Editorial "Health policies and mixed migration – lessons learnt from the 'Refugee Crisis'"

Migration has been swept to the forefront of public debates in Europe. More than anything else, the so-called "refugee crisis" or "migrant crisis" in 2015 has put migration on the agenda. After a short summer of "We can do this!" [1] [1] the momentum has shifted towards anxiety and the panic-stricken determination to "do anything we can to ensure that something like 2015 won't happen again" [2] [2].

Anxiety and panic, quite naturally, tend to blow things out of proportion. Science has the means and the mandate, as the UCL-Lancet Commission on Migration and Health reminds us [3], to be the voice of reason that keeps things in perspective: by checking evidence, by relating it to the bigger picture, and by being mindful and precise about language. In this Special Issue, we want to contribute to reasoned and constructive debates by presenting new evidence, but also by reframing the questions that are being asked about health policies and migration.

What are the lessons that we in Europe can learn from the "refugee crisis"? This question is relevant and urgent, because as long as ecologic, economic, and political crises continue to occur and gross socioeconomic inequalities within and between countries persist, we will continue to see large migratory movements. Technology has irreversibly changed the world. Today, people can access and share information from almost anywhere and within no time; transnational networks for the traffic and trade in information, money, goods, services, and people span the globe; and an increasing share of the world population has the means to travel across countries and continents. It should not come as a surprise if people seize these options to flee violence, political oppression and economic hardship and seek safety in better-off and stable countries. What is needed are sound policy responses to future migratory movements that will improve their outcomes for all parties involved. To this end, it can be helpful to think of a situation as a "crisis" not in the sense of an emergency or a threat, but as a disruption that, welcome or not, has the potential to become a catalyst for long-needed change. This approach allows to appreciate the 2015 "refugee crisis" as an important precedent and opportunity to learn about migration and, importantly, about ourselves. But how and why has this "refugee crisis" challenged us in the way it did?

[1] A. Merkel, German Chancellor, 31.08.2015. The full sentence can be translated as: "We have managed so many things – we will also manage this situation."
[2] A. Kramp-Karrenbauer, successor of A. Merkel as chairperson of the governing CDU (Christian Democratic Party), 11.02.2019. The full statement reads: "We must do anything we can to ensure that something like 2015 won't happen again."

Was it the sheer number of people arriving? Approximately 1.25 million persons sought refuge in 28 EU member states in 2015 [4]. Put into the global context of forced migration, this number is still small. Turkey alone hosts 3.4 million refugees, Pakistan and Uganda host 1.4 million each [5]. The African Great Lakes Region counts 2.7 million refugees, alongside 4.7 million internally displaced people [6] whose health and humanitarian needs are absent from main stream debates on migration. If we look at the larger picture, we must also note that the number of irregular migrants in the EU is dwarfed by "routine" migration. A 2017 EC report recorded 11.8 million intra-EU labour migrants [7]. If some EU states faced "crises of numbers", e.g. overcrowded refugee camps, overstretched services, overburdened bureaucracies, these crises were partly the result of a lack of solidarity among EU member states and their refusal to share responsibilities in sensible and fair ways [8]. Right-wing populists have seized the opportunity to fuel public backlash and overhaul political landscapes. 1.25 million arrivals did not overwhelm our countries; but they taught us a bitter lesson about the fragility of our political institutions.

Was it the sight of the tired, the poor, the huddled masses – not, as usual, televised from an exotic far-away setting, but right here, in our own backyards, train stations, sports halls? Was it the realization that, for better or worse, we are part of an interconnected world? We got used to the joys of globalization. But we are still getting used to the thought that what we do – from governmental decisions, military interventions and arms trade to everyday economic choices, coffee prices and waste disposal – translates into palpable consequences for people whom we used to deem far removed from us. Would we have been as concerned with the conflict in Syria, if no Syrian refugees had knocked on our doors? Or would it have been a couple of fleeting headlines among many others? Would we be able to overlook major ongoing disasters in Yemen and Mozambique as we do, if a million refugees from these countries had washed upon European shores? Things increasingly will "get to us" – which may be a good thing if it teaches us to act with responsibility, locally and globally, if only out of self-interest.

