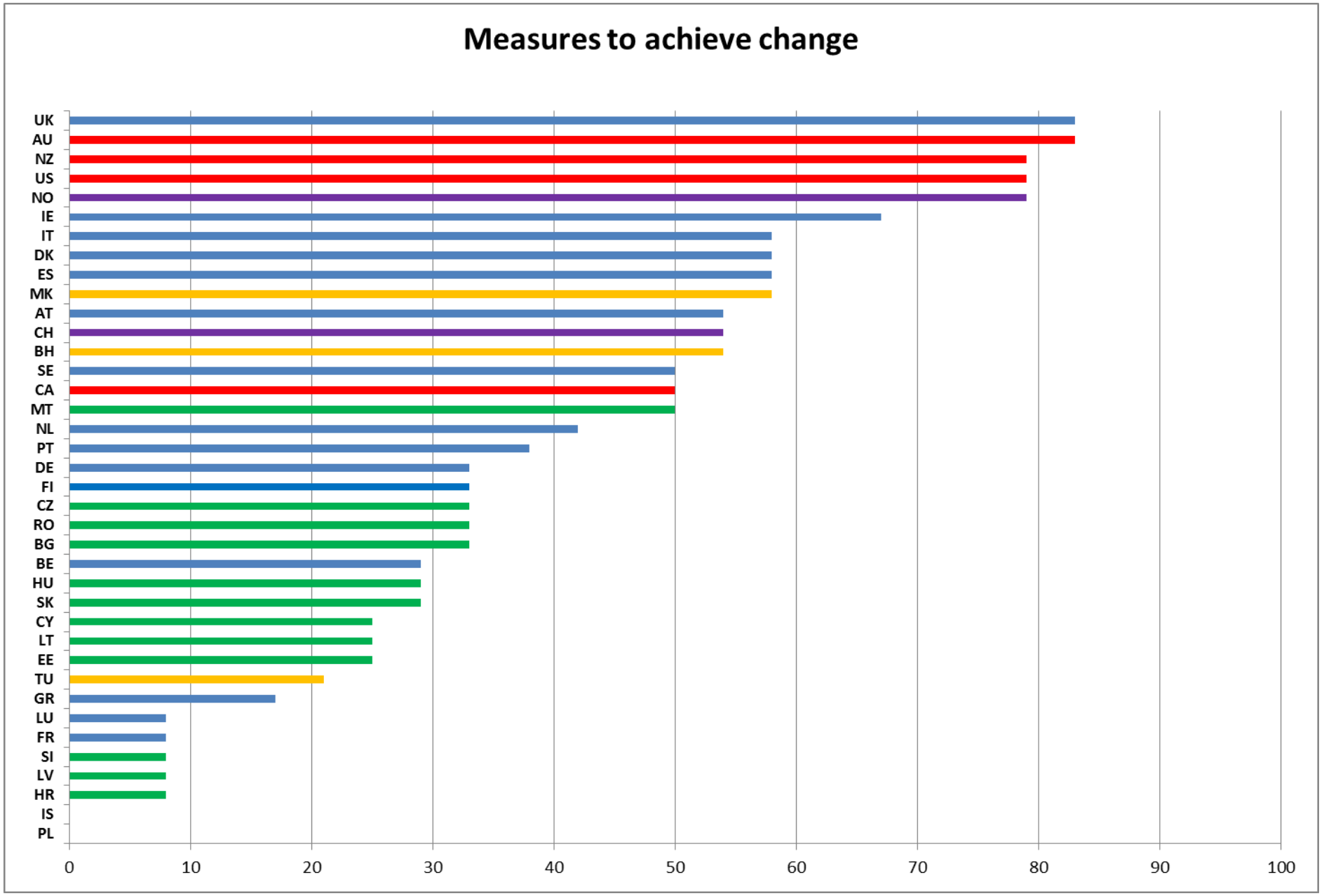
Measures to achieve change
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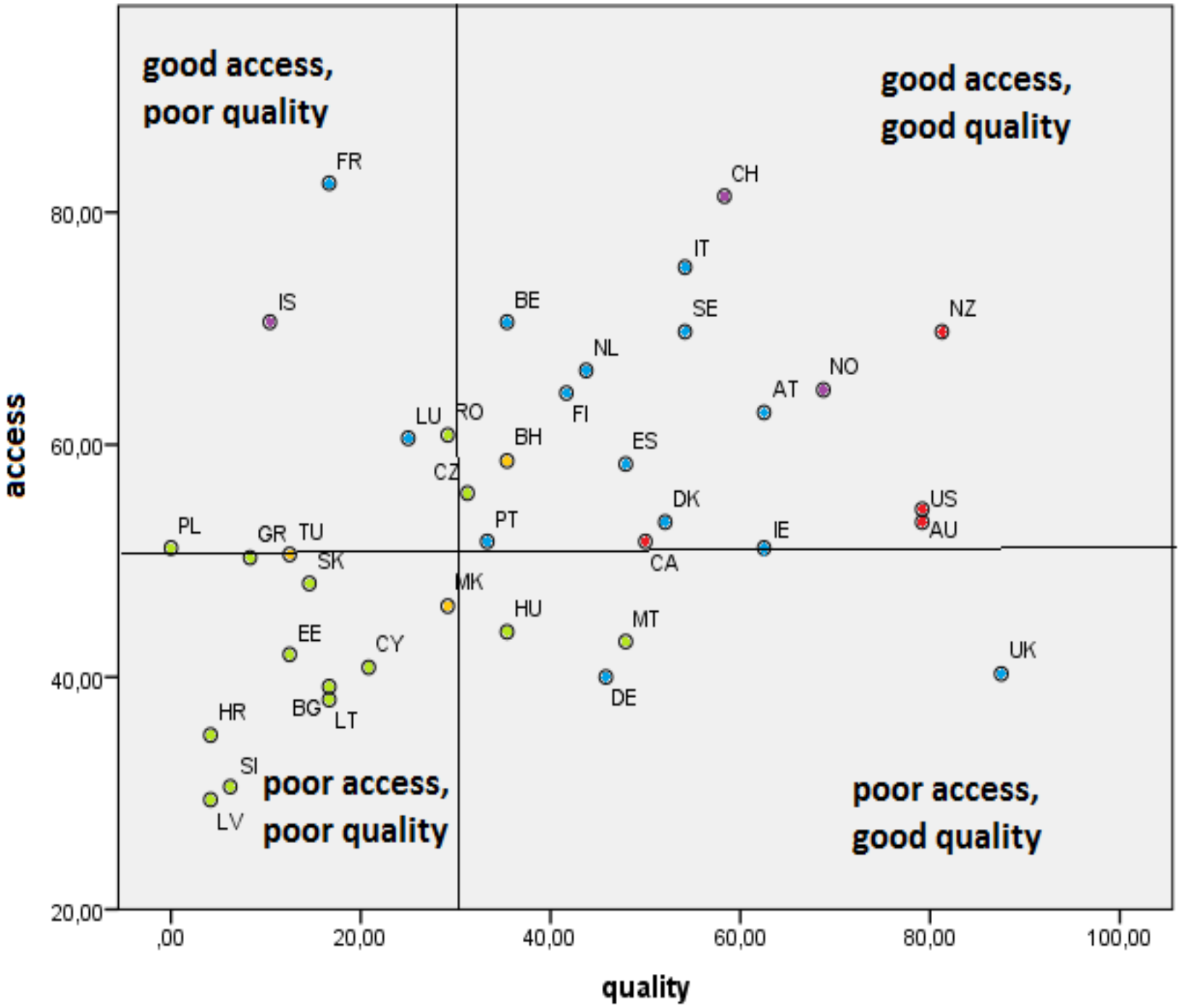
good access,
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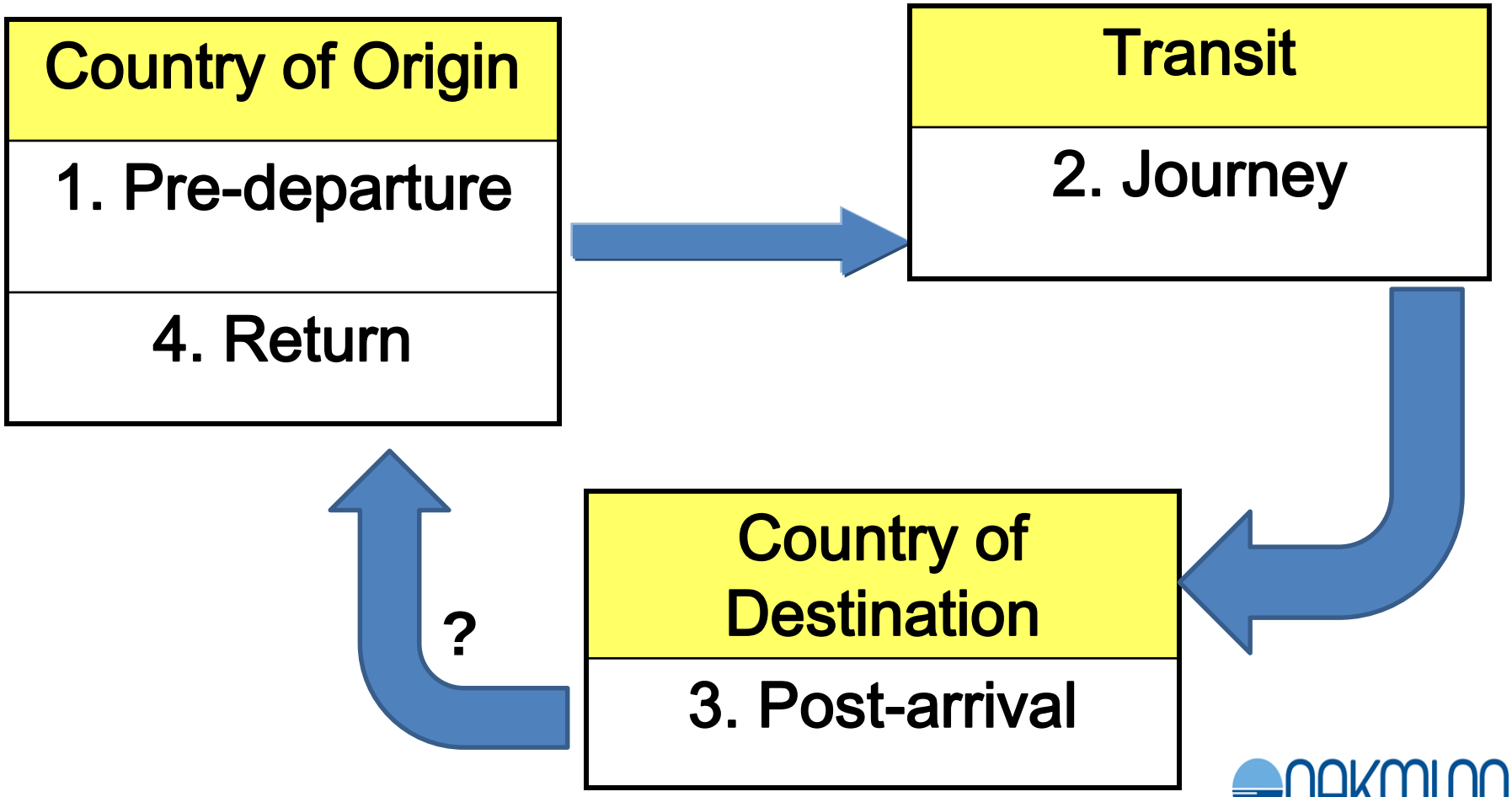
Phases of Migration



