Moving upstream: Changing policy scripts on migrant and ethnic minority health

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ABSTRACT

This article uses the concept of 'policy scripts' to explore the aims and assumptions underlying policies on migrant and ethnic minority health. Firstly, it analyses the shift in health policies from 'downstream' approaches (emphasising health *care* for the sick and injured) to 'upstream' ones (emphasising health *protection* for the whole population). The field of migrant health has been relatively slow to move upstream. Two factors appear to have impeded this shift: (a) the reluctance of the 'social determinants of health' movement to regard migrant status and ethnicity as important causes of health inequities; and (b) the one-sided emphasis on short-term emergency health provisions for migrants arising from the recent increase in forced migration worldwide, in particular the sudden peak in mixed migration to the EU in 2015. The article contends that (a) the usual arguments against treating migration and ethnicity as health determinants do not stand up to critical examination; and (b) the overwhelming emphasis on unauthorised entrants which characterises current discussions of migration policy, including health, is out of all proportion to their volume relative to that of other migrants. Fortunately, recent policy initiatives at UN level have the potential to restore the balance between 'upstream' and 'downstream' approaches, as well as between unauthorised entry and 'routine' migration.

1. Introduction

The first glimpse of the city of Houston, Texas is of a distant clump of skyscrapers rising from the plain. A familiar sight for travellers in the USA, but these are no ordinary skyscrapers: many of them are giant hospitals, part of the largest concentration of advanced medical expertise and technology in the world [1]. This article suggests that these magnificent edifices will one day be looked on as monuments to a health system model that outlived its usefulness. Despite the fact that the US health system consumes 18% of the nation's GDP [2], it is unable to ensure long and healthy lives even for the wealthy – let alone for the many who cannot afford proper health care – because it is overwhelmingly oriented towards treatment rather than prevention. In the long run, such a system is neither cost-effective nor sustainable: for this reason, health systems all over the world are 'going upstream' in order to tackle the root causes of illness and reduce the need for treatment. Though this example puts the spotlight on the USA, that country

is by no means the only one in which 'upstream' approaches are neglected (even if it is perhaps the most conspicuous).

This article will examine in detail what 'going upstream' means, then consider its relevance to migrant and ethnic minority (MEM) health. It examines work on MEM health in the USA, other 'traditional countries of immigration' and Europe, showing how a methodological and theoretical split has arisen between interventions tackling socioeconomic differences and those linked to migrant status and ethnicity. It then examines the effect on approaches to MEM health of the so-called 'migration crisis' that started in 2015. Finally, it argues that recent developments in the United Nations (UN) and its agencies hold out the promise of a better balance between 'upstream' and 'downstream' approaches to MEM health.

The sociological concept of 'policy scripts' will be used to refer to the normative assumptions and goals that underlie the activities of states, intergovernmental organizations (IGOs), international non-governmental organizations and professional groups. Such scripts guide and constrain the way in which organisations frame problems and devise policies to tackle them. Policy scripts embody presuppositions and priorities that are often tacit, treated as self-evident, and not subjected to critical scrutiny. As well as being less visible than the policies that they generate, they exist at a more general level [3].

'Going upstream' has three main aspects. It emphasises research on the social determinants of ill-health; it promotes policies for protecting health rather than simply improving health care; and it intervenes at the level of health systems and governments, rather than health professionals.

This article will show that upstream approaches have been particularly slow to gain acceptance in the field of MEM health. One obstacle has been the reluctance of the influential 'social determinants of health' (SDH) movement to treat migration and ethnicity as important health determinants. We will illustrate the gap between approaches to MEM health and to socioeconomic inequalities through an analysis of projects supported by DG SANCO (the European Commission's Directorate-general for Health and Consumers Protection) from 2003 to 2013. At a global level, the attention paid to migration and ethnicity in WHO's extensive programme on SDH and 'health in all policies' (HiAP) has until recently been minimal.

A second obstacle was a side-effect of the increase in forced migration in 2015, when over a million unauthorised entrants came to Europe in particular. Until that year, the dominant policy script followed by IGOs viewed international migration in a positive light, treating it as a structural feature of modern economies with potential advantages for both sender and receiver countries. Migrants were seen as an intrinsic part of society; public health considerations, human rights and economic logic all dictated that they and their descendants should be included structurally in health systems [4]. In response to rising levels of irregular border crossings, however, the European Commission (EC) and World Health Organization Regional Office for Europe (WHO Euro) switched to a policy script that framed migration as a calamity of external origin, both producing and produced by crises. Viewed through this lens, migration's challenge to health systems resembled that presented by major disasters: countries were urged to strengthen their capacity to deliver rapid, flexible responses to sudden, massive and unpredictable demands for health care. This policy script generated a wave of new projects in which regular migration for purposes of work, family and study dropped almost completely out of sight. Structural, upstream policies to protect the health of these 'routine' migrants threatened to fall even further behind.

