Healing the Gap

Building inclusive public-health and migrant integration systems in Europe

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Executive Summary

The global COVID-19 pandemic has pushed European health-care systems to their limits. Its disproportionate impact on migrants and refugees has also vividly highlighted factors that have long created vulnerabilities for these groups across the continuum of health and well-being, including greater exposure to drivers of ill health (such as low income and poor housing), an associated increased risk of contracting physical and mental health conditions, and barriers to accessing health services. Europe's immigrants may feel the repercussions of the pandemic for a long time to come as these intensified health disparities form barriers to migrant integration.

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The pandemic has acted as a magnifying glass, exposing the cracks and gaps in migrant health policies and approaches. Migrant health has only started to receive significant attention in international and European policy debates since the early 2000s. Yet, this increased interest has failed to translate into a comprehensive, structural approach to migrant health, resulting in diverging, uncoordinated approaches across Europe. Most European countries take a strong downstream approach, focusing on treatment and service delivery and less on prevention and the root causes of health problems, which risks sending individuals back to the conditions that made them sick in the first place. Migrant health policies also diverge by focusing on different health conditions and target populations. Italy, for example, tends to focus on sexual and reproductive health and targets newly arrived, first-generation immigrants, whereas the United Kingdom focuses on mental health and targets established ethnic minorities. Priorities result from assumptions about health needs but carry strong implications for which needs are met and for which groups.

More coordination, harmonisation, and knowledge-sharing would benefit effective policymaking. The trend of increasing international attention to migrant health is promising, yet emergencies often drive this interest, and economic downturns and changes in political leadership have repeatedly extinguished it. The unprecedented challenges facing European health-care systems and the economic fallout of the pandemic threaten to push migrant health once more off the policy agenda, at a time when effective policymaking is especially crucial.

Despite these challenges, the pandemic has also kickstarted rapid, innovative responses by different organisations and service providers. These responses leverage digital tools in new ways, involve new partnerships with civil society, feature increased use of alternative platforms such as videos or social media, and engage community leaders and organisations to reach the most vulnerable populations. These new initiatives allow us to re-envision the organisation of migrant health services. This report identifies the

following trends and issues that the pandemic has triggered or accelerated and that may offer promising directions to policymakers:

- **There is increased awareness of the migrant integration–migrant health nexus and of root causes of health disparities.** The intricate relationship between other policy areas and health has perhaps never been as apparent as during the pandemic. COVID-19 infection and mortality rates have clearly reflected structural societal inequities, highlighting how disparities in employment, socioeconomic status, education, and housing, which are all indicators of migrant integration, cause health disparities. The pandemic has also shown how health problems create an obstacle to migrants' integration and participation in the labour market and society at large. Through deepening health disparities and barriers to participation, the global pandemic may cast a long shadow over migrant integration. If stakeholders can use this increased awareness of the migrant integration–migrant health nexus to reduce the root causes of health problems, the pandemic could be turned from an accelerator of inequalities into a springboard to a more inclusive society. The trend toward a Health in All Policies approach—an approach that accounts for how other policy areas and decisions affect health—may provide a promising path forward.
- **Mainstreaming migrant health care could help European societies meet diverse needs.** Migrants' needs and health challenges vary widely. An intersectional approach would account for this diversity and the varied impacts of socioeconomic status, legal status, and race and ethnicity on health. Mainstreaming migrant health—that is, addressing migrant health as an integral part of other generic policies—is a promising policy trend that would move from targeting a group (e.g., all immigrants or all recently arrived refugees) to a needs-based approach, allowing a more intersectional lens that accounts for the diversity within immigrant populations. However, mainstreaming must not become an excuse to turn a blind eye to the specific challenges and needs that migrants face and the broader population generally does not. To accommodate the complex needs of diverse populations, it is crucial to understand and be sensitive to specific health needs.
- **There is a need to transition from emergency response to structural policy priorities.** Even prior to the pandemic, emergencies often drove migrant health approaches and policies. Ad hoc and uncoordinated responses across Europe result in reinventing the wheel, fragmented and inharmonious approaches, and a lack of alignment with EU international obligations. Academic researchers' and international policymakers' interest in migrant health has increased significantly since the early 2000s, yet this increased attention has not translated into a coordinated approach to addressing migrants' health challenges. Effective long-term policy requires a shift from emergency responses to a comprehensive, dedicated approach to migrant health at the European and national levels. This approach should promote coordination, harmonisation, and mutual learning across European Member States, as well as structural evaluation of what works.
- **The digital shift promises to improve access to care but risks leaving the less digitally savvy behind.** Another promising trend is the increased use of digital tools, which may help make service delivery more efficient and less costly, thereby compensating for the lack of health-care professionals

and resources in overstretched health systems. Digital health tools have played a pivotal role during the pandemic and have further accelerated the trend toward more digitisation. Tools such as live speech translation apps, which people can download for free on their smartphones, could solve some access challenges that migrants face, such as linguistic barriers. Yet, attention must be paid to ensure that the most vulnerable—those who could most benefit from increased access to care—are not left behind in this digital transformation. Migrants and refugees often have limited access to digital tools and limited digital literacy; if stakeholders do not tackle these gaps, the digital shift could deepen inequalities.

- **Civil-society organisations are filling gaps in public health systems, but limited resources often constrain their service quality.** The pandemic has also accelerated the growth of civil-society organisations' role in promoting migrant health and integration, either by filling gaps in government policies and serving those left behind or through partnerships between government and civil society. Local community organisations may be better able to serve immigrant communities due to their greater awareness of local community needs, ability to provide culturally appropriate outreach, and because they are more likely to be considered trusted sources of support compared to government agencies. Yet, these organisations often have limited funding and other resources that affect service quality, must reinvent the wheel when developing programmes, often rely on volunteers, and are located only in certain urban centres, leaving some vulnerable populations without access to critical services. Structural long-term partnerships with government agencies, promoting effective knowledge-sharing and coordination across civil-society organisations, and sufficient funding could improve civil society's ability to serve migrants' and refugees' health needs. These strategies should never replace structural universal health services but could complement and enrich public health services.

A picture of promising trends in a challenging context emerges. The pandemic has deepened socioeconomic inequities that may further exacerbate the health inequities that migrants were already facing. Not tackling these issues may come at a hefty price, as health inequities form a barrier to immigrant integration, contributing to a negative cycle of marginalisation and poor health outcomes. With health-care systems under considerable pressure, new innovations may point the way forward—if policymakers and researchers carefully evaluate what can be learnt from ad hoc initiatives and how European societies can leverage these lessons to tackle migrant health vulnerabilities in an efficient, cost-effective way. And while civil society and digital tools have played crucial roles in quickly tackling challenges during the pandemic and could strengthen future health strategies, stakeholders should analyse the risks of options that rely heavily on underfunded, volunteer-run organisations for essential support or on digital tools that may exclude the most vulnerable. Only then may governments hope for more inclusive health services for migrants.

With health-care systems under considerable pressure, new innovations may point the way forward—if policymakers and researchers carefully evaluate what can be learnt from ad hoc initiatives.

1 Introduction

The global pandemic has pushed European health-care systems to their limits, with almost 36.2 million reported COVID-19 cases and nearly 750,000 deaths in the European Union/European Economic Area as of early September 2021.[1] But these harms have not been felt evenly. Migrants and refugees have had a disproportionately high risk of infection and severe disease[2] and a mortality rate two to five times that of the native born.[3] Migrants have faced challenges especially in social distancing, due to crowded housing conditions and working in frontline and close-proximity jobs. The uneven impact of COVID-19 has also drawn increased attention to factors that have long created vulnerabilities for migrants and refugees across the health continuum, including greater exposure to drivers of ill health (such as low income and poor housing), increased risk of contracting physical and mental health conditions, and barriers to accessing health services.[4] These vulnerabilities carry both individual and societal costs. For example, health problems are among migrants' most pressing obstacles to completing integration courses,[5] negatively affect hourly wages and annual hours worked,[6] and may prevent some individuals from working altogether.[7] Tackling health vulnerabilities and providing equal access to health care is therefore essential both for public health and to ensure inclusive societies.

With COVID-19 likely to radically reshape health-care systems in Europe and worldwide, policymakers must ensure that these structural changes accommodate the complex needs of diverse populations. Migrant health's recent inclusion on the international policy agenda, starting in 2007 and really taking off since 2015 (see Section 3), has so far failed to translate into a more coordinated approach. Whereas some countries, such as Sweden, focus on target groups (e.g., newcomers),[8] other countries, such as Poland, do not target migrants at all in their health policies.[9] A focus on migrant health would address specific needs common within an immigrant population, yet it also risks treating migrants as a uniform group and overlooking diverse health needs within the group. The mainstreaming of migrant health—that is, addressing migrant health as part of general health policies and systems for the broader population—could be a promising policy direction. Yet, so far, many countries have applied group-blind approaches that ignore the specific

1 European Centre for Disease, 'Prevention and Control. COVID-19 Situation Update for the EU/EEA, as of 6 September 2021', accessed 6 September 2021.

2 Erik Hansson, Maria Albin, Magnus Rasmussen, and Kristina Jakobsson, 'Large Differences in Excess Mortality in March-May 2020 by Country of Birth in Sweden', *Lakartidningen* 117 (2020); Jerónimo Jaqueti Aroca, Laura M. Molina Esteban, Isabel García-Arata, and Jesús García-Martínez, 'COVID-19 en pacientes españoles e inmigrantes en un área sanitaria de Madrid', *Revista Española de Quimioterapia* 33, no. 4 (2020): 289–291; *Irish Times*, 'Ireland: Migrants Face Higher COVID-19 Infection Rate', European Web Site on Integration, updated 22 October 2020; Marta Bivand Erdal et al., 'Migrants and COVID-19 in Norway: Five Reflections on Skewed Impacts', PRIO blogs, 6 April 2020.

3 Sylvain Papon and Isabelle Robert-Bobée, 'Une hausse des décès deux fois plus importante pour les personnes nées à l'étranger que pour celles nées en France en mars-avril 2020' (INSEE Focus, no. 198, July 2020).

4 World Health Organization (WHO), 'Promoting the Health of Migrant Workers in the WHO European Region during COVID-19: Interim guidance' (Copenhagen: WHO Regional Office for Europe, 2020), 1–12.