Adapted from Gushulak, 2010

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Migrant Health Myths

- **Unhealthy**
- **Carriers diseases of disease**
- **Have poor health habits**
- **Believe in mysterious health practices**
- **Migrants are a burden on health systems”**
- **“Generous social rights attract more migrants**

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Changes with Migration

- Risk factors will change
- Changes could be positive or negative
- Changes are physical, mental or pyschosocial
- Life course perspective

- Initially a period of euphoria – followed by a period of disillusionment, during which depression is common - finally, a period of adaptation

Grove N.J 2006,Organista 2003, Keefe&Padilla 1987, Berry 1980,

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Hypotheses on health of migrant vs host populations

- *'Healthy migration' effect* (those with resources to migrate and reestablish themselves may be more resourceful, also health wise)
- *'Salomon' effect* (those who or old/sick may have a propensity to return to their country of origin)
- *'Acculturation'* (migrants may adopt healthy/unhealthy behaviors common in their destination country)
- *'Social causation'* (it may be socially burdensome to be immigrants)
- *Data artefact* (weak incentives to out-register may result in statistical 'immortality')

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Migration to Norway

Norway

- Migrant population
  - 1% in 1970 to over 15% today
  - last five years, from 500 000 to 800 000
  - Earlier – fragmented immigrant flows – heterogeneity -221 countries (and commonly not a first destination choice)
  - Last decade, mostly immigrants from Eastern European countries (EU expansion in 2004)
- Reasons for migration:
  - 39% family unification, 31% labor, 22% refugees and 6% education
- Egalitarian social policies, relatively low levels of inequality
  - Immigrants same legal rights as hosts, e.g. free health care etc.
  - MIPEX (‘integration policy index) ranks Norway

NORWAY- STRATEGY ON IMMIGRANT HEALTH

The State shall ensure that:

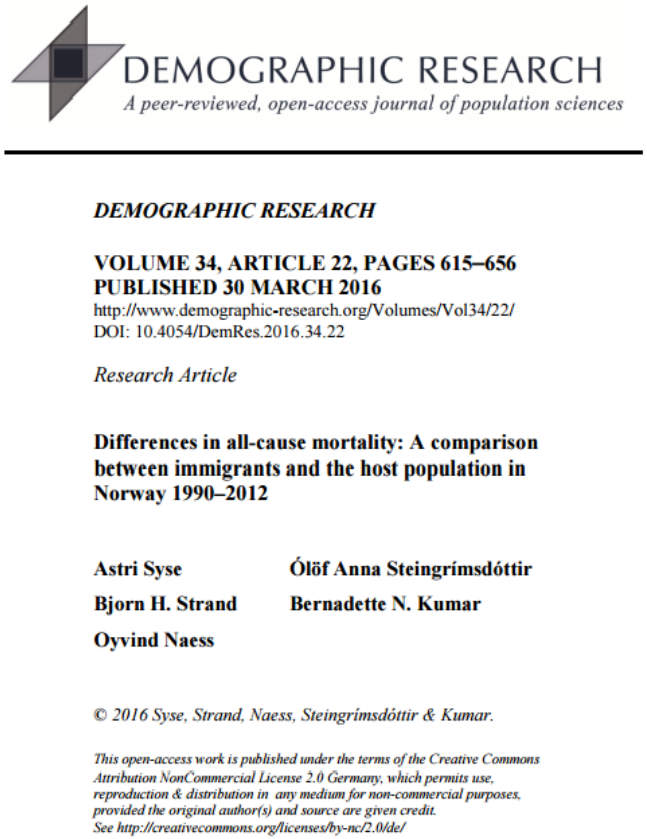
Health care providers at all levels have basic knowledge about various migrant groups' disease incidence and the cultural challenges related to ensuring equitable healthcare services.