In reality, framing all migration as a crisis stood reality on its head: even in the peak year 2015, unauthorised arrivals to the EU were considerably less numerous than 'routine' migrants. Worldwide, examining migrant stock figures published by the UN in 2017 shows that the percentage of forced migrants (refugees and asylum seekers) among all migrants in 2015 was 9.4% – higher than the 6.1% recorded in 2005 and 2010, but lower than the 11.8% seen in 1990. Despite this, the 'crisis' view of migration has profoundly influenced current approaches to migrant health.

Talk of a migrant crisis may have been intended to mobilise public support and strengthen the humanitarian response to the 2015 influx, but it backfired disastrously. Describing migration in these terms fitted in perfectly with the discourse of populist politicians: suddenly, international organisations seemed to be conceding that the xenophobes had been right all along. WHO Euro even deployed its 'toolbox' for coping with earthquakes and tsunamis to deal with the effects of migration, unconsciously mimicking the far right's favourite metaphors. The Brexit referendum and the election of Donald Trump in 2016 showed how widespread the view of migration as a crisis had become. The EC and WHO Euro could do little to counter the perception of migrants as a threat, because they were actively engaged in reinforcing it.

However, one positive effect of the widespread panic about migration was to thrust it to the centre of the global policy stage. IGOs within the UN system harnessed this new sense of urgency to promote major policy initiatives on migrants and refugees that were already in the pipeline, including their incorporation in

the framework of the Sustainable Development Goals (SDGs) for 2016–2030 [5]. The optimistic policy script previously shared by IGOs was revived as the association of all migration with crises and calamities gradually began to weaken, allowing 'routine' migration and its benefits to come into view again.

This latest shift has obliged WHO Euro to revise its policy script on migrant health. As mentioned above, the organisation had previously been reluctant to consider migration and ethnicity as important health determinants: its work on migrant health had been sporadic and mainly focused on forced migration. However, recent developments at the UN have made it increasingly harder to follow this script. WHO, like the International Organisation for Migration (IOM), now embraces an active, upstream approach to MEM health – though this article will argue that the organisation has a lot of catching-up to do if it intends to mainstream migrant health into its current health equity agenda.

Forced migration – driven not only by persecution and organised violence, but also by environmental disasters and crises of governance – is likely to remain an important component of migration, even though its overall volume has always been much less than that of 'routine' migration and will hopefully remain so. Responding to it is above all a humanitarian and human-rights issue. 'Routine' migration, however, is a basic feature of the way modern societies develop, comparable to internal migration (in particular, urbanisation). Just as urbanisation does not have to lead to crises if it is regulated by sound policies, the pre-2015 policy script assumes the same to be true of international migration. Work on migrant health needs to take account of both kinds of migration, and at the same time to take its place in the mainstream of research and policy-making on health equity.

2. Methods

The methods used in this article include a critical review of research and policy documents relevant to (a) the shift from 'downstream' to 'upstream' models of health protection; (b) the priorities for tackling health inequities affecting MEM; (c) migration and ethnicity as determinants of health; and (d) the effects of the 'migration crisis' in the EU. Secondary sources analysing research projects funded by the EC, as well as Eurostat and Frontex data on migration flows to the EU, are also used.

3. Results

3.1. Upstream versus downstream

Table 1 shows how the notions 'upstream' and 'downstream' apply to theories, interventions and levels of intervention [6,7].

A. The most 'upstream' interventions concern improving governance, i.e. the way health systems are run. This involves adopting explicit policies and monitoring their implementation, as well as ensuring that all relevant stakeholders are involved. WHO has played a leading role in highlighting the importance of good health system governance, which depends crucially on the support of national governments.

B. The most radical form of prevention concerns living and working conditions (SDH), which neither individual health workers nor their organisations can effectively influence. Health promotion campaigns can attempt to change lifestyles, but to a large extent lifestyles are influenced by contextual rather than personal factors. Health threats like air pollution by factories or road traffic, contamination of water supplies, unhealthy food and drink, smoking, stress, violence and marginalisation can only be tackled effectively by political action – in particular, because powerful commercial interests are often involved. (The 'medical industry' itself may even be one of these, since reducing the need for health care threatens

Table 1
Upstream versus downstream activities.

		Theoretical focus	Corresponding interventions	Level of interventions
Upstream ↑	A	Health system governance	Promotion, implementation and monitoring of health policy reforms; coordination between stakeholders (including migrants)	IGOs and national governments
	B	Social determinants of health; living and working conditions, social exclusion, discrimination, level of rights and social protection	'Health in All Policies' (HiAP) approach: intersectoral action across government	Health systems, especially stewardship and leadership functions of national governments
	C	Protective and preventive factors reducing health risks that can be influenced by public health organisations	At population level: vaccination, health check-ups (screening), health promotion and education, harm reduction, collection of data	Public health organisations
Downstream ↓	D	Protective and preventive factors reducing health risks that can be influenced by health care providers	At patient level: vaccination, health check-ups (screening), health promotion and education, collection of data	Health service provider organisations
	E	Availability and affordability of health services	Increasing service provision, improving entitlements to coverage	Health care financing system
	F	Effectiveness of treatments and the way they are delivered; non-financial barriers to access	'Whole organisation' approach; interventions to anchor good practices in organisational policy, including reduction of non-financial barriers to access.	Health service provider organisations (including NGOs)
	G	Effectiveness of treatments and the way they are delivered	Development of recommended 'good practices' and training in implementing them	Individual 'front-line' health professionals