5 Bertine Witkamp et al., *Gezondheid en participatie. Een verkennende studie naar de rol van gezondheid van vergunninghouders bij de gemeentelijke dienstverlening richting werk en participatie* (Amsterdam/Utrecht: Regioplan, Verwey-Jonker Instituut, Movisie en Pharos, 2019).

6 Jodi Messer Pelkowski and Mark C. Berger, 'The Impact of Health on Employment, Wages, and Hours Worked Over the Life Cycle', *The Quarterly Review of Economics and Finance* 44, no. 1 (2004): 102–121.

7 Gail Pacheco, Dom Page, and Don J. Webber, 'Mental and Physical Health: Re-Assessing the Relationship with Employment Propensity', *Work, Employment and Society* 28, no. 3 (2014): 407–429.

8 Philipa Mladovsky, 'A Framework for Analysing Migrant Health Policies in Europe', *Health Policy* 93, no. 1 (2009): 55–63.

9 European Web Site on Integration (EWSI) Editorial Team, 'Migrant Health across Europe: Little Structural Policies, Many Encouraging Practices', Migrant Integration Information and Good Practices, updated 12 February 2018.

needs of different segments of their population; only some countries have taken a policy approach that balances mainstreaming migrant health with being sensitive to needs that migrants face and the broader population generally does not.

In addition to increasing challenges, the pandemic has also kickstarted rapid, innovative responses to these challenges by governments, service providers, and civil society. For example, Portugal temporarily lifted all barriers and provided free access to their National Health Service, including for irregular migrants;[10] the Cooperative for Migrant Unions in Sweden launched WhatsApp groups to reach their community and spread information about COVID-19;[11] and many countries launched multilingual websites to inform immigrant populations about the pandemic and how to access care.[12] The pandemic formed a fertile testing ground for the development of new tools supporting health-service access, including digital tools and the increased involvement of civil society, at a time of extensive service restrictions. These new initiatives may lead to lasting changes in outreach, health screening, and service delivery. The pandemic may, paradoxically, have increased awareness of the impact of structural inequalities on migrant health while simultaneously exacerbating these inequalities and pushing health-care systems to their limits.

The pandemic formed a fertile testing ground for the development of new tools supporting health-service access, including digital tools and the increased involvement of civil society.

Times of crisis often lead to considerable experimentation and reform. Yet, history teaches that such innovation does not always translate to long-term or structural change. The 2015–16 influx of migrants and asylum seekers to Europe resulted in a similar burst of activity, with countless initiatives introduced, many of which were technologically advanced or reflected out-of-the-box, community-driven solutions. But this period also saw many projects duplicate efforts or fizzle out.[13] For such initiatives to have a lasting impact, careful analysis and reflection on best practices, effectiveness, and long-term feasibility are essential. Moreover, in a context of increased pressure and competition over government budgets, spikes in xenophobia, discussions about who deserves health care, economic decline, and amplified inequality, governments may struggle to implement crucial policy changes and, thus, risk increasing migrant health vulnerabilities. Moreover, increased reliance on digital (health) tools may be promising for some people but may also leave behind the most vulnerable migrant and refugee populations due to lack of access to technology and limited digital literacy.

This report provides background on and discusses new opportunities to tackle disparities in migrant health and access to health services in the wake of the pandemic. The next section explains why the COVID-19 pandemic has disproportionately affected migrants, specifically the patterns, causes, and consequences of health disparities and the barriers migrants face in accessing health services. Section 3 provides an overview of international and European migrant health-care policies and trends prior to the pandemic. Section

10 Direção-Geral da Saúde publica, 'Informação sobre migrantes e refugiados' (press release, 8 May 2020).
11 Esperanza Diaz et al., 'Situational Brief: Migration and COVID-19 in Scandinavian Countries', Lancet Migration, 18 December 2020.
12 German Trade Union Confederation, 'Corona-Infos und Beratung für Beschäftigte in verschiedenen Sprachen', updated 30 March 2020; Beauftragte der Bundesregierung für Migration, Flüchtlinge, und Integration, 'Was Sie über das Corona-Virus wissen müssen', accessed 6 May 2021.
13 See, for example, Meghan Benton, 'Digital Litter: The Downside of Using Technology to Help Refugees', *Migration Information Source,* 20 June 2019.

4 offers a comparative analysis of recent initiatives and best practices during the COVID-19 pandemic, detailing Portugal's and Denmark's approaches as case studies. The conclusion summarises the most important trends and pressing questions to ensure inclusive health care, migrant health, and immigrant integration.

2 The COVID-19 Pandemic Threatens to Deepen Migrant Health Disparities and Impede Integration

The COVID-19 pandemic threatens to exacerbate migrant health disparities and highlights their complex patterns, causes, and consequences. Migrants and refugees have had higher rates of COVID-19 infections and severe disease[14] and a mortality rate two to five times that of the native born.[15] This uneven impact reflects longstanding health disparities between migrant and native-born populations. A wealth of research conducted prior to the pandemic had already documented how certain conditions, including stroke,[16] hypertension,[17] diabetes,[18] coronary heart disease,[19] post-traumatic stress disorder (PTSD),[20] and depression and anxiety disorders,[21] were more prevalent among some migrant groups.

Yet, disparities differ across health conditions, and patterns of health disparities vary within and between migrant groups. For example, migrants tend to have lower incidence and lower mortality rates for some health conditions, such as cancer, a phenomenon that is often referred to as the 'healthy migrant effect'.[22] In addition, excess mortality due to COVID-19, compared to native-born people in France, differed considerably across migrant groups: excess mortality was 54 per cent higher for those born in Maghreb countries and up to 114 per cent higher among those born in another country in Africa.[23] Such differences illustrate the complexity of migrant health disparities and vary depending on the type of health condition, emphasising the need for an intersectional approach to migrant health that considers legal status, race, ethnicity, and socioeconomic status.

14 Hansson, Albin, Rasmussen, and Jakobsson, 'Large Differences in Excess Mortality'; Jaqueti Aroca, Molina Esteban, García-Arata, and García-Martínez, 'COVID-19 en pacientes españoles e inmigrantes'; *Irish Times*, 'Ireland: Migrants Face Higher COVID-19 Infection Rate'; Erdal et al., 'Migrants and COVID-19 in Norway'.

15 Papon and Robert-Bobée, 'Une hausse des décès deux fois plus importante'.

16 Kenneth G. Keppel, Jeffrey N. Pearcy, and Melonie P. Heron, 'Is There Progress toward Eliminating Racial/Ethnic Disparities in the Leading Causes of Death?', *Public Health Reports* 125, no. 5 (2010): 689–697.

17 Anton Kunst, Karien Stronks, and Charles Agyemang, 'Non-Communicable Diseases', in *Migration and Health in the European Union*, eds. Bernd Rechel et al. (Berkshire, UK: McGraw-Hill Education, 2011).

18 Anoop Misra and Om P. Ganda, 'Migration and Its Impact on Adiposity and Type 2 Diabetes', *Nutrition* 23, no. 9 (2007): 696–708; Kunst, Stronks, and Agyemang, 'Non-Communicable Diseases'.

19 Especially Turkish and Asian migrants. See Björn Albin, Katarina Hjelm, Jan Ekberg, and Sölve Elmståhl, 'Higher Mortality and Different Pattern of Causes of Death among Foreign-Born Compared to Native Swedes 1970–1999', *Journal of Immigrant and Minority Health* 8, no. 2 (2006): 101–113; Lintje Ho, Vivian Bos, and Anton E. Kunst, 'Differences in Cause-of-Death Patterns Between the Native Dutch and Persons of Indonesian Descent in the Netherlands', *American Journal of Public Health* 97, no. 9 (2007): 1616–1618.

20 WHO, *Mental Health Promotion and Mental Health Care in Refugees and Migrants* (Copenhagen: WHO Regional Office for Europe, 2018).

21 Directorate-General for Health and Consumer Protection, *The State of Mental Health in Europe* (Luxembourg: European Commission, 2004).

22 Umar Z. Ikram et al., 'All-Cause and Cause-Specific Mortality of Different Migrant Populations in Europe,' *European Journal of Epidemiology* 31 (2016): 655–665; Matthew Wallace, Myriam Khlat, and Michel Guillot, 'Mortality Advantage among Migrants According to Duration of Stay in France, 2004–2014', *BMC Public Health* 19, no. 327 (2019).

23 Papon and Robert-Bobée, 'Une hausse des décès deux fois plus importante'.

The pandemic also foregrounds the often-overlooked structural inequalities that underlie health gaps not only for COVID-19 but also for other health problems. Low socioeconomic status and low educational attainment,[24] job characteristics such as working in frontline and close-proximity professions,[25] and crowded and poor housing conditions[26] have all been found to explain higher COVID-19 infection rates among migrant groups. This finding is not surprising, as these structural inequalities were already at the root of other health disparities prior to the pandemic. Low socioeconomic status,[27] precarious jobs and unemployment,[28] poor working conditions,[29] and crowded and poor-quality housing[30]—all indicators of migrant integration—as well as discrimination[31] have long threatened physical and mental health outcomes. Yet, policymakers often overlook the roles of migrant integration and other policy areas in migrant health disparities, thereby preventing effective policymaking.

The pandemic also foregrounds the often-overlooked structural inequalities that underlie health gaps not only for COVID-19 but also for other health problems.

The pandemic aggravates these root causes and will likely exacerbate migrant health disparities. Migrants were already at risk of low socioeconomic status prior to the pandemic by having a lower average educational attainment, being more at risk of poverty, and having lower incomes than native-born individuals.[32] Moreover, non-EU migrants are more than twice as likely as native-born people to live in

24 Srikanta Sannigrahi et al., 'Examining the Association Between Socio-demographic Composition and COVID-19 Fatalities in the European Region Using Spatial Regression Approach', *Sustainable Cities and Society* 62 (2020): 102418.

25 WHO, 'Promoting the Health of Migrant Workers'; Raeson Denmark, 'Denmark: Professor Says Culture Is Not the Reason Migrants Are More Affected by COVID-19', European Web Site on Integration, 11 August 2020.

26 Christina Greenaway et al., 'COVID-19: Exposing and Addressing Health Disparities Among Ethnic Minorities and Migrants', *Journal of Travel Medicine* 27, no. 7 (2020).

