The health of migrants and ethnic minorities in Europe: where do we go from here?

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Between 0.4% (Slovakia) and 15.3% (Estonia) of the European population were born in a non-EU-27 (European Union-27) country,¹ and this proportion is increasing in most member states. Given that migrants and ethnic minorities do not always have equal access to health services, their rights to health and health care are important public health topics. To improve the basis for further research and advocacy, these issues were discussed at the fifth EUPHA European Conference on Migrant Minority Ethnic Health in Granada, Spain, in April 2014 (more details of the conference, including the programme and the volume of abstracts, can be found at http://www.eupha-migranthealthconference.com/).

Some of the lessons learned

The health of migrants and ethnic minorities should not be approached from a paternalistic perspective and with a focus only on deficits. On a population level, migrants (and also some ethnic minority groups) are comparatively healthier—especially with regard to non-communicable diseases such as cancer.² Migrants and ethnic minorities are of course also exposed to health risks, such as limited accessibility to health care, or adverse working conditions, but these are often structural rather than related to peculiarities of these groups.

The economic crisis, and in particular the austerity policies some European governments implemented, have dramatic effects on public health services. Populations experience measurable effects on their health, overwhelmingly negative.³ The economic crisis in general, and austerity policies in particular, affect all (or at least all vulnerable) groups in society. If we single out migrants and ethnic minorities in this context, even with the best intentions, we put them at risk of being discriminated against. Such an approach may strengthen negative feelings against migrants because they will be perceived as competing for scarce resources with the majority population.

We need to position migrants and ethnic minorities as full members of society, with the same rights (and under the same economic pressures) as everybody else. Their health is affected primarily by the same factors that affect the general population’s health, namely, social determinants. Politicians as well as the general public need to realize that most interventions to reduce inequalities and inequities addressing ethnic minority and migrant groups will benefit the entire population.

Additionally, specific factors might aggravate their (health) situation, such as negative attitudes of members of the majority population towards migrants and ethnic minorities, and even blatant discrimination. This is particularly obvious in the case of the Roma populations.⁴ Some EU countries still have no (or no longer offer) unrestricted medical care for undocumented migrants (or ‘sans papiers’).⁵ A particular disgrace for the EU is the health hazard of its external borders, with numerous deaths among would-be immigrants and refugees every year. These issues need to be resolved urgently.

Managing diversity in health policy and practice

We need to appreciate that migration status and ethnicity are markers of heterogeneity, among many other such markers in today’s EU societies, such as gender, age, religion or sexual orientation. Managing this diversity is a process that requires sensitivity towards different needs and expectations among all people. Thus, we have moved beyond culture specificity, towards appropriate ways to deal with the increasing diversity of today’s EU societies. Again, every EU citizen will benefit if diversities are respected—migration status and ethnicity being examples but by far not the only ones to be taken into consideration.

Support for Health in All Policies seems to diminish among the EU Commission. The Commission appears to see health policy as largely unrelated to social inequalities, instead supporting stratified (personal) medicine and genomics as the way to go (focus on drug and technology development).² This is highly unlikely to produce a magic bullet for improving the health of either migrants and ethnic minorities or the majority population.

There are a number of normative issues inherent to the field of health of migrants and ethnic minorities. A blatant example is the ideologically tainted messages of right-wing politicians in the Netherlands or France, which openly discriminate against migrants and ethnic minorities. Such messages—unfortunately a feature of many EU countries—and their creators are rarely countered by other politicians who seem to be afraid to lose votes in the next election if they do so. Scientists in the field need to point out more explicitly that these developments have negative effects on the health of migrants and ethnic minorities, in view of the substantial body of literature on the adverse impact of discrimination on health. In addition, the researchers need to discuss how evidence on ways to improve the health of migrants and ethnic minorities will be effectively heard in such a context.

There are many good examples of how researchers have succeeded in having an impact on migrant-related policies, despite the economic crisis, austerity policies and the presence of xenophobic and anti-Islam political parties. These experiences need to be shared more effectively, among scientists as well as policy makers.
The accompanying paper by Kühlbrandt et al.\(^1\) begins to fill the void of quantitative data on access to health insurance coverage by Roma in Central Eastern European (CEE) countries. Survey data from 12 CEE countries clearly show that Roma, Europe’s largest ethnic minority, comprising up to 12% of the population of some of these countries, are significantly less likely to have health insurance than non-Roma in all countries except Slovakia and Serbia. The share of Roma without coverage reaches almost 30% in Bosnia-Herzegovina, over 40% in Bulgaria and Romania and 59.7% and 67.7% in Moldova and Albania, respectively. Throughout the region, Roma face poverty, poor access to education, high levels of unemployment and social exclusion. All of these might be expected to impact adversely on their health. Yet, despite these disadvantages, the size of the problem is difficult to assess because of restrictions on collecting data on health and health-care utilization by ethnic status. Consequently, it is necessary to rely on one-off surveys, which consistently show how the health of Roma is much worse than that of the general population, while they face important barriers in accessing health services.\(^2\) Of those who are able to access health services, more than a third report experience of discrimination.\(^3\)

The Roma Health Project of the Open Society Foundations has supported Roma health programmes since 2001. In the framework of these programmes, Roma Health Mediators (RHMs) assist with acquiring personal documentation and registration for health insurance, facilitate access to health, social and educational services, provide legal referrals for Roma clients who have experienced discrimination or other human rights violations in health-care settings and conduct health education sessions in the community. They provide support for local health authorities in areas such as increasing uptake of vaccination. These programmes operate in Romania, Serbia, Slovakia, Bulgaria, the former Yugoslav Republic of Macedonia and Ukraine. Yet, despite clear successes (such as increased vaccination rates, acquisition of identity documents and health insurance cards, improved interactions between Roma patients and doctors, etc.), a recent report\(^4\) identifies major barriers to scale up and sustainability, including low salaries, poor opportunities for professional development, insecure financing and isolation from the rest of the health system. As the report notes, ‘... the number of mediator jobs is tiny in comparison to the health needs of Roma communities’.

For 2 years, a Swiss–Hungarian cooperation programme has operated in the two most disadvantaged regions of Hungary.\(^5\) Four general practitioner (GP) clusters were created, involving 24 collaborating practices covering ~45 000 people, 30% of whom are Roma. The clusters offer traditional acute, emergency and chronic care and also public health services. They have employed new health professionals (public health professionals, community nurses, physiotherapists, dieticians and health psychologists) to develop new activities, as well as health mediators recruited from the Roma population. These mediators, working closely with other team members, facilitate recruitment of Roma clients and encourage uptake of culturally appropriate preventive services, such as health promotion activities at different settings, health status assessment, lifestyle counselling, screening programmes and maternal and child health services, while working closely with social workers. Some Roma health mediators have enrolled themselves in vocational training and become nurse assistants or social care assistants. These qualifications provide an opportunity for career development, enabling more Roma to gain employment in mainstream health roles.

Neither the health nor the health-care utilization of Roma has attracted sufficient attention from researchers or policymakers despite their importance in a Europe without borders. Roma health needs, their access to care and the effectiveness of measures to improve their lives cannot be assessed without ethnically disaggregated data. Governments should worry about the severe inequities that remain hidden and not about the misinterpreted ‘personal rights’ when they refuse to collect health data on Roma, who still have far to go to achieve the fundamental human right to health.

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