Health care providers at all levels shall facilitate good communication with non Norwegian speaking patients. This includes securing a qualified interpreter when the need arises.

Healthcare services must equipped with updated knowledge about migrants' health and their use of the healthcare service, as well as use the knowledge in the development of services.

DEATH RISK

- Linked administrative population data
- All individuals age 25-79 in 1990-2012 were included
- Around 451 000 deaths in around 4.4 million individuals
  - Immigrants accounted for around 15 % of the individuals (but fewer observation years) and experienced 18 400 deaths
- Discrete time regression models with time-varying covariates was used to assess the relative death risk between hosts and various immigrant groups
- To facilitate comparisons across models, marginal effects were calculated



DEMOGRAPHIC RESEARCH
A peer-reviewed, open-access journal of population sciences

DEMOGRAPHIC RESEARCH

VOLUME 34, ARTICLE 22, PAGES 615–656
PUBLISHED 30 MARCH 2016
http://www.demographic-research.org/Volumes/Vol34/22/
DOI: 10.4054/DemRes.2016.34.22

Research Article

Differences in all-cause mortality: A comparison between immigrants and the host population in Norway 1990–2012

Astri Syse **Ólöf Anna Steingrímsdóttir**
Bjorn H. Strand **Bernadette N. Kumar**
Oyvind Naess

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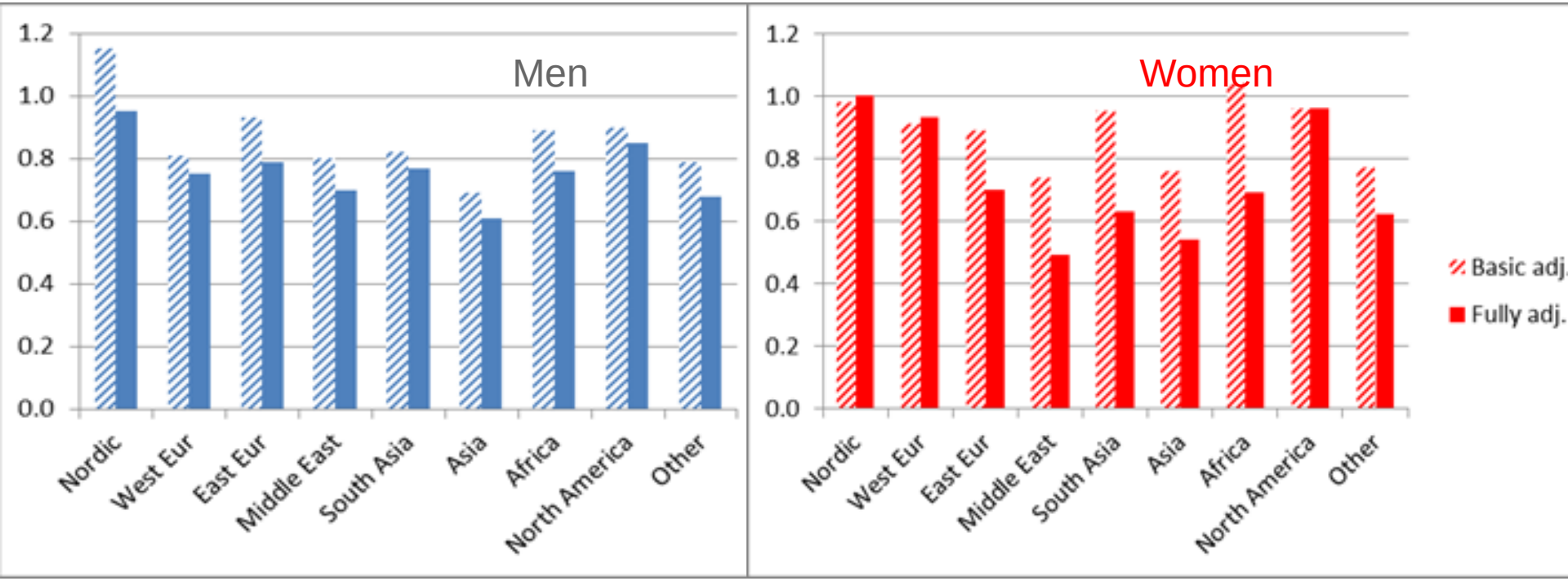
Death risks (ORs) by country group origin



Note: The host population is the reference category (OR=1). Age group and calendar period represent basic adjustment (shaded), whereas full adjustment also includes education, marital and parental status (full).

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Syse 2016

? Healthy Migrant Effect

- Immigrants in Norway have a lower mortality than hosts
- Sociodemographic factors play an important role for immigrants' survival advantage
- Although mortality varies substantially between groups of origin, no group has a higher death risk than the host population after adjustments for sociodemographic factors.
- The convergence in mortality for hosts and immigrants with increasing duration of residence suggests that 'healthy migration' and negative acculturation effects may counteract each another

Health Challenges among Migrants

- In a systematic review; 224 references, mainly published peer-reviewed articles were found:32 articles on lifestyle- and diet-related disorders;41 on mental health;54 on infectious diseases; 21 on reproductive health ;74 on other public health problems
- Higher burden & greater risk of lifestyle- and diet-related disorders, mental health problems, infectious diseases and complications of reproductive health
- Significant variation across gender, ethnic and age groups
- Immigrants from low- and middle income countries have poorer health compared to immigrants from Western countries and Norwegians