Or was it the complexity of migration as such? The unsettling insight that the people arriving are different? And not only different from "us": different amongst them, with varied migration histories, motives, trajectories and experiences. Different, often, from what we expect. Difficult, therefore, to fit into the pigeonholes that our laws, administrative regimes and minds use to make sense of things, to sort, regulate and process them. If this is the challenge – realizing that the traditional pigeonholes do not fit reality – then the "refugee crisis" is an overdue wake-up call to diversity as an irreversible social fact. A reminder that we must come to terms with all kinds of diversities, not only migration-related ones, and with the confusions and uncertainties that they involve. An impetus to step up the efforts to make our social institutions and policies accommodate these diversities.

Language is one such institution – a fundamental one; and this is where our choice to address "mixed migration" comes in. Taking inspiration in George Box - "all models are wrong [and] the scientist must be alert to what is importantly wrong" [9, p. 792] - we decided that for the purpose of health many commonly used differentiations between the various people comprised under the title "refugee crisis" are neither adequate nor useful. On the contrary, they can be harmful (i.e., "importantly wrong"); e.g. if the "hype" about one group renders other groups more invisible, or if different groups' needs are pitched against each other. We therefore decided that it is a futile endeavour to try and make labels more concise and exact. Instead, we pragmatically broadened the scope to "mixed migration" to be able to capture being-on-the-move in its various shapes and forms. This is not to say that the problem of categorizing migrants can or should always be dodged; these categorizations have very real consequences as they are applied in other domains and translated into stratified rights, resulting also in inequalities *amongst* migrants. Welfare states, international agencies and NGOs – they all categorize, stratify and prioritize, not least to direct support to where it is most needed. It is an everyday practice in which the elemental power of language unfolds. For this very reason, it is crucial to critically reflect on the categorization of people as the biopolitical act that it is: assigning differential worth to different persons' suffering and lives, establishing "hierarchies of humanity" [10, p. 516].

This concerns us all. The "refugee crisis" may have raised tricky questions about social institutions such as welfare states and health systems: Who ought to have which entitlements? Who is deserving for what and why? But these questions have become relevant for all of us and they will gain further relevance in the future, be it for demographic reasons, due to economic crises and austerity, or in view of neoliberal cuts to the welfare state. The "refugee crisis" can help us to face these thorny questions and facilitate open and honest public debates on how we want to distribute our common resources. Beyond formal entitlements and access, the "refugee crisis" has also highlighted issues of informal accessibility and responsiveness of health systems to the needs of marginalized groups. These, too, are important questions; but they should be easier to answer, simply because there is nothing to lose and a lot to gain from making amendments. Improving the accessibility and responsiveness of a health system to diversified needs can yield better outcomes for all [11–14]. By increasing the accessibility and responsiveness of health services we help not only marginalized groups get better care but ourselves. Thus, the question is not whether, but rather how.

Finally, it is important to underline that, alongside challenges and failures, many things have worked well in the reception of and provision for newly arriving migrants. There may be outstanding case-studies and there may be things that just worked without further ado – and for this very reason went unnoticed. One central goal of this Special Issue is to acknowledge positive examples and to offer a platform for sharing and learning from them. This is also a political statement. In showing that it is feasible to implement sensible

health policy responses to migration and achieve good outcomes for all, this Special Issue illustrates that "We can do this!" is not merely a motivational catchphrase or naïve romanticism but an empirical fact. Public health has often taken sides for those at the margins of societies and demanded changes to the underlying causes of health inequities, even if this was politically undesirable. Rudolf Virchow, one of the discipline's founding fathers, himself became a political refugee after his 1848 investigation of a typhus epidemic in Upper Silesia had antagonized the Prussian government. No wonder, as he recommended, inter alia, comprehensive land reforms, public education and voting rights to resolve the problem. To the elite's outrage against his meddling with politics he famously responded: "Politics is nothing but medicine on a grand scale" [15]. Not but least, the "refugee crisis" can remind us of the discipline's roots and basic premises.