its growth.) Health must therefore be mainstreamed into all policy sectors by adopting a 'Health in All Policies' (HiAP) approach [8]. Responsibility for health must be accepted by all sectors; health is not just an issue for health ministries.

C and D. The preventive activities, health education and health promotion carried out by service providers are limited to the people these organisations come in contact with, who are mostly patients. To reach the wider society, these activities must also be carried out at a nation-wide level, for example by public health organisations. The inclusion of MEM in activities such as population screening or health promotion campaigns is often left to chance, but incomplete coverage will result if no special efforts are made to target them [9,10].

E. Tackling shortages in service provision (availability of care) and financial barriers to access (entitlements) requires making changes to the way financial resources are generated and distributed. Such matters are usually regulated by national, regional or municipal governments [11].

F and G. Row G is the 'shop floor' or the 'front line', while F is its organisational setting. As well as promoting 'diversity-sensitive' or 'culturally-competent' methods of service delivery, service provider organisations can tackle certain non-financial barriers to access by undertaking outreaching activities involving MEM communities [12].

Ideally, upstream activities should complement and reinforce downstream ones, rather than replacing them. WHO health systems policy since the 1978 Declaration of Alma-Ata [13] and the 1987 Ottawa Charter [14] has increasingly stressed the importance of prevention and health promotion – but however effective these become, health care for the sick and injured will always remain necessary. The core notion underlying 'upstream' activities is summed up by Sir Michael Marmot's rhetorical question: "Why treat people then send them back to the conditions that made them sick?" [15]. More health gain can usually be obtained by preventive measures than by treating illnesses and injuries resulting from their absence [16].

Moreover, in terms of governance, structural and systemic interventions are more likely to be effectively regulated and monitored, sustainable, and capable of offering both continuity and integration with the rest of the health and welfare systems. The other side of the coin is that tight 'top-down' control leaves less room for *ad hoc,* spontaneous initiatives, adaptation to local circumstances and individual discretion. An interesting finding of the MIPEX (Migrant Integration Policy Index) Health strand [17] was that countries with tax-based health financing tend to have higher scores on 'measures to achieve change' than those with insurance-based financing. One possible reason is that health system governance in the latter tends to be looser and less centralised. However, the disadvantage of 'top-down' approaches is that they may lack support from 'lower' levels. Initiatives taken in consulation with all relevant stakeholders are more likely to succeed than government *dictats.*

3.2. Work on migrant health from 1950-2000

3.2.1. The USA and 'traditional countries of immigration'

In the 20th century MEM health received more attention in the 'traditional countries of immigration' (the USA, Canada, Australia and New Zealand) than in Europe, although the differences are less pronounced today [18]. For historical reasons, most work in the USA has focused on racial and linguistic minorities rather than migrants as such, although migrants and their immediate descendants make up a large proportion of these minorities. Turning points were the rise of the Civil Rights Movement and the passing of the 1964 Civil Rights Act, which to this day provides the legal backbone of interventions to improve delivery of health care to minorities.

In 1966 Martin Luther King famously declared that "of all the forms of inequality, injustice in health is the most shocking and inhuman". So pervasive was the assumption in the 20th century that health care was the key to health that those who quoted King usually replaced the word 'health' by 'health care' [19]. However, despite Medicare and Medicaid being passed into law in 1965, serious financial barriers still restrict coverage for low-income minority-group members. Coverage for all groups was extended by the *Patient Protection and Affordable Care Act,* adopted in 2010 (though not fully implemented and still the target of vigorous efforts by the Republican Party to dismantle it). Despite recent improvements, migrants to the USA can still only access Medicare and Medicaid after five years of residence [20].

The year 1985 saw the publication of the first in a series of government-sponsored studies of inequities (in the USA referred to as 'disparities') in health status and health care delivery for minorities [21]. Nevertheless, interventions to reduce disparities

Table 2
Characteristics of the two main clusters of projects.