Abebe 2010

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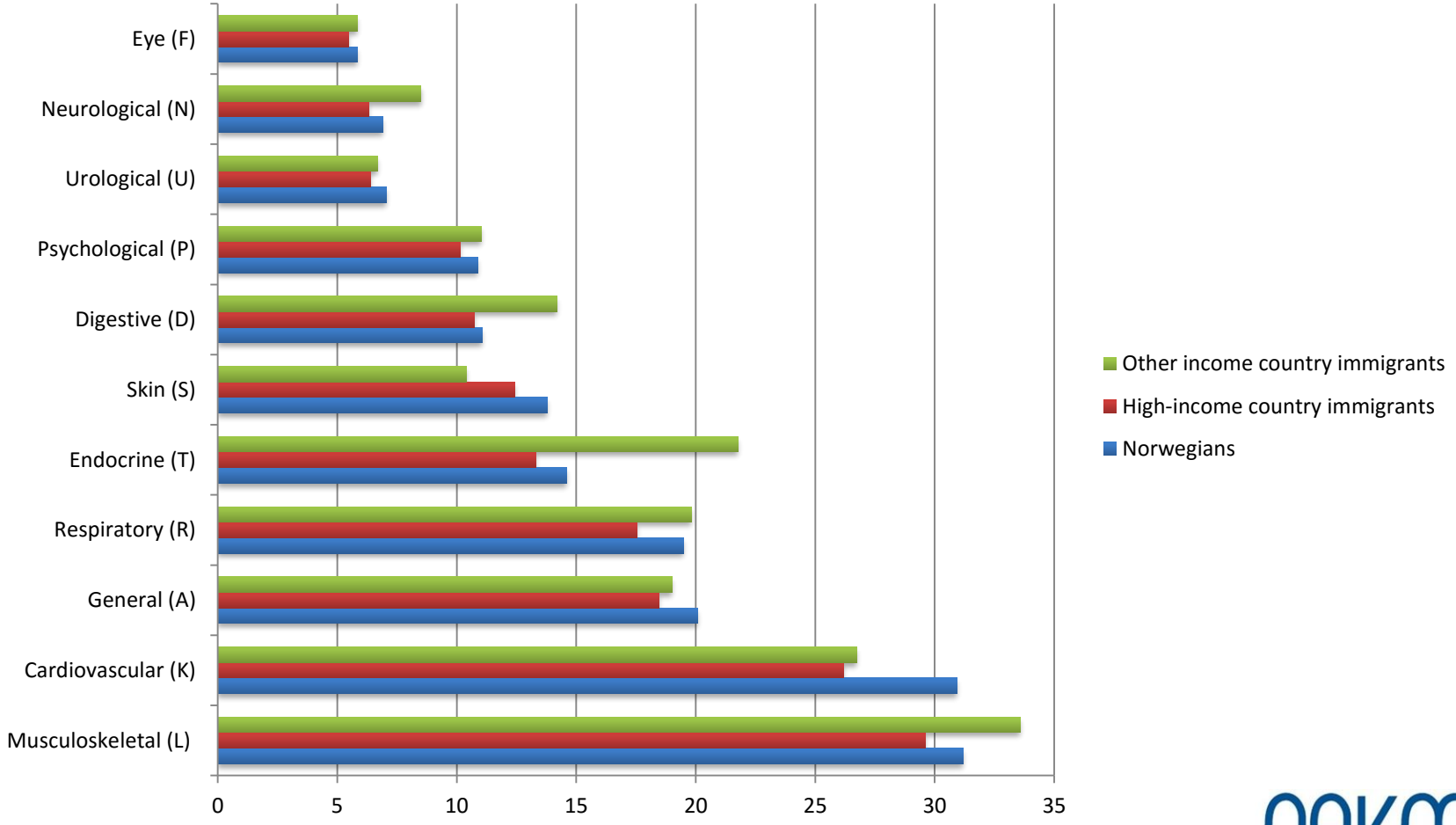
Nasjonal kompetanseenhet for minoritetshelse

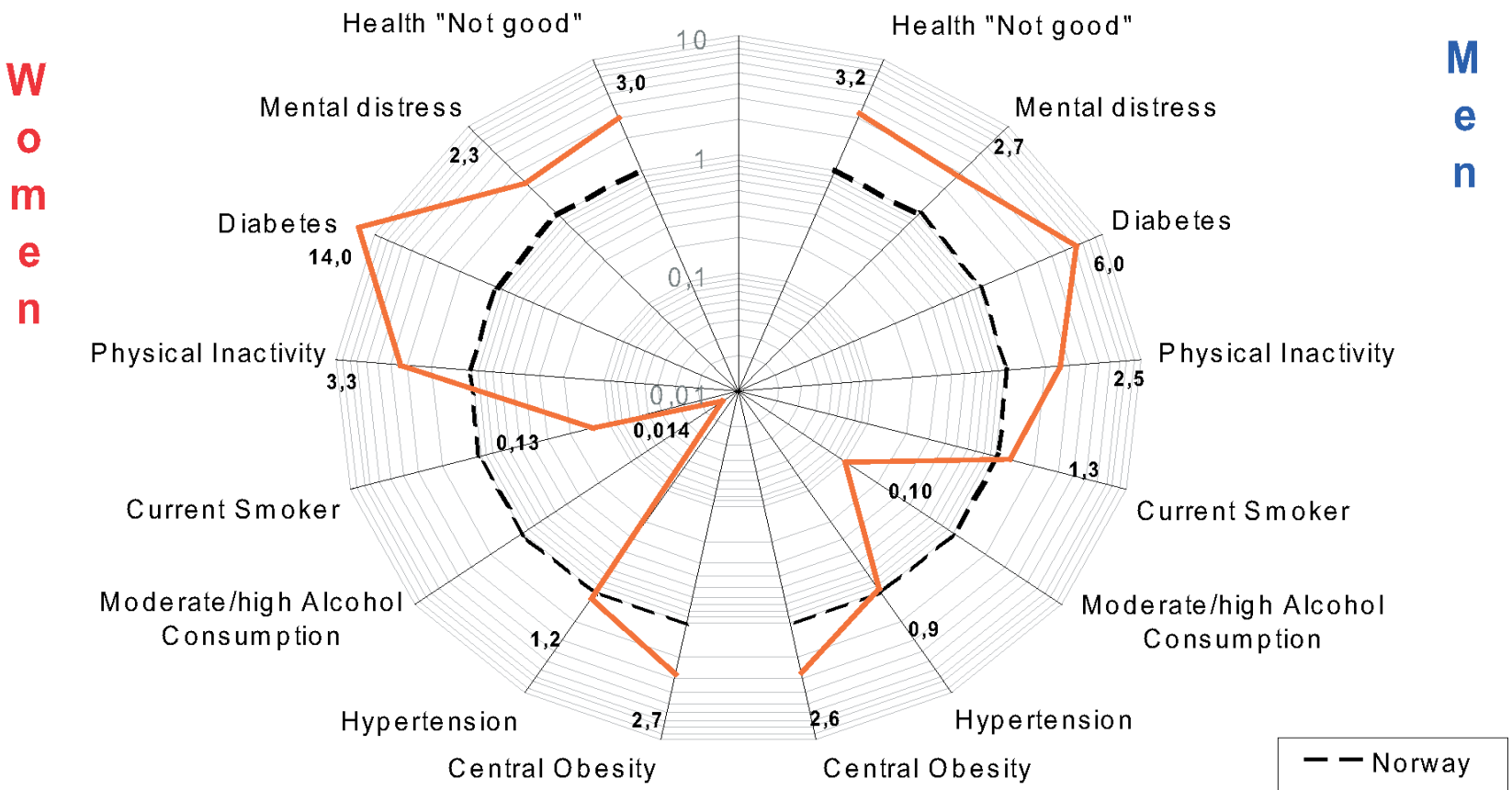
Age and gender-adjusted proportion of the population with at least one diagnose. Diagnoses (ICPC-2 chapters) given by either the General Practitioner or at Emergency Primary Care services.