David Ingleby's contribution opens this Special Issue on a similar note. It introduces the concept of policy scripts to explain how major contemporary paradigms in public health – like the upstream approach and the social determinants of health movement – could pass by the field of migrant health. The "refugee crisis" is seen, on the one hand, as part of the problem, by leading to a disproportionate focus on short-term emergency responses aimed at displaced populations; on the other hand, it is also viewed optimistically as an important impetus to redress the disconnect.

The two following papers examine implications of the "refugee crisis" from the perspective of national health systems. While the two papers represent different geopolitical and economic contexts, they also pinpoint commonalities. Notably, health system fragmentation and lack of coordination between different actors are described as common problems. Amplifying such systemic weaknesses, the "refugee crisis" represented a strain and at the same time an impulse for health policy reforms. In Greece, economic crisis, austerity, and difficulties to provide for the health needs of the general population form the backdrop of the contribution of Aula Abbara et al. Recounting the geopolitical processes that turned Greece into a "frontline country", the authors explain how challenges in providing for the new arrivals were compounded by pre-existing economic constraints. Reflecting critically on the role of NGOs in filling the vacuums in healthcare provision for both migrant and local populations, they describe that authorities were eventually compelled to implement coordinated policy measures and strengthen local health systems, for the benefit of both migrant and "native" populations. By way of comparison, Karolina Tuomisto et al. explain how the refugee crisis played out in Finland, a destination country with a robust economy, social and health system, including an established separate system for healthcare provision to asylum-seekers. Yet, large numbers of new arrivals in 2015 put the system to the test, exposing how the combination of ambiguous legislation on the one hand and strong decentralization and lack of governance on the other hand led to *de facto* deficits

in healthcare provision. Based on these experiences, policy recommendations include the abolishment of parallel structures for migrant health care.

Three papers of the Special Issue deal with aspects of access to health care: Two studies from Austria describe health needs among asylum-seekers and undocumented migrants, pointing to differential access barriers and care-seeking behaviours; and one paper explores reasons and implications of regional differences in healthcare provision for asylum-seekers in Germany. Judith Kohlenberger et al. present research results on the health needs and healthcare utilization among asylum-seekers in Austria. They point to the central role of structural factors and illustrate how these factors play out differently with regard to different migrant groups. While some barriers apply uniquely to asylum-seekers, others affect all users of the health system, e.g. long waiting times for psychotherapy treatment, information deficits and difficulties navigating the health system. The study thus underscores the potential to create win-win-situations by addressing systemic barriers to health services. In contrast, the study of Yuki Seidler et al. is dedicated to undocumented Chinese migrants in Austria. Based on medical records retrieved from an NGO, it indicates considerable unmet health needs and barriers to health services. The authors highlight the role of NGOs not only as stopgaps where public healthcare provision fails, but also as holders of important information on otherwise unseen health needs in the population. The authors argue for better collaboration between government and civil society, and between science and practice to achieve a better evidence base for health policy-making. Using the example of one federal state in Germany, Kristin Rolke et al. describe how local authorities seize the leeway left by federal law to implement divergent models and strategies to provide access to health service for asylum-seekers. The paper offers insights into the contextual factors and considerations that shape policy choices at the local level, including (contradictory) economic assumptions and local authorities' take on the importance of controlling asylum seekers' healthcare utilization. The authors also describe how, within the given policy frameworks, local gatekeepers use their scope for action to fulfil their role in asylum seekers' healthcare provision in varied ways, beyond exerting control over access and costs.