27 Marilyn A. Wnkleby, Danus E. Jatulis, Erica Frank, and Stephen P. Fortmann, 'Socioeconomic Status and Health: How Education, Income, and Occupation Contribute to Risk Factors for Cardiovascular Disease', *American Journal of Public Health* 82, no. 6 (1992): 816–820.

28 Karsten I. Paul and Klaus Moser, 'Unemployment Impairs Mental Health: Meta-Analyses', *Journal of Vocational Behavior* 74, no. 3 (2009): 264–282; Merel Schuring, Suzan JW Robroek, Hester F. Lingsma, and Alex Burdorf, 'Educational Differences in Trajectories of Self-Rated Health before, during, and after Entering or Leaving Paid Employment in the European Workforce', *Scandinavian Journal of Work, Environment & Health* (2015): 441–450.

29 Elena Ronda Pérez, 'Differences in Working Conditions and Employment Arrangements among Migrant and Non-Migrant Workers in Europe', *Ethnicity & Health* 17, no. 6 (2012): 563–577; Sally C. Moyce and Marc Schenker, 'Migrant Workers and Their Occupational Health and Safety', *Annual Review of Public Health* 39 (2018): 351–365; Emily Sousa et al., 'Immigration, Work and Health in Spain: The Influence of Legal Status and Employment Contract on Reported Health Indicators', *International Journal of Public Health* 55, no. 5 (2010): 443–451.

30 Victoria Team and Lenore Manderson, 'How COVID-19 Reveals Structures of Vulnerability', *Medical Anthropology* 39, no. 8 (2020): 671–674.

31 Naomi Priest et al., 'A Systematic Review of Studies Examining the Relationship between Reported Racism and Health and Wellbeing for Children and Young People', *Social Science & Medicine* 95 (2013): 115–127; David R. Williams, Jourdyn A. Lawrence, Brigette A. Davis, and Cecilia Vu, 'Understanding How Discrimination Can Affect Health', *Health Services Research* 54 (2019): 1374–1388.

32 On average, 34 per cent of non-EU-born migrants have completed tertiary education, compared to 41 per cent of the native-born population in the European Union. Moreover, non-EU-born migrants are more at risk of poverty and social exclusion, with 45 per cent of migrants at risk compared to 20 per cent of native-born individuals. The gap in median income between native-born and foreign-born individuals has increased over the past few years. For example, the native born in France earn a stark 50 per cent more than foreign citizens, and in Croatia, Cyprus, Greece, and Italy, the native born earn about 40 per cent more. See Eurostat, 'Migrant Integration Statistics – Education', updated 27 April 2021; Eurostat, 'Migrant Integration Statistics – At Risk of Poverty and Social Exclusion', updated 9 February 2021.

overcrowded housing,[33] and unemployment rates of third-country nationals in the European Union were already more than twice that of EU citizens prior to the pandemic.[34] The pandemic has increased these inequalities. Approximately 50 per cent of migrants and refugees, especially the most vulnerable groups with temporary or no legal status, report that the pandemic has strongly deteriorated their daily living conditions, specifically their financial means, work, and housing.[35] Moreover, COVID-19 has increased unemployment rates across the board but especially for migrants.[36] The pandemic has also triggered a spike in hate speech and violent crimes against migrants, which are known causes of health problems.[37] If stakeholders do not take proper action, the disproportionate economic fallout of the pandemic will likely deepen existing health disparities.

In this context of potentially intensifying health disparities, migrants face multiple intersecting barriers to accessing health services. Access is determined at the macro level through health policies and entitlements to health care, at the medium level through the organisational structure of services, and at the more micro level through clinical encounters between health professionals and migrants.[38] Barriers to health services include:[39]

- **Legal right to access care.** Despite the fundamental human right to health care under European and international law,[40] asylum seekers and irregular migrants are often entitled only to emergency care, and what is promised on paper does not always translate to access in reality.[41] In conflict with many international agreements, some countries even (used to) restrict access to emergency care.[42]
- **Linguistic and sociocultural barriers.** Even when migrants are legally entitled to health care, linguistic barriers may prevent them from accessing or benefitting from it. Even if they see a health-care professional, they may be unable to communicate clearly about symptoms or understand the diagnosis and treatment options.[43] Linguistic barriers and poor communication with migrant patients

33 The gap in overcrowded housing is especially large in Austria, Cyprus, France, Ireland, the Netherlands, Slovenia, and Spain, where migrants are 3.5 to 4.2 times more likely than native-born individuals to live in overcrowded conditions. See Eurostat, 'Migrant Integration Statistics – Housing', updated 9 February 2021.

34 The gap in income levels between migrants and the native born have further increased over the past years. See Eurostat, 'Migrant Integration Statistics – Labour Market Indicators', updated 26 April 2021.

35 WHO, *ApartTogether Survey: Preliminary Overview of Refugees and Migrants Self-Reported Impact of COVID-19* (Geneva: WHO, 2020).

36 Instituto Nacional De Estadistica, 'Spain: Migrant Unemployment Rate Rises after COVID-19', European Web Site on Integration, 7 September 2020; Martina Sekulova, 'Slovakia: Migrant Employment Decreases due to COVID-19', European Web Site on Integration, 1 June 2020.

37 European Union Agency for Fundamental Rights (FRA), *Migration: Key Fundamental Rights Concerns* (Vienna: FRA, 2020).

38 Marie Nørredam and Allan Krasnik, 'Migrants' Access to Health Services', in *Migration and Health in the European Union*, eds. Bernd Rechel et al. (Berkshire, UK: McGraw-Hill Education, 2011).

39 Bernd Rechel et al., 'Migration and Health in the European Union: An Introduction', in *Migration and Health in the European Union*, eds. Bernd Rechel et al. (Berkshire, UK: McGraw-Hill Education, 2011); Judith Healy and Martin McKee, *Accessing Health Care: Responding to Diversity* (Oxford: Oxford University Press, 2004).

40 WHO, 'World Health Declaration', May 1998, 22–23; WHO, 'Health of Migrants, Resolution of the 61st World Health Assembly', 24 May 2008.

41 Whether the migrant's health situation constitutes an emergency is sometimes left up to the discretion of providers. See Giacomo Solano and Thomas Huddleston, *Migrant Integration Policy Index 2020* (Barcelona and Brussels: Barcelona Centre for International Affairs and Migration Policy Group, 2020), 30.

42 Carin Björngren-Cuadra and Sandro Cattacin, *Policies on Health Care for Undocumented Migrants in the EU27: Towards a Comparative Framework. Summary Report* (Malmö: Health Care in NowHereland, Malmö University, 2010).

43 Alexander Bischoff et al., 'Language Barriers between Nurses and Asylum Seekers: Their Impact on Symptom Reporting and Referral', *Social Science & Medicine* 57, no. 3 (2003): 503–12; Alexander Bischoff and Patricia Hudelson, 'Access to Healthcare Interpreter Services: Where Are We and Where Do We Need to Go?', *International Journal of Environmental Research and Public Health* 7, no. 7 (2010): 2838–44.

may lead to misunderstandings and nonadherence to treatment and will negatively affect health.[44] The pandemic has again underlined the importance of translating health information into minority languages and has made gaps in translation and interpretation services painfully visible.[45] Moreover, communication goes beyond the translation of words into another language. Cultural barriers may also stand in the way of effective communication, resulting in misunderstandings.

- **Administrative and financial barriers.** Financial barriers to health services exist even for those who have insurance. Some health systems require copays or have obligatory deductible expenses, causing some migrants to avoid health services because they lack the financial means. Bureaucratic and administrative hurdles such as technical registration forms, unfamiliar referral systems, copays, and health insurance restrictions on which health-care providers are covered all complicate access to health services. In most states in Germany, for example, asylum seekers must apply for treatment vouchers from their local welfare office to receive health care.[46] This barrier may critically delay diagnosis, treatment, and protective measures,[47] especially when welfare offices operate for limited hours, and thus increase health risks to patients and their environments.

- **Fear and distrust.** On top of these barriers, some migrants—especially irregular migrants who fear deportation—avoid seeking health care due to distrust of authorities.[48] Certain medical conditions also prompt feelings of shame or stigma, especially among those with communicable diseases such as HIV.[49] If migrants avoid the health services they need, this may exacerbate their health conditions, resulting in more serious illness and higher costs in the long run.

As the pandemic illuminates longstanding health disparities and deepens the root causes of these disparities in a context in which migrants face multiple barriers to health services, an effective policy response is crucial. This response is especially important as the pandemic, in addition to deepening health disparities, threatens to raise obstacles to immigrant integration. Migrant integration affects migrant health by shaping the root causes of health outcomes; in turn, migrant health affects immigrant integration, resulting in a mutually reinforcing relationship.[50] The disabling effects of health problems can prevent migrants from participating in integration and language courses,[51] education, and the labour market,[52]

44 Joke C. M. van Wieringen, Johannes A. M. Harmsen, and Marc A. Bruijnzeels, 'Intercultural Communication in General Practice', *European Journal of Public Health* 12, no. 1 (2002): 63–8; Hans Harmsen et al., 'When Cultures Meet in General Practice: Intercultural Differences between GPs and Parents of Child Patients', *Patient Education and Counseling* 51, no. 2 (2003): 99–106.

45 Council of Europe, 'Minority Languages Matter – Particularly in a Health Crisis', accessed 5 May 2021.

46 Nora Gottlieband and Mirjam Schülle, 'An Overview of Health Policies for Asylum-Seekers in Germany', *Health Policy* 125, no. 1 (2021): 115–121; Kayvan Bozorgmehr and Oliver Razum, 'Negotiating Access to Health Care for Asylum Seekers in Germany', in *Health Diplomacy: Spotlight on Refugees and Migrants,* eds. Santino Severoni et al. (Copenhagen: WHO, 2019), 269–80; Marcus Wächter-Raquet, *Einführung der elektronischen Gesundheitskarte für Asylsuchende und Flüchtlinge* (Gütersloh, Germany: Bertelsmann Stiftung, 2016).

47 Kayvan Bozorgmehr and Oliver Razum, 'Effect of Restricting Access to Health Care Expenditures among Asylum-Seekers and Refugees: A Quasi-Experimental Study in Germany, 1994-2013', *PLoS ONE* 10, no. 7 (2015): 1994–2013.