Diaz 2014

Nasjonal kompetanseenhet for minoritetshelse

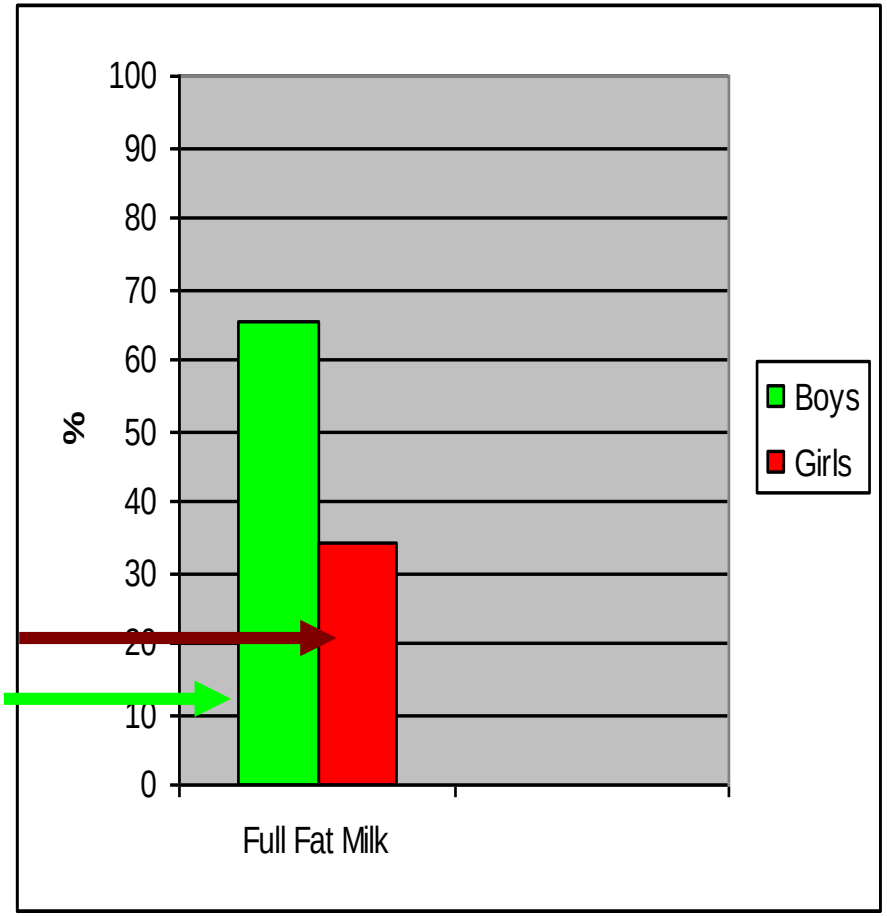
Health Status and Selected Risk factors among Pakistanis

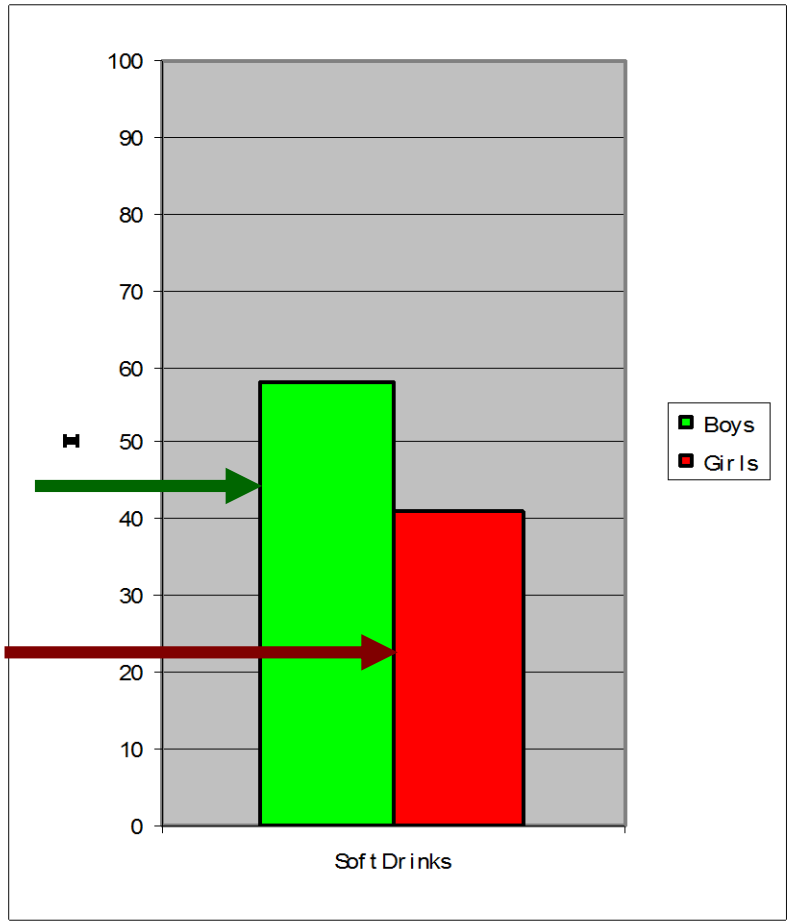


Kumar B. N et al Oslo Immigrant Health Profile , FHI 2008

NAKMI
Nasjonal kompetanseenhet for minoritetshelse

`Double Jeopardy'
- frequency of high intake* of soft drinks and full fat milk among Ethnic Minority Adolescents in Oslo.





**High Intake indicates 1 – 4 or more glasses of soft drink/milk/ day*

Kumar BN et al2003

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Nasjonal kompetanseenhet for minoritetshelse

Difficult diagnosis – Dementia and Migrants

–Studies from several countries report the use of cognitive tests in different groups

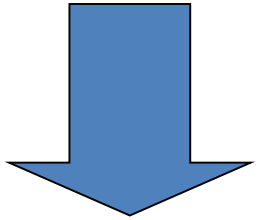
–Language skills/communication challenges common in the assessment of dementia

– Level of Education and stage of dementia when testing play a role as well

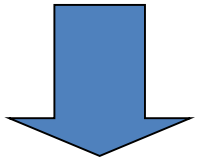
–Standardized cognitive tests (e.g MMSE) for assessment of dementia are not well suited for some groups, particularly immigrants with lower levels of education.

Migrants' access to healthcare

- **Formal factors** (legal rights; financial barriers)
- **Informal factors** (patient- and system related)