	'Vulnerable groups' cluster	'Health gradients and gaps' cluster
Type of inequalities targeted	Heath problems of migrants, ethnic groups and 'at-risk' groups	Socioeconomic differences and effects of sex, age and country of residence
Health problems addressed	- Infectious diseases - Addictions - NCDs (for ethnic groups)	- Life expectancy - Healthy life years - NCDs
Interventions undertaken or proposed	- Improving health care (access, quality, training) - Health promotion, harm reduction and prevention via health services	- Collecting and analysing data - Intersectoral action on social determinants of health

focused mainly on improving the quality of health service delivery, rather than going further upstream to improve insurance coverage or tackle the SDH revealed by epidemiological studies. 'Cultural competence' became a major priority in US health care [22]: this notion was also adopted in other 'traditional countries of immigration' and the UK. In 2000 the Office of Minority Health published the *National standards on culturally and linguistically appropriate services (CLAS) in health care* [23], which within a decade had been adopted by a wide range of service providers in the US. Since 2012, the 'enhanced' version of the CLAS standards [24] has included attention for "socio-economic status, race, ethnicity, disability status, sexual orientation, gender identity and other factors" [25]. The CLAS website has now been renamed 'Think Cultural Health', although the notion that 'cultural differences' are the main factor determining inequities in service provision resulting from all these types of disparity is hard to defend. Is it the culture of disabled people that makes it necessary to make buildings more accessible for them?

The CLAS Standards are not completely downstream, because they target service provider organisations rather than individual health professionals. Endorsement by the Federal government, together with the partial legal back-up provided by the Civil Rights Act, make the Standards to some extent an 'upstream' intervention – but like the 'cultural competence' movement in general, they steer clear of the thorny political issues of health care coverage and SDH.

3.2.2. Europe

Although WHO Euro and the Dutch government organised an international conference on MEM health as early as 1983 [26], European researchers and policy-makers prior to 2000 showed only sporadic interest in the topic [27]. Despite this, American ideas about 'cultural competence' enjoyed some influence – particularly in the UK, which also shared a focus on ethnic minorities rather than migrants, as well as the use of 'racial' classifications. (Criticism of the 'race' concept often overlooks the fact that in both the USA and UK, classification is based on self-ascription: a person can be 'Black' or 'White' regardless of the colour of their skin. 'Race' is now a self-ascribed identity, not a physical characteristic.) On the European continent, the experience of Nazi occupation in World War II had led to both race and ethnicity being widely regarded as scientifically dubious and politically tainted concepts. As a result, while the discourse on health inequities in both the US and the UK tends to neglect migrant status in favour of ethnicity [28], attention for ethnicity on the European continent is usually limited to long-standing indigenous minorities and the Roma; migrants tend to be studied as such, rather than by using ethnicity as a proxy. The European Public Health Association (EUPHA) regards *both* migrant status and ethnicity as potentially important variables to study [29].

In response to the surge in forced migration to the EU in the 1990s, much work was carried out on refugee health. Most of this was downstream, being focused on treatments for health problems (especially post-traumatic stress disorder or PTSD) rather than on the current living conditions of asylum seekers and refugees [30]. In addition, certain approaches to migrant health based on anthropological theories, such as *ethnopsychiatrie* in France and *Ethnomedizin* in Germany, prioritised cultural differences and were implemented in specific locations. However, the notion of adapting health services to diversity did not become widely known until the 21st century. Ironically, towards the end of the 1990s the concept of multiculturalism – which is closely linked to this notion – was already starting to lose favour among politicians in Europe [31]. In the present century, therefore, workers on MEM health have increasingly had to swim against the political tide.

3.3. Developments in the 21st century

3.3.1. The split between work on MEM and on socioeconomic inequalities

Although a landmark article in 1995 by Paula Bollini and Harald Siem had drawn attention to the effects of the living and working conditions of migrants on their health [32], research and policy-making on MEM remained mainly focused on health care delivery until about 2007. In relation to socioeconomic inequalities, by contrast, 'upstream' approaches to health showed vigorous growth. The *Report of the WHO Committee on the Social Determinants of Health* (CSDH) in 2008 [33] signalled the start of an energetic global campaign under the leadership of Sir Michael Marmot, which soon acquired the status of a movement.

The contrast between work on socioeconomic inequalities and on MEM is clearly revealed by an analysis of 64 actions on health inequalities between 2003 and 2013 that were supported by DG SANCO in its First and Second Health Programmes [34]. Exploratory factor analysis of the characteristics of these actions showed that they could be grouped into two largely separate clusters, which in this publication were labelled 'Vulnerable groups' and 'Health gradients and gaps'. Almost all projects on MEM fell into the first cluster, together with projects on 'at-risk' groups such as intravenous drug users or sex workers. Table 2 (taken from p. 7 of the report) shows the most important differences between the two clusters.

Although all 64 actions concerned inequalities, they were based on very different aims and methods.

- Work on 'vulnerable groups' was mostly downstream: it focused on health care and preventive or harm-reducing activities carried out by health services, used small samples, remained close to the target groups (often involving NGOs) and aimed to develop and share 'good practices' rather than to get policies changed. It paid little attention to collecting and analysing data, investigating SDH, or promoting long-term policy changes (at least, not outside the health sector).
- Work on 'social gradients and gaps' was exclusively upstream, examining mainly socioeconomic determinants of health, con-

fining itself to health conditions on which population-based data were available, and prioritising intersectoral action on SDH ('the causes of the causes'). Despite ample evidence that socioeconomic inequalities in health care also exist, these were hardly ever mentioned.