48 Bernd Rechel et al., eds., *Migration and Health in the European Union* (Berkshire, UK: McGraw-Hill Education, 2011).

49 Marianne A. Schoevers,, Maartje J. Loeffen, Maria E. van den Muijsenbergh, and Antoine LM Lagro-Janssen, 'Health Care Utilisation and Problems in Accessing Health Care of Female Undocumented Immigrants in the Netherlands', *International Journal of Public Health* 55, no. 5 (2010): 421–428; Ibidun Fakoya, Rebecca Reynolds, Glenys Caswell, and I. Shiripinda, 'Barriers to HIV Testing for Migrant Black Africans in Western Europe', *HIV Medicine* 9 (2008): 23–25.

50 Jasmijn Slootjes, Saskia Keuzenkamp, and Sawitri Saharso, 'Narratives of Meaningful Endurance–How Migrant Women Escape the Vicious Cycle between Health Problems and Unemployment', *Comparative Migration Studies* 6, no. 1 (2018): 1–16.

51 Witkamp et al., *Gezondheid en participatie*.

52 Pacheco, Page, and Webber, 'Mental and Physical Health'.

and can negatively affect hourly wages and annual hours worked.[53] The pandemic could therefore set back migrant integration both directly through economic fallout and indirectly by increasing health disparities.

3 The Migrant Health Policy Context

The pandemic has acted as a magnifying glass, exposing pre-existing cracks and gaps in migrant health policy approaches. The importance of migrant health in international and national policy agendas has grown, especially since 2007. Nonetheless, the emergence of migrant health on the international policy agenda has not yet brought together the fragmented European migrant health policy landscape.

A. Putting migrant health on the international policy map

General conventions since the late 1940s have enshrined individuals' right to the highest attainable health,[54] yet international policy agendas took a long time to address migrant health specifically. International interest in migrant health originated in Europe. In 2007, migrant health received attention at an EU conference under the auspices of the Portuguese presidency of the Council of the European Union[55] and through the World Health Organization (WHO) Regional Office for Europe's launch of a special initiative on migrant health in 2011. However, Professor David Ingleby, an expert in migrant health policy, highlights how this initial interest faded after the 2008 economic crisis, when competition for limited resources dampened enthusiasm and resulted in a period of limited international action.[56]

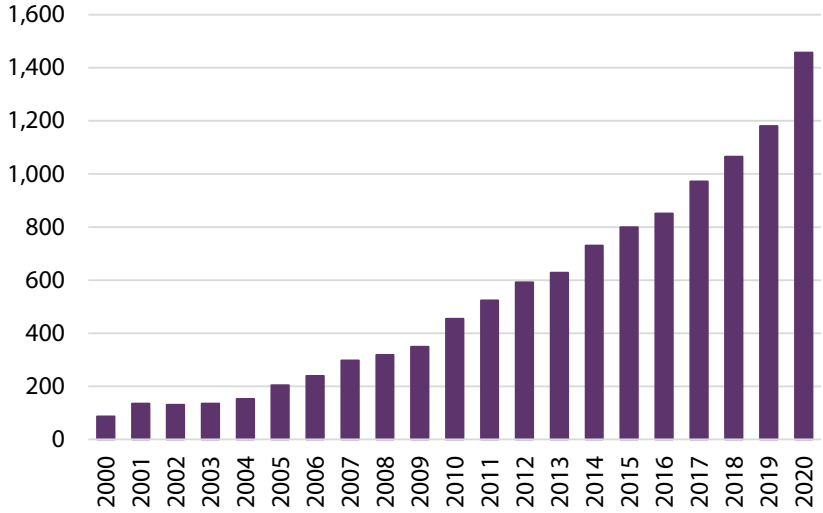
The launch of the UN Sustainable Development Goals in 2015 provided new impetus for an international commitment to migrant health.[57] The influx of migrants and asylum seekers arriving in Europe starting in 2015 heightened the urgency of migrant health issues, but also directed this focus predominantly to those arriving via the Mediterranean, causing many to overlook immigrants entering European countries through other migration channels and those already residing in these countries. Despite these flaws, migrant health policies have come a long way since the early 2000s and are now included in various international frameworks and pacts, including the Global Compact for Migration. This increased policy interest grew in tandem with scholars' growing interest in migrant health. After decades of stagnation in the annual number of publications on migrant health, the number increased tenfold between 2000 and 2020 (see Figure 1). Yet, this surge in academic and policy interest did not translate into binding treaties, resulting in a gaping void among lofty goals, national policies, and practices on the ground.

53 Messer Pelkowski and Berger, 'The Impact of Health on Employment, Wages, and Hours Worked'.
54 WHO, 'Constitution of the World Health Organization', 1948, accessed 20 July 2021; UN Human Rights Office of the High Commissioner, 'International Covenant on Economic, Social and Cultural Rights', 1966, accessed 20 July 2021; United Nations, 'United Nations Millennium Declaration', accessed 20 July 2021.
55 Council of the European Union Permanent Representatives Committee, 'Health and Migration in the EU - Policy Debate / Adoption of Council Conclusions', 29 November 2007.
56 Author interview with David Ingleby, affiliated researcher at the Centre for Social Science and Global Health, University of Amsterdam and Emeritus Professor of Intercultural Psychology at Utrecht University, 19 July 2021.
57 UN Department of Economic and Social Affairs, 'Sustainable Development Goals – The 17 Goals', accessed 21 July 2021.

The pandemic has further accelerated interest in migrant health. Whereas the highly politicised nature of topics related to migration often hinders policy change, Dr. Santino Severoni, Director of the Migrant Health Programme at the WHO, describes the depoliticising effect of the public-health crisis, resulting in a more pragmatic approach to migrant health.[58] Whether this approach will endure after the pandemic remains a question. For example, Germany's active global leadership under Angela Merkel and the United States' leadership under the Obama administration were key in spurring earlier developments, yet both countries no longer play this role. With its nonideological mission, the WHO presents itself as a technical institution serving as a gateway to knowledge and connecting different actors to promote public health, but it does not play a leading role in migrant health policy development. Who, then, will take the lead in pushing forward the migrant health policy agenda remains to be seen. In a context of economic fallout from the pandemic, the risk of losing momentum looms, just as it did after the economic crisis that began in 2008.

FIGURE 1

Publications on PubMed Identified in a Search for 'Migrant Health', by Year of Publication, 2000–20



Source: U.S. National Institutes of Health, National Library of Medicine, 'Search Results for "Migrant Health"', accessed 2 September 2021.

B. Migrant health policies in Europe

European health policies vary in the extent to which they focus on migrant health, whether they take an upstream or downstream approach, and which health conditions and target populations they prioritise. At the European level, instruments such as the European Social Charter and the Charter of Fundamental Rights protect migrant health; legally binding directives such as those on long-term residents,[59] the minimum standards for the reception of asylum seekers,[60] and racial equality[61] mention migrant health. The latest instrument is the 2020 European Pact on Migration and Asylum, which would introduce compulsory health checks as part of pre-entry screening to identify health needs early on. Yet, none of these instruments introduce a comprehensive approach to migrant health, and despite these more universal international and European frameworks, European countries have taken a less-than-universal approach to migrant health policy.

58 Comments by Santino Severoni, Director of the Migrant Health Programme at the WHO, during the Migration Policy Institute Europe webinar 'How Will the Pandemic Reshape Public Health for Migrants?', 14 September 2021.

59 'Council Directive 2003/109/EC of 25 November 2003 Concerning the Status of Third-Country Nationals Who Are Long-Term Residents', *Official Journal of the European Union* 2004 L016, 23 January 2004.

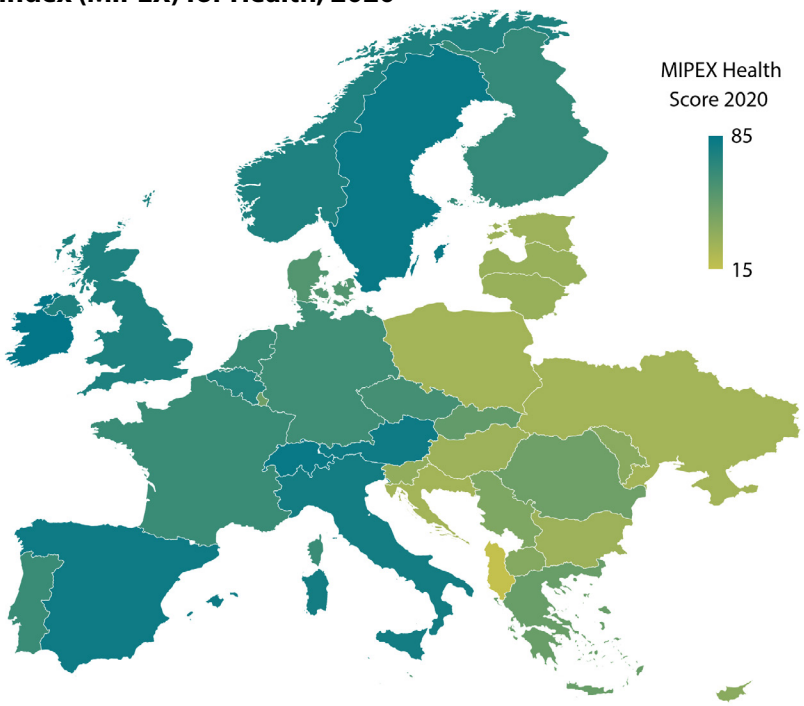
60 'Council Directive 2003/9/EC of 27 January 2003 Laying down Minimum Standards for the Reception of Asylum Seekers', *Official Journal of the European Union* 2003 L31/18, 6 February 2003.

61 'Council Directive 2000/43/EC of 29 June 2000 Implementing the Principle of Equal Treatment between Persons Irrespective of Racial and Ethnic Origin', *Official Journal of the European Union* L180/22, 19 July 2000.