- **Delay in diagnosis and treatment – low quality service**



- **Increased morbidity and mortality**

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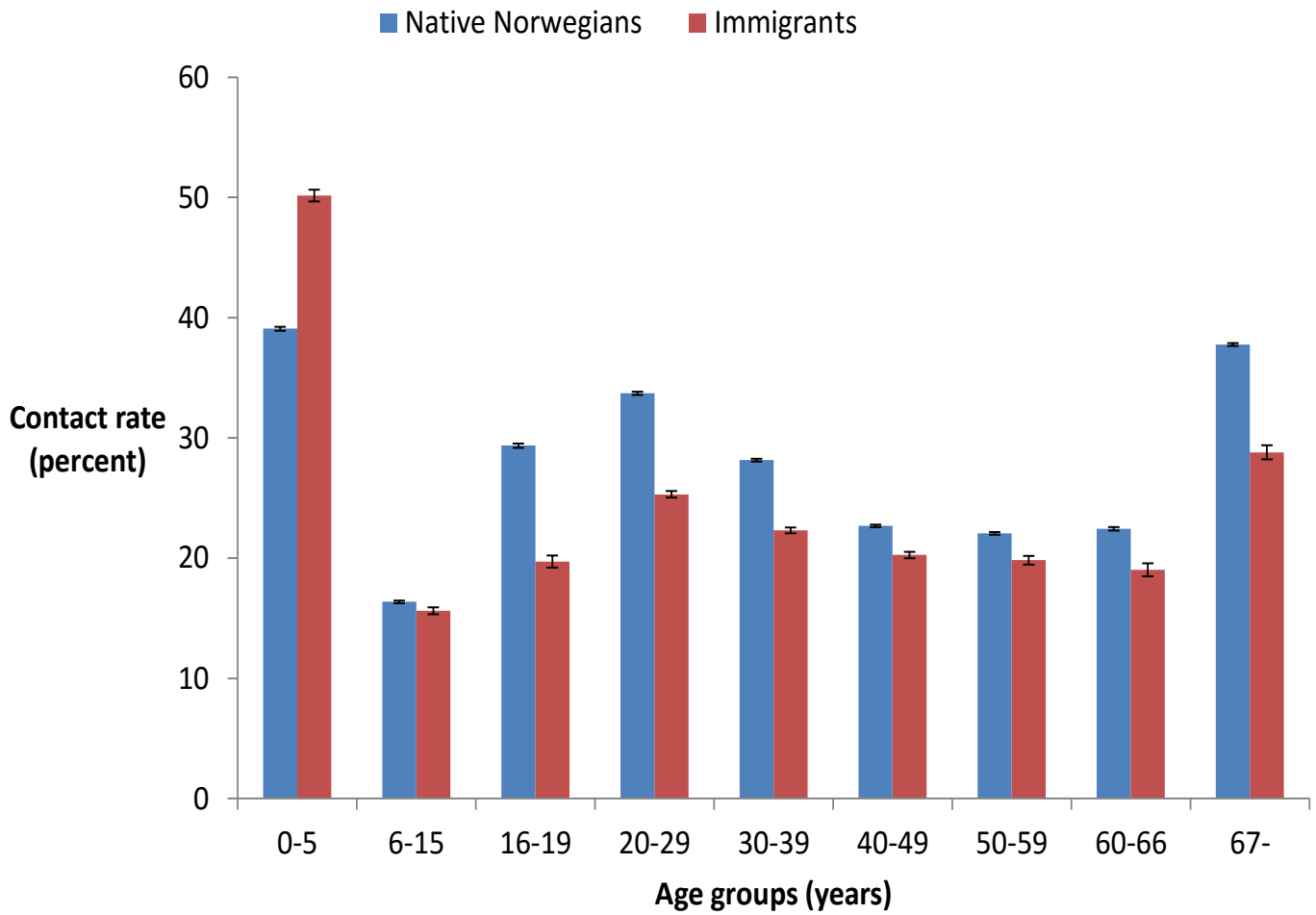
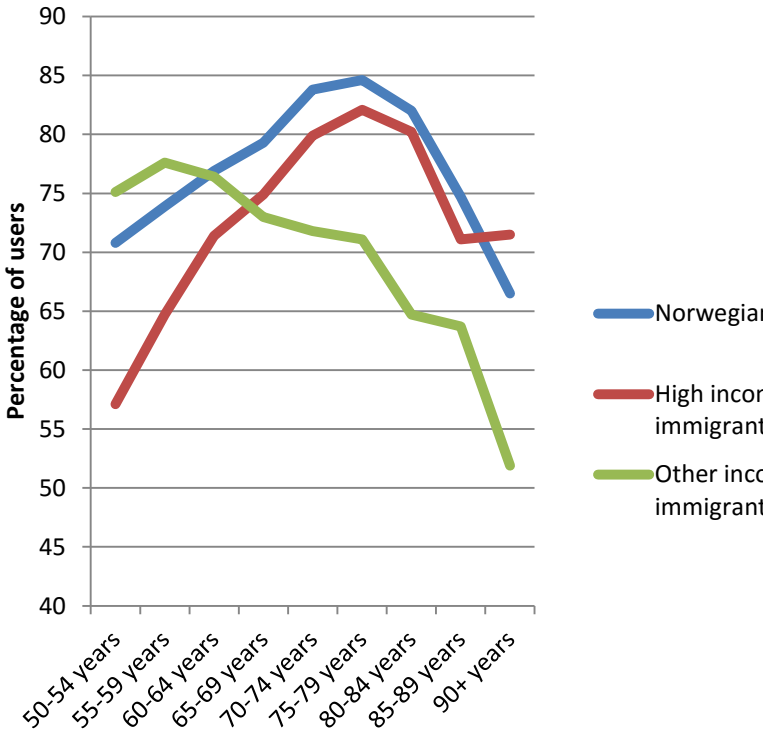
Sandvik, Hunskår, Diaz. BMC Immigrants' use of emergency primary health care in Norway: a registry-based observational study. BMC Health Services Research 2012



Proportion of Primary Health Care users in 2008 by age group. Norwegians and immigrants from high-income and other-income countries.



Diaz and Kumar *BMC Health Services Research* 2014, **14**:623
http://www.biomedcentral.com/1472-6963/14/623

BMC Health Services Research

RESEARCH ARTICLE Open Access

Differential utilization of primary health care services among older immigrants and Norwegians: a register-based comparative study in Norway

Esperanza Diaz[1,2*] and Bernadette N Kumar[2]

Abstract

Background: Aging in an unfamiliar landscape can pose health challenges for the growing numbers of immigrants and their health care providers. Therefore, better understanding of how different immigrant groups use Primary Health Care (PHC), and the underlying factors that explain utilization is needed to provide adequate and appropriate public health responses. Our aim is to describe and compare the use of PHC between elderly immigrants and Norwegians.

Methods: Registry-based study using merged data from the National Population Register and the Norwegian Health Economics Administration database. All 50 year old or older Norwegians with both parents from Norway (1,516,012) and immigrants with both parents from abroad (89,861) registered in Norway in 2008 were included. Descriptive analyses were carried out. Immigrants were categorised according to country of origin, reason for migration and length of stay in Norway. Binary logistic regression analyses were conducted to study the utilization of PHC comparing Norwegians and immigrants, and to assess associations between utilization and both length of stay and reason for immigration, adjusting for other socioeconomic variables.

Results: A higher proportion of Norwegians used PHC services compared to immigrants. While immigrants from high-income countries used PHC less than Norwegians disregarding age (OR from 0.65 to 0.92 depending on age group), they had similar number of diagnoses when in contact with PHC. Among immigrants from other countries, however, those 50 to 65 years old used PHC services more often (OR 1.22) than Norwegians and had higher comorbidity levels, but this pattern was reversed for older adults (OR 0.56 to 0.47 for 66-80 and 80+ years respectively). For all immigrants, utilization of PHC increased with longer stay in Norway and was higher for refugees (1.67 to 1.90) but lower for labour immigrants (0.33 to 0.45) compared to immigrants for family reunification. However, adjustment for education and income levels reduced most differences between groups.

Conclusions: Immigrants' lower utilization of PHC services might reflect better health among immigrants, but it could also be due to barriers to access that pose public health challenges. The heterogeneity of life courses and migration trajectories should be taken into account when developing public policies.

Keywords: Immigrant, Primary care, Primary health care use, Health services, Norway

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Utilization of Health Care services

- A higher proportion of Norwegians used PHC services compared to immigrants.
- Immigrants' lower utilization could be appropriate if it reflects better health among immigrants,
- However it could also be due to barriers for utilization of services, posing a public health challenge.