Different policy scripts underlay this split [35]. The SDH approach had a strong focus on socioeconomic status (SES), usually measured by education, occupation and income or some combination of the three. The terms 'socioeconomic' and 'social' in relation to inequalities are still regularly used by SDH researchers as synonyms. Revealingly, the websites of WHO Euro and its HPH (Health Promoting Hospitals and Health Services) Network both used the former term in place of the latter, until this was pointed out and corrected in December 2011 [36]. This is an example of the rhetorical device 'synecdoche' or *pars pro toto,* comparable with using the word 'England' to refer to the United Kingdom. Synecdoche is not simply a mistake: it also suggests that the parts being overlooked are not important enough to be mentioned.

As well as SES, the 2008 CSDH report also mentioned 'gender, age, ethnicity, disability and geography' as determinants of inequality [33, p. 18]. However, no recommendations were made concerning ethnic minorities. Migrants were mentioned in passing, but the only recommendation made about them concerned internal (rural-urban) rather than international migration. The 2010 study of health inequalities in the UK, *Fair Society, Healthy Lives: The Marmot Review* [37], was criticised as a 'missed opportunity' because of its scant attention to ethnicity [38]; it made no mention at all of migrants. The 2014 *Review of social determinants and the health divide in the WHO European Region* [39], to which 13 cross-disciplinary Task Groups contributed, was unusual in paying attention to irregular migrants, migrant workers and the Roma. But neither the 634-page EUROTHINE report on health inequalities in Europe [40], nor the 2018 report of the FEAM/ALLEA Committee on Health Inequalities [41] discussed migrants or ethnic minorities. A 2015 review article on immigration as a social determinant of health, drawing mainly on work in the USA, noted the 'lack of dialogue' between work on SDH and immigration, as well as the paucity of efforts to tackle this [42].

Perhaps the most conspicuous omission of MEM occurred in the *Rio Political Declaration on Social Determinants of Health,* adopted during WHO's World Conference on Social Determinants of Health in October 2011 [43]. This neglect provoked a sharp rebuke from the IOM's Director General, William Lacy Swing [44]. What is striking – and puzzling – is that some of the leading contributors to the SDH movement, such as Michael Marmot, Johan Mackenbach and Harald Kunst, have themselves carried out important work on MEM health in the past.

3.3.2. Possible reasons for the split

(a) One possible reason for this reluctance to consider migration and ethnicity as important determinants of health may be the notion that doing so 'racialises' or 'ethnicises' health problems of MEM by suggesting that they are due to genes or fixed cultural patterns – in effect, 'blaming the victims'. However, this overlooks the possibility that the active ingredient in MEM status may be the societal reaction. Discrimination against MEM is endemic; it can impair health directly as well as indirectly, by limiting social rights, entitlements, and access to well-paid work and education. (MIPEX covers eight such areas of integration, including Health [45]). Many migrants work below the level for which they are qualified, while many are financially burdened by sending remittances home. All such barriers and burdens can prevent them from realising their full socioeconomic potential [35, pp. 335–336], making societies less meritocratic and more like stratified caste systems.

(b) Another possible reason is that when SES differences are 'partialled out', the association between MEM status and health becomes weaker or disappears altogether, which is thought to demonstrate that SES is the 'real' determinant of health. This argument implies that MEM status has little or no real effect on health, but that because SES is associated with both variables, it acts as a confounder and produces a spurious association. However, 'controlling for SES' makes no sense if the latter variable lies on the causal path between the first two (as was suggested in the previous paragraph). If that is the case, it must be treated as a mediator, not a confounder. But in any case, 'controlling for SES' does not always weaken or remove associations between health and MEM status; moreover, serious methodological problems accompany attempts to do this [46].

(c) Yet another reason why the influence of MEM status may be downplayed is that it is not, in fact, invariably associated with poor health. The 'healthy immigrant effect' refers to the fact that migrants, particularly on arrival, may have a health advantage [47]. Gruer et al. [48] found that most of the larger ethnic minority groups in Scotland had longer life expectancies than the White Scottish majority. Migrants may be exposed to higher health risks in the workplace, but unless they have work, this will not affect them. Male and female migrants may also show different types and levels of health disadvantage or advantage [49,50]. Yet such variability can be found in all SDH: it demonstrates the importance of an 'intersectional' approach, i.e. one that allows many factors to be taken account of simultaneously, paying as much attention to interactions as to main effects [51]. The fact that health risks for MEM are often specific, rather than general, does not justify ignoring them. It simply means we have to be cautious about making generalisations.

All three of the above arguments lead to the conclusion that there is no scientific justification for ignoring MEM status as a social determinant of health. Indeed, it should be regarded as one of the 'causes of the causes', even further upstream than SES.