National approaches are key to complying with these international and European standards, yet a study found that at the end of 2017, no EU Member States had a structural health strategy or action plan targeting migrant health. Moreover, the study notes that some Member State policies refer to other vulnerable groups but do not refer specifically to migrants. Other Member States had a national health strategy that mentioned migrants yet lacked targets and goals for accountability.[62] The Migrant Integration Policy Index (MIPEX) on health—which, reflecting the relatively recent interest in migrant health, was the last policy strand to be added to MIPEX in 2014—highlights the stark differences across European countries, even on paper. Ireland, Switzerland, Sweden, Spain, and Austria topped the global ranks in 2020 with the most favourable migrant health policies, as opposed to many Eastern European countries which had some of the least favourable migrant health policies globally.[63]

FIGURE 2

European Countries' Rating on the Migrant Integration Policy Index (MIPEX) for Health, 2020



Source: Migration Policy Group, 'Migrant Integration Policy Index 2020 - Health', accessed 3 September 2021.

It is also useful to distinguish between migrant health policies that take an upstream approach, focusing on tackling root causes of health disparities and prevention, and those with a downstream approach, focusing on effective treatment. Most European migrant health policies have a downstream emphasis, focusing on intercultural competence, interpretation services, and effective delivery of treatment to migrants.[64] Even though these measures are crucial for improving migrant health and health-care access, focusing only on treatment runs the risk of sending people back to the conditions that initially made them sick. As discussed in the previous section, structural inequalities in employment, housing, and education drive health disparities. A more upstream health policy would take these root causes into account. Using the increasingly popular Health in All Policies approach, which is intersectoral and accounts for the impact of different policy

62 EWSI Editorial Team, 'Migrant Health across Europe'.

63 The Migrant Integration Policy Index (MIPEX) health policy score uses policy experts' assessments to create a comparable and standardised score reflecting the favourability of migrant health policies that can be compared across countries based on entitlements, accessibility, responsiveness to migrants' needs, and measures to achieve change. MIPEX combines qualitative information to make quantitative scales. Answers to the questionnaire items are scored on a three-point scale. Average scores are calculated for each of the four sections separately, and the average of these four scores constitutes the overall health strand score. Based on these four sections, an average score is attributed to each country. See International Organization for Migration (IOM), *Summary Report on the MIPEX Health Strand and Country Reports* (Geneva: IOM, 2016), 24–34; Solano and Huddleston, *Migrant Integration Policy Index 2020*.

64 David Ingleby, 'Moving Upstream: Changing Policy Scripts on Migrant and Ethnic Minority Health', *Health Policy* 123, no. 9 (2019): 809–817.

areas on public health, would be a promising route forward. The WHO defines Health in All Policies as 'an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity.'[65]

Lastly, the migrant groups and health issues that European countries prioritise reflect stark divergences. In a comparative analysis, the United Kingdom and the Netherlands, for example, stood out by focusing strongly on mental health issues, whereas Italy focused more on sexual and reproductive health. The same applies to target groups, with some countries, such as Sweden and Italy, focusing strongly on newly arrived, first-generation immigrants, and other countries, such as the United Kingdom, focusing more on established ethnic minorities.[66] These patterns reflect migration history, as countries newer to immigration tend to focus more on newly arrived migrants. Decisions to target particular migrant groups, or to not target migrants at all, often stem from broader policy discussions related to mainstreaming. Mainstreaming is a trend in migrant integration policies in which countries shift from a target group to a whole-of-society approach and from state-centric to more polycentric governance modes.[67] European societies are increasingly superdiverse; the within- and between-group differences in patterns of health disparities among migrants discussed above highlight how target-group thinking can be harmful by homogenising a group and failing to account for diverse needs. Mainstreaming, with its polycentric approach, would furthermore fit with a Health in All Policies approach and account for the intricate links between other policy areas and the root causes of health and health outcomes.

However, mainstreaming does not mean turning a blind eye to the specific needs of different groups; knowledge of and sensitivity to such needs remains essential. In terms of the broader policy context, migrant health has only recently appeared on the policy agenda, and most public-health policies still fail to address migrants' and refugees' specific needs. Most countries do not apply a conscious policy of mainstreaming migrant health but, rather, remain blind to migrant health.

C. Broader political and economic considerations

Two main drivers have shaped migrant health policies in the few years prior to the pandemic: political will and funding/economic context. First, changes in ruling political parties can result in dramatic positive or negative changes in migrant health-care accessibility and entitlements. For example, in 2018 the new Spanish government restored health coverage for irregular migrants but left bureaucratic barriers in place. In the same year, the new Italian government reduced access to health care by imposing administrative barriers for asylum seekers.[68] Sudden changes to entitlements and health-care policies complicate migrants' attempts to navigate the already complex European health-care systems.

A second trend is the large role that economic context and available funding play in shaping migrant health-care policies, as austerity measures bring cuts to health-care entitlements, and external funding

65 WHO, *Health in All Policies (HiAP) Framework for Country Action* (N.p.: WHO, 2014), 1.
66 Mladovsky, 'A Framework for Analysing Migrant Health Policies in Europe'.
67 Peter Scholten, Elizabeth Collett, and Milica Petrovic, 'Mainstreaming Migrant Integration? A Critical Analysis of a New Trend in Integration Governance', *International Review of Administrative Sciences* 83, no. 2 (2017): 283–302.
68 David Ingleby, 'Changes between Health Strand Scores in the 2015 and 2020 Rounds', accessed 30 April 2021.

promotes better access to health care. Greece, Portugal, and Spain, for example, reduced migrants' health-care entitlements as part of austerity measures.[69] Economic recession due to COVID-19 and further pressures on government funds during the post-pandemic recovery may therefore result in health-care entitlement cuts in a time of increased needs. Nonetheless, EU funding from programmes such as the European Commission's Asylum, Migration, and Integration Fund (AMIF) are important for promoting improvements in migrant health policies. Latvia, which in 2014 had the least favourable migrant health policies among all European countries,[70] now provides interpretation services free of charge, thanks to AMIF financing. Croatia and Lithuania, both lacking inclusive health policies, now provide health education and health services information to migrants through projects supported by AMIF.[71] Although these are steps in the right direction, interpretation and information alone are not enough to tackle the many intersecting vulnerabilities and barriers that migrant communities face in these countries.

BOX 1
The Broader Policy Context: Health Care Pushed to Its Limits

The pandemic has pushed European health-care systems to their limits, creating additional challenges to improving migrant health and inclusion. The pandemic has dramatically worsened the pre-existing shortage of health-care workers, with almost all European countries reporting a shortage of health-care workers in 2020, especially of nurses. The Italian government aims to tackle this shortage by investing 660 million euros to recruit 20,000 health workers. Some European countries rely heavily on foreign workers in the health-care sector. For example, Germany has 29,000, Switzerland has 20,000, and Spain has 11,000 foreign health-care professionals who have lived in the country for fewer than six years, indicating health care's high reliance on labour mobility. Ongoing travel restrictions may limit new foreign workers' entry into the labour market at a time of especially high demand. Even worse, the unprecedented demands on health-care workers have resulted in a stark increase in mental health problems among these workers. COVID-19 restrictions, delays in procedures, and reallocation of resources and personnel have also extended waiting times for certain procedures. In addition, health inequalities were already a main challenge for European public health, and the pandemic has exacerbated this issue.

Funding or personnel resources could help solve these issues, yet governments are in a double bind regarding the economics of health care. Ageing populations, the development of more costly advanced treatments, and technology use are driving up costs, while pressure on public revenues leaves less to spend on these growing demands. This situation existed prior to increased government spending on stimulus packages to address the economic fallout from COVID-19. In a context of limited resources, discussions about who deserves access to limited health-care resources may become more heated and, therefore, increase pressure to restrict some migrant groups' already limited health-care access. The increased pressure on European health-care systems may therefore provide a challenging context in which to improve migrant health after the pandemic.

Sources: John McGrath, *Analysis of Shortage and Surplus Occupations 2020* (Brussels: European Commission, Directorate-General for Employment, Social Affairs, and Inclusion, 2020); Benedetta Armocida et al., 'The Italian Health System and the COVID-19 Challenge', *The Lancet Public Health* 5, no. 6 (2020); Niall Galbraith, David Boyda, Danielle McFeeters, and Tariq Hassan, 'The Mental Health of Doctors during the COVID-19 Pandemic', *BJPsych Bulletin* 45, no. 2 (2021): 93–97; Organisation for Economic Cooperation and Development (OECD) and European Union, 'Waiting Times for Elective Surgery', in *Health at a Glance: Europe 2020: State of Health in the EU Cycle* (Paris: OECD Publishing, 2020); Zsuzsanna Jakab, 'The Public Health Situation in the European Union' (presentation, World Health Organization Regional Office for Europe, 15 April 2011).

69 Thomas Huddleston, Özge Bilgili, Anne-Linde Joki, and Zvezda Vankova, *Migrant Integration Policy Index 2015* (Barcelona and Brussels: Barcelona Centre for International Affairs and Migration Policy Group, 2015), 38.
70 Migration Policy Group, 'Migrant Integration Policy Index 2014 – Health', accessed 9 September 2021.
71 Ingleby, 'Changes between Health Strand Scores'.

4 The European Response to COVID-19 and Migrant Health

In a policy context where migrant health has received attention only recently, European governments had to quickly adapt to the challenges the pandemic posed for the health of their diverse populations. This section analyses the flurry of responses that sprang up during the pandemic, looking at health-care entitlements and access for migrants; translation, information, and outreach; and a surge in civil society initiatives filling the gaps left by government policies. These initiatives have often been fuelled by recent trends, including increased pressure on health-care systems, digital transformation, and increased civil society-government partnerships. Yet, questions remain about the potential lasting effects of this flurry of activity and the opportunities and risks for migrant and refugee health and inclusion.