Diaz 2014

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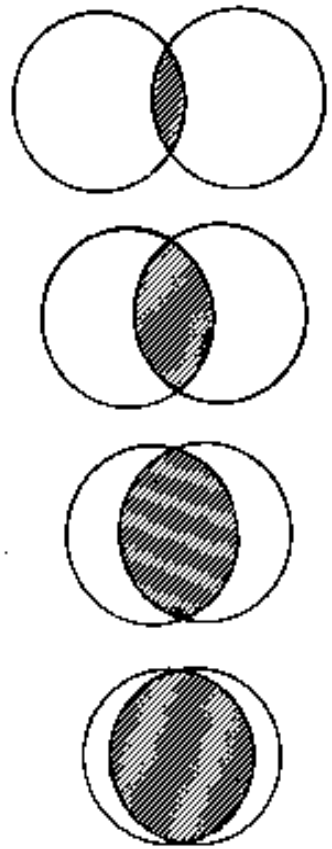
CULTURAL DIFFERENCES - BRIDGING THE GAP



Kulturavstand

NORGE OG JAPAN

NORGE OG FRANKRIKE

NORGE OG SVERIGE

ØSTLANDET OG VESTLANDET

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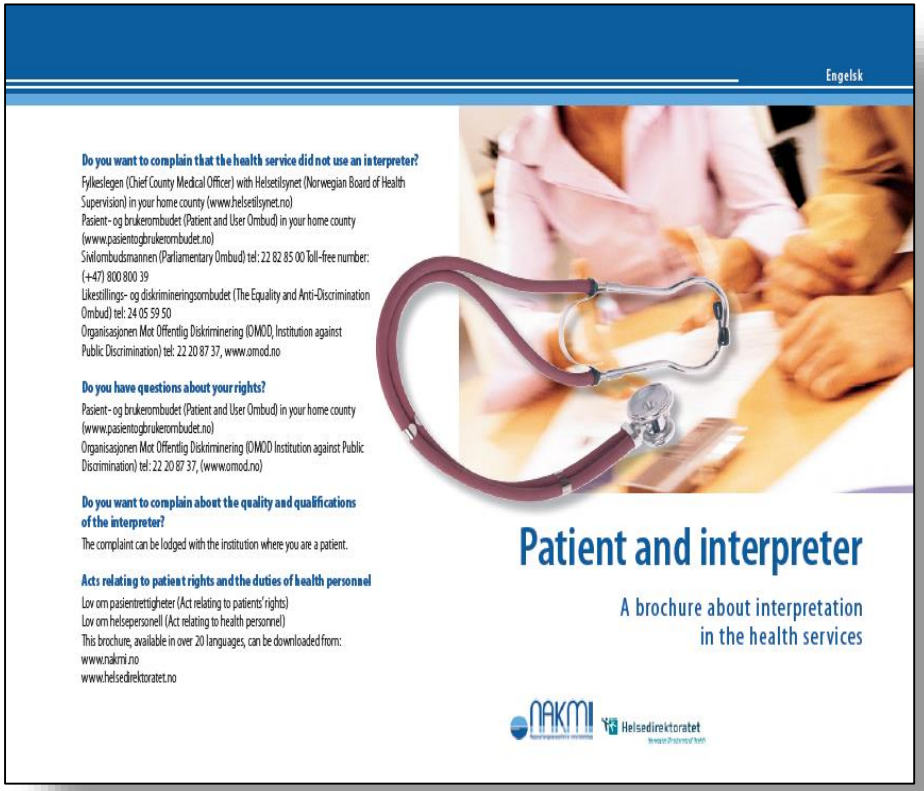
DIALOGUE
Language is EVERYTHING!

- People have a fundamental right to be heard and to receive information and guidance.
- Patient Rights Act establishes the patient's right to participation and information in § 3.1 and § 2.3, and the patient's right of access in § 3-5. Act regulations emphasize that „people who speak the Sami language, people who speak foreign language and people with disabilities" have the right to facilitated communication (section 11)



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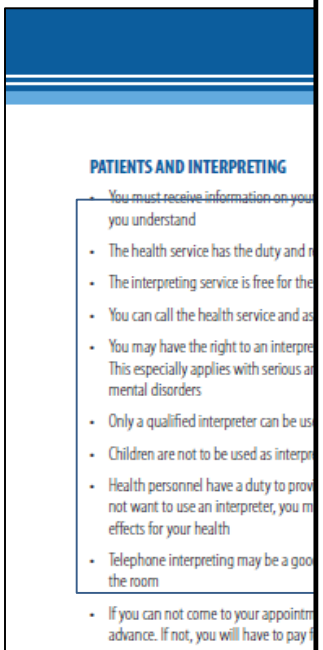
Patient rights in brochure



- You must receive information on your health condition and treatment in a language you understand
- The health service has the duty and responsibility to book an interpreter
- The interpreting service is free for the patient
- You can call the health service and ask them to book an interpreter
- You may have the right to an interpreter even if you speak Norwegian on a daily basis. This especially applies with serious and chronic diseases, and with consultations on mental disorders
- Only a qualified interpreter can be used
- Children are not to be used as interpreters
- Health personnel have a duty to provide health care in a professional way. If you do not want to use an interpreter, you must be informed that this can have negative effects for your health

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WHEN I WENT TO THIS DOCTOR, HE ASKED ME WHY COULD I NOT SPEAK NORWEGIAN. THIS WAS HIS FIRST QUESTION: WHY WAS I NOT SPEAKING NORWEGIAN.

You must receive information on your health condition and treatment in a language you understand

Each time I had to ask for the interpreter. Once they forgot to arrange an interpreter for me. I didn't know that I was going to be on my own so I didn't get a chance to prepare for this visit. I didn't prepare the right terminology, the stuff that I wanted to say, medical stuff. These words are not normally used in everyday language so it's difficult to remember them.

The health service has the duty and responsibility to book an interpreter

You can call the health service and ask them to book and interpreter

I used a dictionary and tried to ask for an interpreter over the phone. At the begining the receptionist told me that it wasn't necessary but I asked if the interpreter could come anyway. I had to repeatedly ask her but she told me that the doctor could speak English. When I actually went there later on, it turned out that we would have had nothing to talk about. She [the doctor] was able to say only 'hello' and 'goodbye' and that was all.

The interpreting service is free for the patient

She [a friend] had to arrange for the interpreter herself. This is how it is here. Sometimes they provided her with an interpreter and other times they would say that they are very sorry, but they couldn't get her an interpreter because it is too expensive for them to organise one and she has to bring her own interpreter along to the visit.

Czapka 2015

You may have the right to an interpreter even if you speak Norwegian on a daily basis. This especially applies with serious and chronic diseases, and with consultations on mental disorders

This nurse was quite stubborn. There were two such cases. Once I got an interpreter over the phone. But the second time, it was in X... And there, you could say, it turned into a fight. The nurse, said that I couldn't [get an interpreter] and I said that I needed one. She was really stubborn but she finally called for an interpreter. There is a way of doing it. When she says something and I understand it, I can always say that I can't understand her. No matter what she is saying I can always reply: 'I dont' understand, I don't understand'.

Children are not to be used as interpreters

My son was an interpreter… We didn't speak Norwegian and our English was not good enough. We asked the doctor if the son could interpret for us. He was standing somewhere there and the doctor was doing his job. My son was interpreting.

Only a qualified interpreter can be used

This lady that I know came with me and interpreted for me (...) When I had a hernia operation, they organised an interpreter for me, but she [the friend] was there with me as well. And thank goodness she was there because the interpreter had a limited availability and quickly disappeared, but she was with me untill the end.

Czapka
2015

Vi tat det vi har…..MAKING DO

The evidence was found for violation of 7 out of 8 patients' rights!

- Migrants were rarely asked whether they needed a translator
- Migrants are unaware of the health personnel's obligation to provide a translator
- Migrants were sometimes asked to cover the cost of translation, or they were actively convinced that they could manage without one

How migrants cope-

- cancellation of the visit
- bringing their own Polish-Norwegian medical dictionary
- using the child as an interpreter
- asking friend to translate for them by phone

Czapka 2015

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Challenges

- **Changing context of Diversity** - The changing composition of populations draws attention to diverse populations of which migrants are an important sub group.
- **Similarities and Differences-** Although medical/nursing management of a particular disease might be the same globally, the biggest challenges lie in the context - establishing patient needs, ideas and expectations related to a particular situation.
- **Patient Centered Care-** Recognise individual needs and respond appropriately which involves adapting according to the need.