Three papers are dedicated to mental health and mental health care in the context of forced migration. While the studies follow different methodological approaches, their results are in agreement about two points: a discrepancy between high mental health need and low utilization of mental health services, and the importance of collaborations between different service providers to offer low-threshold mental healthcare and foster continuity of care. A systematic review by Emily Satinsky et al – beyond juxtaposing high mental health needs with underutilization of mental healthcare in refugees and asylum-seekers across European countries - points to a shift of the treatment burden towards other healthcare providers, including emergency care. Summarizing the state of the art on barriers to mental health care, the study notes that no evidence on

interventions to improve access and utilization for forced migrants could be identified. Christoph Nikendei et al. followed up on asylum-seekers with mental health indications after their transfer from a reception centre to communal housing in Germany. In reporting, inter alia, that only half of the participants continued to take prescribed medications and none received the prescribed psychotherapy, the study provides evidence that mental healthcare provided to asylum-seekers stands in no relation to diagnosed mental health needs and lacks continuity of care. The third paper on mental health care by Louise Biddle et al. is an economic modelling study assessing the cost-effectiveness of screening for depression in asylum-seekers in Germany. Its results demonstrate a high probability that such screening is cost-effective, despite data scarcity concerning the different treatment parameters. At the same time, the study allows for insights into the relative importance of these different parameters; namely, in line with the previous two papers, that aspects related to continuity of care are crucial to ensure the cost-effectiveness of the intervention. Based on these results, the authors call for research and interventions to shift the focus from treatment efficacy and psychometric instrument validation to organizational and process parameters.

Infectious disease health services are the subject of the following contribution: A scoping study by Kayvan Bozorgmehr et al. compares the respective services for asylum-seekers and refugees in six EU states, including first-entry, transit and destination countries. The results highlight a lack of standardization and coordination on inter- and intra-state levels that pertain to the provision of health assessments and curative services, data collection, and exchange of health-related information. The authors conclude that improvements in the area of infectious disease services in migration contexts are necessary to ensure critical health system functions including health monitoring and emergency preparedness.

In the final paper of the Special Issue, Valentina Chiesa et al. present the results of a systematic review of the current body of knowledge on health records for migrants, including a typology, an overview over the respective strengths and weaknesses, and the current geographic distribution. Based on the overall evidence as well as examples of good practice, the authors conclude that health records can offer effective solutions for registering and monitoring the health of migrants, in particular in strategic transition settings. Yet they also note that a more definite judgment on the value and viability of health records in migration contexts will require further research on risks and benefits, cost-effectiveness, and the acceptability for migrants and health workers.

When considering the contributions to this Special Issue, it is noticeable that some areas of research, some forms of evidence, and some perspectives are missing from this compilation. Despite our intentions to make room for research on health policies for various migrant groups, the predominant focus is on forced migrants, namely asylum-seekers and refugees. To a certain extent this reflects the very “refugee hype” that

we, editors and authors, ourselves criticized. We deem it an important responsibility of public health research to also bring the health needs of other marginalized populations back to mind, not in the sense of a zero-sum-game, but rather as potential win-win-situations. Furthermore, the contributions in this Special Issue reflect a focus on health services research, while leaving interrelations of health with other social domains unaddressed.

One central objective of this Special Issue was to share knowledge on good practices and successful interventions. Yet, few of the contributions make use of practical examples. The call for the study of good practices, for intervention research, and for research on how to translate existing evidence into policies – including in-depth analyses of political decision-making processes in the realm of migration and health - remains relevant and urgent. It will also be important for practitioners to share more of their practice wisdom with academia and policy-makers. Moreover, we would like to see more research originating from low- and middle-income settings, from migration-sending, "frontline" and transition countries. Finally and importantly, we need to do a better job in doing research not about or for migrants, but with them. Not a single submission to this Special Issue applied participatory approaches or methodologies. Migrants have had the agency, capabilities and the courage to get up and move towards building a better life for themselves and their kin. Engaging them in research is an opportunity to tap into their emic knowledge and thus gain important insights in migration and health research.

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