A. Increasing health-care entitlements and access for migrants

The pandemic prompted many countries to increase health-care entitlements for irregular and uninsured migrants. While countries such as Belgium and Spain already provided comprehensive health entitlements, others did not and only after the pandemic began expanded health-care access to irregular migrants,[72] often free of charge.[73] Portugal, for example, temporarily lifted all administrative barriers to their National Health Service, allowing all migrants, including irregular migrants, to access care free of charge (see Box 2 for details).[74] As legal status is among the most pressing obstacles to accessing health care, the UN Special Rapporteur on migrants called for the regularisation of irregular migrants to facilitate their access to health services during the pandemic.[75] Italy included regularisation in their May 2020 stimulus package, providing temporary residence permits to people working in specific labour market sectors; however, this policy's scope was restricted to alleviate pandemic-driven labour shortages and reportedly exposed irregular migrants to fraud and exploitation.[76]

At the same time, some local governments played an important role in extended access to health services established by national authorities. Berlin, for example, provided temporary, anonymous, and no-cost access to ambulatory care for uninsured migrants.[77] Similarly, the City of Amsterdam allowed irregular migrants with COVID-19 symptoms to access free testing through the public health service,[78] and the municipality of Oslo covered the costs of a general practitioner at the Health Centre for Undocumented Migrants.[79] Access to health care has also been particularly important for access to COVID-19 vaccinations, especially when

72 Platform for International Cooperation on Undocumented Migrants (PICUM), *Non-Exhaustive Overview of European Government Measures Impacting Undocumented Migrants Taken in the Context of COVID-19* (Brussels: PICUM, 2020).
73 Belgium, Estonia, Greece, Finland, Lithuania, Luxembourg, Spain, Poland, and Slovakia. See European Migration Network (EMN) and Organisation for Economic Cooperation and Development (OECD), *EU and OECD Member States Responses to Managing Residence Permits and Migrant Unemployment during the COVID-19 Pandemic* (Brussels: EMN, 2020).
74 Direção-Geral da Saúde publica, 'Informação sobre migrantes e refugiados'.
75 Office of the UN High Commissioner for Human Rights, 'UN Experts Call on Governments to Adopt Urgent Measures to Protect Migrants and Trafficked Persons in Their Response to COVID-19', updated 3 April 2020.
76 See PICUM, 'Regularising Undocumented People in Response to the COVID-19 Pandemic', accessed 2 August 2020; Human Rights Watch, 'Italy: Flawed Migrant Regularization Program', accessed 2 August 2020.
77 Berlin Senate Department for Health, Care and Equality, 'Ab sofort hausärztliche Versorgung für Menschen ohne Krankenversicherung' (press release, 17 April 2020).
78 PICUM, *Non-Exhaustive Overview of European Government Measures*.
79 Thea Rabe, 'Could Covid-19 Lead to Increased Access to Healthcare for Irregular Migrants in Norway? ', IMISCOE PhD Blog, 23 June 2020.

supplies were limited and vaccination programmes were moving ahead slowly.[80] An analysis by the Platform for International Cooperation on Undocumented Migrants (PICUM) paints a varied picture of access to vaccinations for irregular migrants in Europe: Bulgaria, Czechia, Greece, Hungary, Poland, and Slovakia bar these migrants from accessing vaccines, whereas Belgium, Finland, France, Ireland, the Netherlands, Portugal, and the United Kingdom provide full access to vaccinations without the need for proof of residency or identity documents. Some countries, such as Germany, do not explicitly bar irregular migrants from accessing vaccinations, but these migrants may risk deportation as federal law requires health-care providers to report irregular migrant patients to immigration authorities. In other countries, such as Italy, Norway, and Spain, policies differ locally, making it harder for irregular migrants to navigate these systems.[81]

Countries often cite attempts to reduce health-care costs and fears of attracting additional irregular migration as reasons to restrict entitlement to health care. Yet, denying access to primary care can lead to delayed treatment, conditions becoming more serious, and much higher treatment costs in the long run.[82] Research in Germany[83] and Southern Africa[84] and a vignette approach by health experts at the International Organization for Migration[85] show that, contrary to common beliefs, expanding entitlement to health care could reduce costs. But as health-care systems, already pushed to their limits, emerge from the challenges of the pandemic, rising discrimination, public backlash, and political opposition may limit willingness to extend these entitlements after the pandemic ends. This may occur especially because while COVID-19 infections among vulnerable (irregular) migrant populations directly threaten the general population, other (noncommunicable) health conditions pose less of a threat to the general public, creating less incentive to provide universal (free) access to health care.

BOX 2
Case Study of Portugal: Increasing Eligibility and Active Outreach

Portugal is among the leaders in Europe in terms of taking a comprehensive approach to migrant health policies. Starting in 2014, after a period of reduced access to health care due to austerity measures, Portugal expanded health-care entitlements for the foreign population. In 2019, with the adoption of the new Health Care Basic Law, regular migrants, asylum seekers, refugees, and irregular migrants living in Portugal for more than 90 days gained access to the full range of health-care services, on the same conditions as nationals. Irregular migrants must present proof of residency issued by the local borough council. Irregular migrants in the country for fewer than 90 days, or unable to prove it, are not completely excluded from health care; they are entitled to nearly free access for specific medical needs, such as vaccinations and emergency, maternal, and paediatric care. However, migrants without any official documents proving their stay are referred to a National Immigrant Support Centre or to a Local Immigrant Integration Support Centre after their treatment to initiate their regularisation. Despite this inclusive framework for migrant health care, many immigrants still face additional bureaucratic and administrative challenges, ranging from difficulties obtaining proof of residency and fear of being reported and risking deportation, to more general obstacles such as linguistic and cultural barriers.

80 Council of Europe, Committee on Bioethics, 'COVID-19 and Vaccines: Ensuring Equitable Access to Vaccination During the Current and Future Pandemics', updated 22 January 2021.
81 PICUM, 'The COVID-19 Vaccines and Undocumented Migrants: What Are European Countries Doing?', accessed 12 August 2021.
82 David Ingleby and Roumyana Petrova-Benedict, *Recommendations on Access to Health Services for Migrants in an Irregular Situation: An Expert Consensus* (Brussels: IOM, 2016).
83 Bozorgmehr and Razum, 'Effect of Restricting Access to Health Care Expenditures'.
84 Oxford Policy Management, 'Developing Financing Mechanisms to Support the Implementation of the Draft 'Policy Framework for Population Mobility and Communicable Diseases in the SADC Region', *Draft Proposals for Financing Mechanisms and Involvement of the Private Sector* (Oxford: Oxford Policy Management in association with IOM, 2015).
85 Ursula Trummer, Sonja Novak-Zezula, Anna-Theresa Renner, and Ina Wilczewska, *Cost Analysis of Health Care Provision for Irregular Migrants and EU Citizens Without Insurance* (Brussels: IOM, 2016).

BOX 2 (cont.)
Case Study of Portugal: Increasing Eligibility and Active Outreach

After the outbreak of the COVID-19 pandemic, Portugal announced on 27 March 2020 the temporary regularisation of all foreigners with pending applications and provided temporary, free access to the national health system. To access this regularisation measure, foreigners had to provide evidence of an ongoing residency request with the Foreigners and Borders Service (SEF), either an asylum claim or a work permit request. According to the Portuguese government, 130,000 migrants benefited from this temporary regularisation. This milestone decision of the Portuguese authorities aimed to close the gap that irregular migrants experience between the inclusive legal framework and practical access to health care. Essentially, the temporary regularisation made proof of a pending application with SEF equal to proof of residency in Portugal for more than 90 days. While documents provided by SEF are a necessary condition to access basic rights, since the latest amendments to the Foreigners Act, the SEF authorities' capacity to process all requests has been disrupted. The SEF has been reporting severe shortages of human resources since 2008 and the situation reached a breaking point in recent years. The Foreigners Act of 2017 introduced digitalisation of procedures requiring new technical staff that have been hard to find, further exacerbating the shortages in human resources.

In addition to providing temporary regularisation, Portugal offers free COVID-19 tests to everyone with a prescription from the national health system. However, lack of information, linguistic barriers, and fear of being reported to authorities may hinder migrants' access to testing. Portugal went further than most European countries by not only providing information in multiple languages but also collaborating with local organisations in door-to-door awareness campaigns and developing health-literacy activities in neighbourhoods highly affected by COVID-19, including those with significant migrant populations. National authorities could replicate this experience by recognising nongovernmental actors' key role in informing migrant health strategies and reaching migrant communities after the pandemic.

Note: On 15 April 2021, the Foreigners and Borders Service (SEF) changed its name to the Foreigners and Asylum Office (SEA).
Sources: Thomas Huddleston, Özge Bilgili, Anne-Linde Joki, and Zvezda Vankova, *Migrant Integration Policy Index 2015* (Barcelona and Brussels: Barcelona Centre for International Affairs and Migration Policy Group, 2015), 177; Article 83(1)(2) of *Foreigners' Act* (Law 23/2007, 4 July, last amended by Law 28/2019, 29 March); Order 25 360/2001, 12 December 2001; Directorate General of Health, 'Circular Informativa 12/DQS/DMD', updated 7 May 2009; Jesuit Refugee Service Portugal, *Livro Branco Sobre os Direitos dos Imigrantes e Refugiados em Portugal* (Lisbon: Jesuit Refugee Service Portugal, 2019); Article 52 of the *Asylum Act* (Law 27/2008, 30 June, last amended by Law 26/2014, 5 May); Order of the Ministry of Health no 25350/2001, *Official Gazette* n. 286/2001, 16 November 2001; Lúcia Raposo and Violante, 'Access to Health Care by Migrants with Precarious Status during a Health Crisis: Some Insights from Portugal', *Human Rights Review* (2021): 1–24; 'Direção-Geral da Saúde', (Informação No. 010/2020, 8 May 2020); Renascença, 'Coronavírus. MAI confirma que 130 mil imigrantes ficaram provisoriamente com situação regularizada', updated 5 May 2020; Sónia Dias et al., 'Situational Brief: COVID-19 Response & Migrant Health in Portugal', Lancet Migration, 31 July 2020.

B. Translation, information, and outreach

Providing understandable information in appropriate languages and ensuring that this information reaches vulnerable migrant populations have been crucial for stopping the spread of COVID-19 and saving lives. Many countries provided information about COVID-19 measures, guidelines, and recommendations in the most prominent migrant languages, including Belgium (29 languages),[86] Denmark (19 languages),[87]

86 Flemish Agency for Integration, 'Belgium: Multilingual Covid-19 Information', European Web Site on Integration, 3 November 2020.
87 Corona Denmark, 'Information from the Danish Authorities on the Corona Virus/Covid-19 Situation in Denmark', accessed 6 May 2021.