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WAY FORWARD

- Adaptating to address the needs
- User Involvement - Raise the potential for improving health through empowerment of the users
- Continue to generate evidence - studies that provide valuable insight into how to achieve change –intervention studies
- Building skills and competence - health providers and researchers to develop approaches to adapting interventions than has hitherto been the case.

THE ROAD TO HEALTH WITH HEADS AND HEARTS

Family doctors are pivotal in enabling individuals and communities to improve their health

The refugees will keep trying until they succeed or die.”

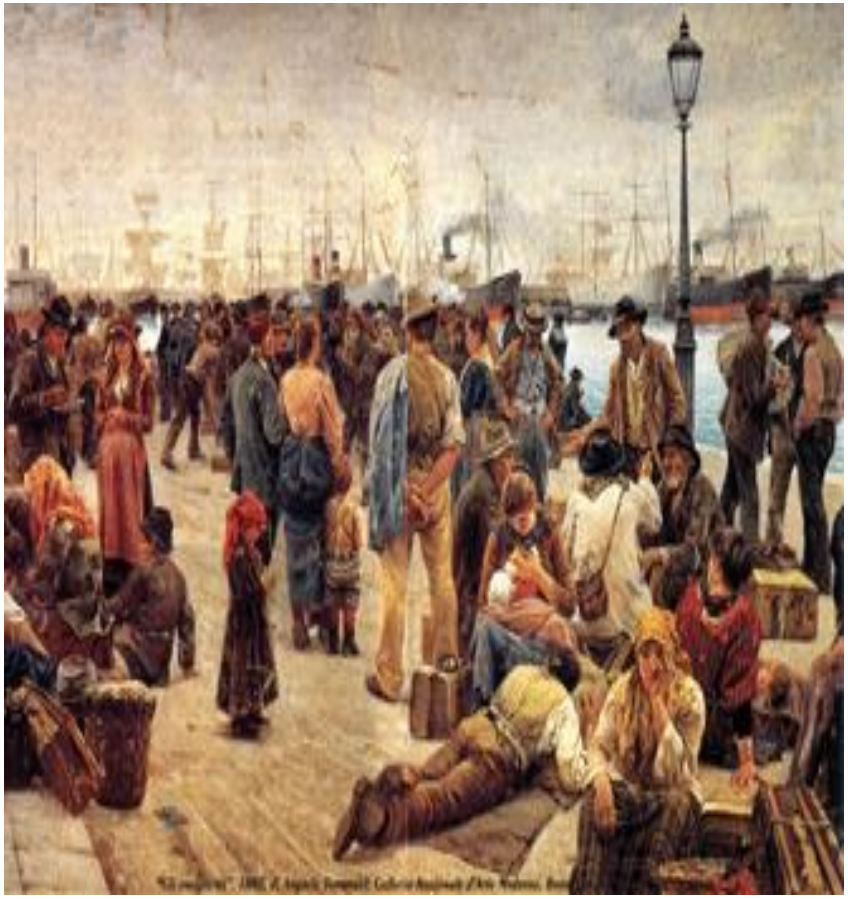
A volunteer rescue worker

Cathedral of Noto / Sicily, April 1st, 201

APPRECIATING DIVERSITY

"The land flourished because it was fed from so many sources --because it was nourished by so many cultures and traditions and peoples."

- Lyndon B. Johnson



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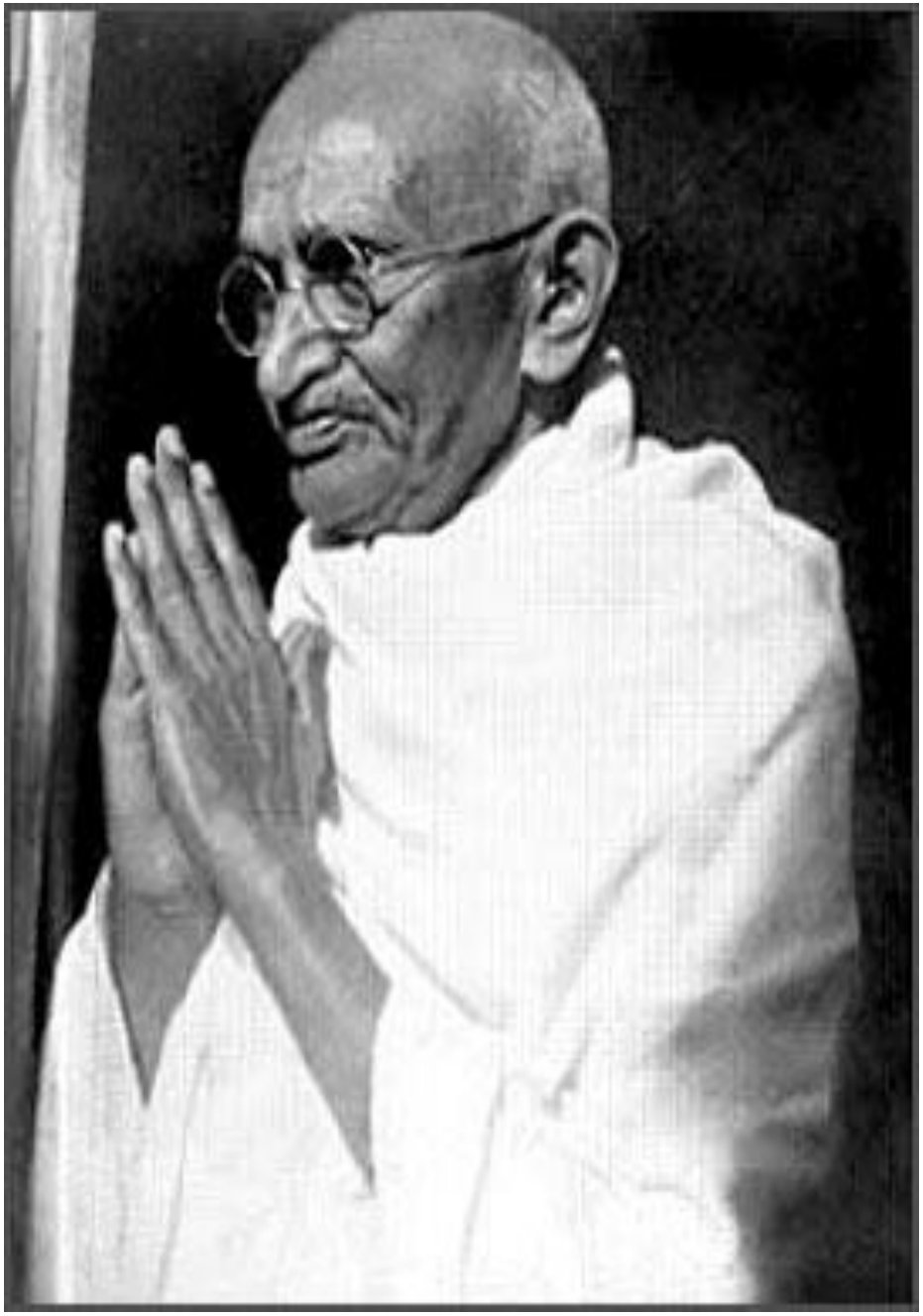
You have to be the change that you want to see in this world

- Gandhi



A FAIR CHANCE FOR ALL


6th
EUPHA
MEMH
OSLO
2016

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