3.3.3. Signs of a shift upstream

Despite the mainly downstream orientation of work on MEM health, the 21st century has seen important efforts to move upstream. As in the USA, research has tended to run ahead of policy, as can be seen from the increasing volume of work on MEM health in epidemiology, public health, sociology, anthropology, social geography and policy studies.

Most of the upstream policy initiatives have been launched by IGOs. A series of high-level declarations, resolutions and recommendations starting in 2007 [52–56] went beyond the familiar appeals for more accessible and migrant-friendly health care to stress data collection and research, intersectoral action to protect the health of migrants, and improved governance to coordinate these efforts. They emphasised health protection and the systems that ensure it, rather than only health care and the services that provide it. However, most of these ambitious policy goals have remained on paper. Beyond organising Global Consultations with the IOM in 2010 [57] and 2016 [58] and publishing overviews [e.g. 59], WHO followed up hardly any of the 10 concrete action points listed in Resolution WHA61.17 [55].

The EC also lagged behind. In the 2010 communication *Solidarity in Health* [60], recommendations regarding MEM health concerned almost entirely downstream interventions: "raising awareness and promoting actions to improve access and appropriateness of health services, health promotion and preventive care for migrants and ethnic minorities and other vulnerable groups". Improved data collection was only recommended for "age, sex, socio-economic status and geographic dimension" – not for migrant status or ethnicity [60, p. 6]. This document reflects the

same split seen in the projects supported by the EC's DG SANCO in 2003-2013. Even now, the EC states on its Public Health website that its policies and actions aim "to protect and improve the health of *EU citizens*" [61], while its successor DG SANTE says it aims "to make Europe a healthier, safer place, where *citizens* can be confident that their interests are protected" [62] (our italics). Apparently, this concern does not extend to the 21 million third-country nationals or TCNs – i.e. non-citizens – who also reside in the EU.

3.4. Effects of the 2015 'migration crisis'

3.4.1. What exactly was the crisis?

From 2012 to 2015 the annual number of unauthorised arrivals and asylum applications in the EU grew at an accelerating rate. Most of these migrants arrived in small boats on the EU's southern shores. This influx was a classic example of 'mixed migration', in which people fleeing from persecution and organised violence travelled together with migrants who had little chance of obtaining international protection. Despite clear warning signs, the arrival of over a million such migrants in 2015 seems to have taken the EU completely by surprise: there were no plans or policies for coping with such an increase. The resulting administrative crisis led to a radical shift in the way migration is perceived and talked about.

Unfortunately, instead of trying to combat exaggerations and subdue panic, the EC poured oil on the flames by overstating the numbers of unauthorised arrivals [63] and asylum seekers [64, p. 6], as well as by repeatedly talking about unauthorised entrants as if they were the only migrants coming to Europe (another example of synecdoche – cf. Section 2.3.1).

It has been known for a long time that the general public tends to overestimate, often drastically, the proportion of migrants in their own country, especially irregular ones [65,66]. Far from countering this tendency, frequent references by the EC to a 'massive influx' (in reality less than 0.2% of the EU's population) only exacerbated it. In this way, the Commission itself helped to promote the nightmare image of 'uncontrolled mass migration' spread by populist politicians. Populists redefined the migration agenda in terms of protecting Europe against an overwhelming invasion and the Commission duly followed – as if they had never heard of 'agenda-setting' as a political tool. In this way, the very meaning of the word 'migrant' has been changed. The iconic image of migrants has become a mass of people packed into a tiny boat, or trekking in long columns across a landscape: even in 2019, a search for images of migrants in Google yields almost exclusively pictures like these.

To be sure, the numbers in 2015 were large – but the EU had coped with a comparable influx over a longer period in the 1990s, when the Union was far smaller and economically less robust. (Germany, for example, was still struggling with the aftermath of reunification.) This time, countries in the Middle East were having to cope with influxes of up to 25% of their population – 100 times greater than the EU's 2015 figure of 0.2%. Moreover, numbers coming to the EU declined rapidly after 2015: the ratio of unauthorised arrivals to newcomers admitted on visas for 'routine' purposes (i.e. family, work, education, 'residence only' and 'other purposes not specified', excluding international protection) was 1 to 2.4 in 2015, 1 to 8 in 2016 and 1 to 15 in 2017 [64, p. 6].

Of course, these are figures for the whole EU, but because of the absence of a common asylum policy and mechanisms for burden-sharing, the influx was largely concentrated in a small number of countries (in particular Sweden, Germany, Austria, Italy and Greece). An important effect of the EU's 'Dublin Regulation', which obliges asylum seekers to make their claim in the first Member State they enter, was to exempt wealthier Member States not on the Southern and Eastern frontiers of the EU from having to share the burden of processing asylum applica-

tions with those who were. Only thanks to the breakdown of 'Dublin' in 2015 was it possible for the influx to spread as far as it did.