Germany (20 languages),[88] Italy (14 languages),[89] Norway (almost 50 languages),[90] and Portugal (11 languages).[91] Yet, to be effective, translations must also be of sufficient quality and provided in a timely manner. In Denmark, for example, nonprofessional interpreters working at nongovernmental organisations with limited resources and qualifications translated all information, which affected the quality and timeliness of the translated resources (see Box 3).[92] And while timely and up-to-date information was crucial to prevent the further spread of COVID-19, especially at the pandemic's onset, keeping information in several languages up to date has proven difficult in such a fast-moving situation. In Greece, the government announced that it would provide linguistically appropriate information to refugee camp residents in March 2020.[93] Yet, as of July 2020 the government had still not fully implemented this plan.[94]

Keeping information in several languages up to date has proven difficult in such a fast-moving situation.

Communicating critical information in an effective format is another challenge. Even when information is available in multiple languages, it is often provided in heavily text-based formats, which may present a barrier for migrants with limited literacy. A promising development for overcoming this barrier is the use of alternative formats and digital tools, such as graphics, videos, hotlines, and online live sessions. Denmark,[95] France,[96] Germany,[97] and Sweden[98] provide interesting examples of multilingual videos and graphics to communicate information about COVID-19 to hard-to-reach immigrant populations. Yet, whether these alternative formats have been more successful than text-based communications is unclear. Evaluating whether and which formats are most effective is crucial for allowing policymakers to learn from the initiatives launched during the pandemic.

Even with these improvements, many initiatives involve passively sending information in ways that allow little opportunity for migrants to engage and ask questions. Some civil-society organisations took action to fill this need. In Denmark, after a lack of translation and outreach efforts by the Danish government at the pandemic's onset, civil-society organisations, such as the Danish Refugee Council, launched a COVID-19 hotline available in 25 languages (see Box 3).[99] Efforts of this kind often use social media platforms to inform and reach migrant and refugee populations. In Italy, the United Nations Children's Fund (UNICEF) launched a platform using Facebook live sessions called 'U Report on the Move'. These sessions focus on different aspects of migrants' lives during the pandemic, such as practical rules to minimise the risk of infection when

88 German Trade Union Confederation, 'Corona-Infos und Beratung für Beschäftigte in verschiedenen Sprachen'; Beauftragte der Bundesregierung für Migration, Flüchtlinge und Integration, 'Was Sie über das Corona-Virus wissen müssen'.
89 UN High Commissioner for Refugees (UNHCR) and Association of Social Promotion (ARCI), 'Juma Map', accessed 6 May 2021.
90 Helsenorge, 'Information about Coronavirus in Other Languages', accessed 6 May 2021.
91 Alto Comissariado para as migrações, 'Portugal: Multi-Language Information on COVID-19', European Web Site on Integration, 17 November 2020.
92 Diaz et al., 'Situational Brief: Migration and COVID-19 in Scandinavian Countries'.
93 Human Rights Watch, 'Greece: Island Camps Not Prepared for Covid-19', updated 22 April 2020.
94 Elspeth Carruthers, Apostolos Veizis, Elias Kondilis, and Sophie McCann, 'Situational Brief: Asylum Seekers and Refugees in Greece During COVID-19', Lancet Migration, 22 September 2020.
95 Danish Health Authority, 'Information på andre sprog', updated 5 February 2021.
96 Ville de Paris, 'Mars 2020 – Coronavirus: santé et droits – langues française et étrangère (YouTube video, 3 December 2020).
97 Infektionsschutz.de, 'Informationen in anderen Sprachen', updated 14 December 2020.
98 European Web Site on Integration, '#TellCorona - Video Messages to Reach Marginalised Communities', updated 9 April 2020.
99 Danish Refugee Council, 'Denmark – New Hotline in 25 Languages about Coronavirus', European Web Site on Integration, 6 April 2020.

living in shared housing.[100] In addition, the use of digital tools has accelerated during the pandemic, fuelled by social-distancing measures and temporary bans on in-person service provision. Yet, despite the promise of digital health tools to expand access to care, these tools may not benefit some migrants due to limited digital literacy, limited access to internet and digital devices, and cultural barriers.[101] Digital health tools may therefore leave the most vulnerable populations behind.

C. Civil-society initiatives

Although often overlapping with the above-mentioned information and outreach initiatives, civil-society initiatives and responses to the pandemic deserve specific attention. Civil-society, migrant, and community organisations have played an important role during the pandemic by quickly identifying migrant communities' needs and filling gaps in government service provision. First, they ensured that COVID-19-related information reached the most vulnerable and hard-to-reach populations. Examples of such outreach efforts are countless, including migrant organisations working with the German government to disseminate information,[102] and community leaders, street educators, and social media in Belgium informing migrant youth about COVID-19.[103] In Sweden, the Cooperative for Migrant Unions in Uppsala spread information via WhatsApp,[104] and in Italy, Doctors for Human Rights launched multimedia services and tutorials to support migrants further marginalised by the pandemic.[105] In Portugal, Health Unites partnered with local nongovernmental organisations in door-to-door awareness campaigns and to organise health-literacy training in health community groups.[106] One outcome of these efforts in Portugal was deeper ties among health services, nongovernmental organisation, and local communities, which could inform and benefit post-pandemic strategies to tackle migrant health vulnerabilities.

One outcome of these efforts in Portugal was deeper ties among health services, nongovernmental organisation, and local communities, which could inform and benefit post-pandemic strategies to tackle migrant health vulnerabilities.

Besides providing outreach to migrant communities, many organisations adjusted their activities and developed new services. A partnership of Vietnamese migrant organisations in Czechia and Poland, for example, imported COVID-19 tests, provided protective gear for medical personnel, and provided free meals to frontline workers.[107] Civil-society organisations have also combatted increased discrimination

100 United Nations Children's Fund (UNICEF) Italy, 'U-Report on the Move', accessed 6 May 2021.
101 Guy Fagherazzi et al., 'Digital Health Strategies to Fight COVID-19 Worldwide: Challenges, Recommendations, and a Call for Papers', *Journal of Medical Internet Research* 22, no. 6 (2020): e19284.
102 Nora Gottlieb, Maren Hintermeier, and Kayvan Bozorgmehr, 'Situational Brief: COVID-19 & Migration in Germany', Lancet Migration, 28 May 2020.
103 Sylvia Falcinelli, 'Foyers de coronavirus en Belgique : cibler la com' pour mieux cibler les transmissions?', RTBF, updated 20 July 2020.
104 Diaz et al., 'Situational Brief: Migration and COVID-19 in Scandinavian Countries'.
105 Alberto Barbieri, 'CoViD-19 in Italia: la popolazione senza fissa dimora ha bisogno di protezione', *Recenti Prog Med* 111 (2020): 1–2.
106 Sónia Dias et al., 'Situational Brief: COVID-19 Response & Migrant Health in Portugal', Lancet Migration, 31 July 2020.
107 For an example in Poland, see Wawalove, 'The Vietnamese Community in Poland Supports Fight against COVID-19', European Web Site on Integration, 30 March 2020. For an example in the Czech Republic, see Lam Cha Me, 'Vietnamese Community in Czech Republic Helps Fight against COVID-19', European Web Site on Integration, 12 May 2020.

against migrants, especially those of Asian descent. For example, the online platform GoVolunteer in Germany started a campaign to highlight migrants' and refugees' important role in fighting COVID-19.[108] It is too early to say how the current boom of initiatives compares to the post-2015 civil-society boom-and-bust cycle. However, it is clear that structural change and more permanent partnerships will succeed only through proper evaluation and continued investment.

BOX 3
Case Study of Denmark: Restrictive Approaches and Civil Society Filling the Gaps

Denmark is one of the few European countries adopting a progressively restrictive approach toward migrant integration, and the health sector is no exception. Taxes finance the Danish health-care system, which provides universal access for taxpayers, including regular migrants and asylum seekers. Irregular migrants have the right only to emergency care, maternal and child care, and treatment for infectious diseases and severe mental health issues. Irregular migrants face multiple informal barriers to the national health system, such as arbitrariness in who health-care professionals decide to treat, fear of being reported to the police, linguistic barriers, and lack of knowledge about the system. Nongovernmental and civil-society organisations fill the gaps in government health policies. In 2011, the Danish Red Cross, Danish Medical Association, and Danish Refugee Council established health clinics in Copenhagen and Aarhus dedicated to irregular migrants, and these clinics fully rely on donations to provide free treatments and medication.

In contrast to other countries in Europe, Denmark did not expand health-care service eligibility for foreigners during the COVID-19 pandemic. And in the absence of government efforts to communicate critical health information to migrant populations at the onset of the pandemic, the Danish Refugee Council established a COVID-19 hotline in 25 languages. When the media started to criticise the government's information strategy, national authorities introduced targeted measures for migrants. The Danish National Board of Health translated written material on COVID-19 prevention measures into 19 languages but did not disseminate it to people in need. In August 2020, the government established a national group of experts to advise on the prevention of COVID-19 among ethnic minorities and migrant communities.

The pandemic brought intensified anti-immigrant sentiment in the country, as in many other countries. Already in May 2020, 18 per cent of infected residents were migrants, although they constitute only 9 per cent of the total population. Without investigating the root causes of these disparities, some politicians began to scapegoat migrant communities. When a COVID-19 cluster was found among the Somali community in the city of Aarhus, a member of European Parliament from one of the two largest political parties in Denmark accused migrants of not taking the pandemic seriously and called for a lockdown of immigrant neighbourhoods. At the same time, the Somali community began to experience an increase in discrimination and harassment. Since then, anti-immigrant attitudes seem to have become widespread. A 2020 study found that up to one in five Danes would prioritise a native-born COVID-19 patient over an immigrant, in case of a shortage of hospital beds. This tendency is even stronger toward recent migrants with Muslim names. The public sentiment is consistent with Denmark's political willingness to restrict migrants' access to welfare benefits, as a strategy to disincentivise permanent integration. Through a law

108 Press and Information Office of the State of Berlin, 'Geflüchtete helfen in der Coronakrise – neue Kampagne macht Engagement sichtbar und lädt zum Mitmachen ein' (press release, 16 April 2020).

BOX 3 (cont.)
Case Study of Denmark: Restrictive Approaches and Civil Society Filling the Gaps

adopted in Spring 2019, the Danish government officially shifted its migration approach from long-term integration to short-term stay and return. Despite concerns raised about this new policy, Denmark seems determined to implement the controversial return of migrants whose temporary humanitarian protection has expired or been revoked. In this context of increasing anti-immigrant sentiment, further restrictions to migrant health entitlements may occur in the aftermath of the pandemic.

Source: Giacomo Solano and Thomas Huddleston, *Migrant Integration Policy Index 2020* (Barcelona and Brussels: Barcelona Centre for International Affairs and Migration Policy Group, 2020), 93; Aniek Woodward, Natasha Howard, and Ivan Wolffers, 'Health and Access to Care for Undocumented Migrants Living in the European Union: A Scoping Review', *Health Policy and Planning* 29, no. 7 (2014): 818–30; Dan Biswas et al., 'Access to Health Care for Undocumented Migrants from a Human Rights Perspective: A Comparative Study of Denmark, Sweden, and The Netherlands', *Health and Human Rights* 14, no. 2 (2012): 49–60; Dan Biswas, Maria Kristiansen, Allan Krasnik, and Marie Norredam, 'Access to Healthcare and Alternative Health-Seeking Strategies Among Undocumented Migrants in Denmark', *BMC Public Health* 560, no. 11 (2011); Medicon Valley Alliance, 'Red Cross Health Clinic for Undocumented Migrants', accessed 18 May 2021; WHO Regional Office for Europe, 'Closing the Gap in Universal Health Coverage', updated 9 May 2018; Danish Refugee Council, 'Denmark – New Hotline in 25 Languages about Coronavirus', European Web Site on Integration, updated 6 April 2020; Danish Health Authority, 'Nye oversættelser af information om ny coronavirus', updated 29 July 2020; Esperanza Diaz et al., 'Situational Brief: Migration and COVID-19 in Scandinavian Countries', Lancet Migration, 18 December 2020; Statens Serum Institut, 'Borgere med ikkevestlig baggrund udgør 9% af Danmarks befolkning men 18% af de COVID-19 smittede', updated 7 May 2020; Anders Byskov Svendsen, 'Pia Kjærsgaard tordner efter stigning i coronasmitte blandt indvandrere: "Luk ghettoer"' DR, updated 5 August 2020; Martha Sif Karrebæk and Solvej Helleshøj Sørensen, 'Covid-19 Exposes Language and Migration Tensions in Denmark', Language on the Move, 9 September 2020; Mikkel Haderup Larsen and Merlin Schaeffer, 'Healthcare Chauvinism during the COVID-19 Pandemic', *Journal of Ethnic and Migration Studies* 47, no. 7 (2020): 1455–1473; European Web Site on Integration, 'Governance of Migrant Integration in Denmark', accessed 18 May 2021; European Web Site on Integration, 'UNHCR Urges Denmark to Change Refugee Policy', updated 11 January 2021; Amnesty International, 'Denmark: Hundreds of Refugees Must Not Be Illegally Forced Back to Syrian Warzone', updated 26 April 2021; Amnesty International, 'Denmark: Plans to Send Asylum-Seekers to Rwanda "Unconscionable and Potentially Unlawful"', updated 5 May 2021.

5 Addressing Future Health Vulnerabilities

The COVID-19 pandemic has shined a light on migrants' triple vulnerability: disproportionate exposure to disease, root causes of health problems, and barriers to accessing health services. The pandemic has deepened these disparities and may threaten migrant integration and participation in society. Yet, this time of renewed awareness of health inequalities provides a unique opportunity to tackle these structural issues. With COVID-19 likely to reshape health-care systems in Europe and worldwide, policymakers must ensure that these structural changes accommodate the complex needs of diverse populations. The pandemic has triggered or accelerated different trends and developments that could push these discussions in a promising direction. These include:

- **The migrant integration–migrant health nexus: toward a Health in All Policies approach.** One interesting development emerging from the pandemic is the increased awareness of how health affects a variety of other policy areas. The pandemic has highlighted once more how structural inequalities in society and lack of inclusive migrant integration policies cause severe health disparities, not only for COVID-19 but also for other health conditions. The pandemic has exacerbated these root causes of health issues, especially for migrants. Without timely action, these increased

inequalities will undermine migrant integration. Health problems create obstacles to labour market integration, education, and active participation in society. Yet, policy debates often ignore the migrant integration–migrant health nexus. The increased awareness fuelled by the pandemic provides an excellent opportunity to shift to a Health in All Policies framework, which takes into account the links between health and other policy areas and tackles the root causes of health problems. Through this approach, health promotion and disease prevention could reduce migrant health problems and result in more long-term, cost-effective strategies reflecting the reasoning that prevention is better than a cure. Promoting health will, in turn, enable migrants to successfully participate in the labour market and in society, potentially reducing their dependence on social welfare and increasing tax revenues.

- **Taking an intersectional approach to the mainstreaming of migrant health.** Policy debates on health disparities often focus only on migrants' legal status, socioeconomic status, or on ethnicity and race. The pandemic underscores the diversity of health vulnerabilities and needs within and across migrant groups. An intersectional approach that considers different structural fault lines of inequality would help to disentangle root causes of health disparities and to identify specific at-risk populations. The trend to mainstream specific goals across policy areas fits neatly with the goals of the Health in All Policies approach. Mainstreaming migrant health would move away from a target-group approach and toward a needs-focused approach, thereby making room for an intersectional strategy that effectively meets the wide range of health needs within immigrant populations. Yet, policymakers must ensure that mainstreaming does not become an excuse to ignore health challenges that are more common among migrants than the general population. To accommodate a population's diverse needs, knowledge and sensitivity to the specific health needs of different groups within a society are essential. In short, a needs-based rather than group-based approach would consider migrants' specific needs and avoid treating migrants as a uniform group.

- **The opportunities and risks of digital tools.** Another promising trend is the increased use of digital tools, which may help make service delivery more efficient and less costly, compensate for limited numbers of health-care professionals, and help migrants overcome some of the barriers they face to accessing health care. Digital health tools have played a pivotal role during the pandemic, allowing stakeholders to inform the public of health guidelines, locate and book tests online, and provide virtual health check-ups.[109] The pandemic has accelerated the trend toward digitisation not only in health care but also in the labour market, education, and other areas.[110] Digital health strategies are especially successful at distributing information widely, promoting community engagement, and helping to empower people to adopt preventive measures and healthy lifestyle decisions.[111] Digital tools may also alleviate some pressures on the health-care system. While there is a shortage of medical professionals and pressure on public-health budgets, digital tools can reduce pressure by moving parts of professionals' work online, providing it more efficiently and at lower costs. Digital tools such as live speech translation, which people can download for free on their smartphones, could solve

109 Kimberly Lovett Rockwell and Alexis S. Gilroy, 'Incorporating Telemedicine as Part of COVID-19 Outbreak Response Systems', *American Journal of Managed Care* 26, no. 4 (2020): 147–148.
110 European Commission, 'Digital Solutions during the Pandemic', accessed 14 September 2021.
111 WHO, 'Statement—Digital Health Is about Empowering People', accessed 22 March 2021.

some of the challenges migrants face when accessing services, such as linguistic barriers. Yet, while advancing this digital transformation, stakeholders must attend to the most vulnerable, including migrant and refugee groups. The use of digital tools will only reduce inequalities if stakeholders tackle structural disparities in access to digital tools and digital literacy.

- **Civil society filling the gaps.** Civil-society organisations have played a crucial role in promoting migrant health and integration during the pandemic, either by filling gaps in government policies, serving those left behind by government policies, or through partnerships between government and civil society. Local community organisations may be better able to serve migrant communities because of their awareness of local needs, by providing culturally appropriate outreach, and because migrants see them as a more trusted source of support compared to government agencies. Yet, many potential risks emerge when migrants must rely on local community organisations for essential health services. These organisations often have limited funding and resources, must reinvent the wheel when developing programmes and support for their communities, and are located only in certain urban centres, leaving some vulnerable populations without access to critical services. Structural long-term partnerships with government agencies, promoting effective knowledge-sharing and coordination across civil-society organisations, and sufficient funding could improve civil society's ability to serve migrants' and refugees' health needs. Yet, reliance on civil society should never replace structural government policy; rather, these strategies should be viewed as complementary.
- **Shifting from emergency response to structural, comprehensive policies.** Emergencies have predominantly driven approaches to migrant health, both during the 2015–16 influx of migrants and refugees arriving in Europe and during the global pandemic. Ad hoc and uncoordinated responses result in reinventing the wheel, fragmented and inharmonious approaches, and lack of alignment between national policies and EU international obligations.[112] Short-term funding often supports these responses, without measures to evaluate efficacy and efficiency, resulting in a boom-bust cycle of initiatives with limited opportunities to assess what works and what lessons can be learnt for long-term, effective promotion of migrant health. Migrant health became part of the international and European policy agendas only after a long period, as economic downturns and fading or changing international leadership dampened interest. The economic impact of the pandemic may threaten the interest in migrant health that its proponents have painstakingly developed. Great progress has been made, with important pacts on migration mentioning health issues and research interest increasing dramatically over the past two decades. Yet, mentioning migrant health is not enough; effective long-term policy requires a shift from emergency-driven responses to a comprehensive, dedicated approach to migrant health; measures to promote coordination, harmonisation, and mutual learning across European Member States; and structural evaluation and assessments of what works.

112 Karl Puchner et al., 'Time to Rethink Refugee and Migrant Health in Europe: Moving from Emergency Response to Integrated and Individualized Health Care Provision for Migrants and Refugees', *International Journal of Environmental Research and Public Health* 15, no. 6 (2018): 1100.

A pattern of promising trends in a challenging context emerges. Yet, many questions remain for stakeholders to explore in order to ensure inclusive migrant health in the years to come. Policymakers and researchers should carefully evaluate what can be learnt from ad hoc initiatives that arose during the pandemic and how European societies can leverage these lessons to tackle migrant health vulnerabilities in an efficient, cost-effective way. Civil society and digital tools have played crucial roles in quickly tackling challenges during the COVID-19 pandemic. Policymakers and researchers should carefully study how to incorporate these elements into future health strategies in more structural terms. Yet, these stakeholders should also analyse the risks of these options when migrants may have to rely on underfunded organisations run by volunteers for essential support or on digital tools that may exclude the most vulnerable people due to lack of access to technology or limited digital literacy. Only then may governments hope for more inclusive health services for migrants.

Policymakers and researchers should carefully evaluate what can be learnt from ad hoc initiatives that arose during the pandemic and how European societies can leverage these lessons to tackle migrant health vulnerabilities in an efficient, cost-effective way.

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