Even today, the EC continues to put out statements about migration that tacitly ignore 'routine' migration. Press releases about migration since 2015 have used the word mainly, and often exclusively, to refer to unauthorised entrants. The Commission's desire to respond to public anxieties is understandable, but its failure to label numbers accurately is not.

This failure may, however, have a very simple explanation: lack of good data. In Eurostat's datasets on migration flows (*migr_imm1ctz* and *migr_imm3ctb*), TCNs were not disaggregated until 2013, annual totals are not published until at least 15 months after the year's end, and the metadata indicating which countries include asylum seekers and refugees in their totals are seriously incomplete. It is therefore impossible to compare totals for asylum seekers or unauthorised entrants with the flow statistics for other migrants. (For this reason the figures quoted above were compiled from data on first-time residence permits issued – though these too require careful interpretation.)

Typical of EC policy statements is the 'European Agenda on Migration', announced in 2015 and regularly updated [67]. The agenda has four pillars: Discouraging irregular migration; Saving lives and securing borders; Managing asylum; and (at the very end, as if talking about distant future prospects) "Developing a new policy for legal migration in view of future demographic challenges". One would hardly suspect that the wealthier EU Member States have been countries of immigration since the 1960s, when millions of 'guest workers' helped to power their rapid economic growth, and that they still rely heavily on TCNs to supplement their workforce.

3.4.2. Effect of the crisis on EU projects on migrant health

The EC's policy script redefining migration as crisis was faithfully reflected in the actions supported by DG SANTE (the EC Directorate-General for Health and Food Safety, successor to DG SANCO) from 2015 onwards. In the third Health Programme (2014–2020) no calls for projects on migrants were published until October 2015, when a call was hastily launched to 'Support Member States under particular migratory pressure in their response to health related challenges' [68]. This led to five projects, all focused on short-term responses to the influx. In addition, the IOM received substantial direct grants from the EU for developing a Handbook for Health Professionals and training programmes for front-line health staff. As recently as November 2017, a tender document [69] claimed that the majority of people arriving to the EU/EEA since 2015 "have been exposed to conflicts and violence in their countries of origin, hardships during their migration journeys, and many belong to highly vulnerable groups, such as elderly, unaccompanied minors, or pregnant women".

Most of the EU-supported projects focus on health care and short-term interventions, with little or no attention for tackling 'upstream' determinants of health and promoting structural policy changes. Hardly any attention is paid to the health threats arising from current reception conditions, asylum procedures, problems of integration and discrimination, as well as the severe marginalisation of rejected asylum seekers. The relation between migration policies and the deaths by drowning of thousands of migrants is not discussed. These projects show a great deal of continuity with the actions on migrants that had been supported in the first and second Health Programme (2003–2013). Training is usually limited to 'front-line' workers: even then, a 'whole organisation approach', such as that incorporated in the 2000 CLAS standards in the USA or the WHO-HPH Health Network's *Equity Standards,* [12] is not considered.

3.4.3. The WHO Euro project PHAME (Public Health Aspects of Migration in Europe)

PHAME has grown and changed in character considerably since the first steps towards setting it up were taken in 2011, in response to the arrival on Lampedusa of tens of thousands of migrants fleeing the upheavals in Egypt, Tunisia, Syria, Libya and other countries affected by the so-called 'Arab Spring' in 2010. In April 2011 a High Level Meeting took place in Rome, leading to the inauguration of the PHAME project in 2012 [70].

In the beginning PHAME was exclusively focused on acute, temporary, emergency situations; it was mainly financed by the Government of Italy, although its title suggested much wider ambitions. (Indeed, the WHO European region is even larger than the EU/EEA, comprising 53 Member States and stretching eastwards all the way to Vladivostok.) Not only was PHAME's geographical coverage unclear, so too was its policy script. Did it only focus on forced and irregular migration, or was it supposed to cover 'routine' migration as well? Did it frame migration as a crisis or as a normal, structural phenomenon – or was the aim to combine the two?

In the beginning, the 'crisis' script dominated: indeed, the first instrument used to assess health system preparedness was WHO Euro's 2012 *Toolkit for assessing health-system capacity for crisis management* [71], which addressed the full range of possible disasters that have "a potentially catastrophic impact on human health". Not only was this document ill-adapted to the specific nature of migrant influxes; the very idea of framing migration as a 'disaster' was, to say the least, controversial. In the modified instrument that was eventually developed and published in 2016 [72], the term 'disaster' was avoided.

As the likelihood of a repetition of the 2015 influx decreased, the project underwent a metamorphosis, becoming broader in its geographical coverage and paying more attention to 'routine' migration. Since 2015, WHO Euro's Health Evidence Network (HEN) has contributed nine synthesis reports for PHAME [73], most of them broadly oriented. A 'Knowledge Hub on Health and Migration' [74] was set up in 2016, while in 2017 WHO Euro established a Collaborating Centre for Migration and Health at the University of Pécs. PHAME's new identity is aligned with WHO Euro's 2016 *Strategy and Action Plan on Refugee and Migrant Health* [75], aimed at promoting intersectoral approaches, collaborative networks and international dialogue, and oriented towards the 2018 *Global Compact on Migration*. The project shows how one and the same project can be informed during its lifetime by quite different policy scripts.

3.5. Reviving the shift upstream

The anxious concern that had been generated by the world-wide increase in forced migration was harnessed by the IOM and WHO to boost their efforts to get MEM health on the global agenda. However, this strategy was not without risks: increased levels of forced migration certainly drew the attention of the world's media, but at the same time led to the shift in the meaning of the word 'migrant' that we have discussed above.

In general, the UN and its agencies have done very little to counteract this shift. Nevertheless, a much more balanced view of migration was visible in the SDGs, which focused mainly on 'routine' migration and drew on the traditional IGO policy script treating migration as a structural and positive phenomenon. Important milestones were the UN Summit for Refugees in 2016 [76] and the *New York Declaration for Refugees and Migrants* resulting from it [77]. In 2017 WHO published a detailed *Framework of priorities and guiding principles on Promoting the Health of Migrants and Refugees* [78]. The *Global Compact for Safe, Orderly and Regular Migration* [79] and the *Global Compact on Refugees* [80] have provided further opportunities for getting MEM health on the global policy agenda. At regional level, WHO Euro's 2016 *Strategy and Action Plan on Refugee and Migrant Health* (see section 3.4.3) was based on its strikingly 'upstream' *Health 2020 policy framework and strategy,* announced in 2012 [81].

It is to be hoped that these efforts by IGOs, especially the Global Compacts and SDGs, will be able to provide some pushback against the recent surge of 'fake news' about migration – some of it disseminated, as we have seen, by the EC – and anti-migrant attitudes and policies. However, WHO in particular will have some catching-up to do if it is to incorporate an inclusive attitude to MEM in its work on inequalities, which for years has tended to exclude these groups.

The goal of Universal Health Coverage (UHC) can never be realised as long as MEM are not included in the definition of 'universal'. This does not simply mean that irregular migrants should be entitled to health care. The MIPEX Health strand (supported by the EC and IOM) included detailed information on entitlement policies and uncovered serious inequities for regular and irregular migrants, as well as asylum seekers, in practically all of the 38 countries studied [11]. WHO is heavily committed to the expansion of UHC and maintains a large database and instrumentarium on the topic, yet hardly any of this work relates to MEM. Most of the *Health Systems in Transition (HiT)* reports on national health systems, produced by WHO Euro, do not mention MEM. Looking beyond questions of access to health services, as we saw in Section 2.3.1, WHO's work on SDH has largely been based on the assumption that migrant status and ethnicity are not important health determinants. Indeed, the very structure of WHO's Head Office indicates that the organisation still regards 'Health and Migration' as basically a downstream issue: it is allocated to the Service Delivery and Safety Department (SDS), though apparently not considered important enough to deserve a mention in this department's brochure.

Within WHO Euro, the PHAME project has undergone a rapid metamorphosis from being an EU-centred, downstream, crisis-management project, to an upstream programme covering the whole European region and both 'routine' and 'unauthorised' migration. Inevitably, this has created some anomalies and contradictions. The project's earlier 'crisis' view of migration often seems to set the tone. A recent publication begins "The number of international migrants escaping from conflict and war, natural or manmade disaster, or as a result of financial crises and climate changes, reached globally 244 million in 2015" [70, p. 19]. This statement frames *all* migration as the result of things that go wrong. In the activities of PHAME there is also a stress on unexpected, massive movements, though these are only characteristic of forced migration: by and large, 'routine' migrants do not travel in large cohorts.

4. Conclusions

The development of upstream approaches to MEM health has been impeded by the reluctance of the SDH movement to consider migration and ethnicity as important health determinants, as well as by the sudden diversion of attention to the mixed-migration influx of 2015. Recent initiatives at the UN will hopefully encourage a more balanced approach, with equal attention for both unauthorised and 'routine' migration and for upstream as well as downstream issues. However, it is not yet clear how much influence this resetting of the agenda at UN level will have on policies at regional and national level.

This article has only been able to attempt a preliminary exploration of the various policy scripts relating to MEM health. Much remains to be investigated. In particular, it is often difficult to understand the reasons why policymakers sometimes adopt aims and assumptions that run contrary to empirical evidence. 'Inside knowledge' about the motives and mentality of policy-makers (such as the research carried out by Kentikelenis and Seabrooke [3] on the International Monetary Fund) would be required to shed

light on this issue. This exploration has also been selective: out of the six WHO regions we have focused only on WHO Euro, but other regions may have their own policy scripts on MEM. Within the EC we have focused on DG SANCO and DG SANTE, yet other DGs have also concerned themselves with MEM health and may have approached the issues differently. Hopefully, however, the article has shown that 'policy scripts' can be a useful concept in trying to understand how policies are made.

Declaration of Competing Interest

None

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