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Measuring and communicating the real impact of migrants in the receiving societies: the example of health systems

Session 4.B: Communicating data on migration

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Presentation outline

- Measuring & identifying evidence for policy-making
- Why projects like GlobalStat?
- Motivations
- Health inequalities and migration in Europe
- The European welfare systems
- Disentangling the data narratives: UK case of study
- Possible path for evidence-based policy making

Measuring & Identifying Evidence for Policy-Making

By measuring we use data to evaluate progress and development, because statistics:

- are key instruments to quantify, qualify and compare complex processes, structures and situations
- are used to evaluate many aspects of abstract concepts & realities of development
- not only measure, but create reality and impact on behaviour and hence have potential to change paradigms, ideas, and relationships between actors

Identifying reliable evidence and data is hence important as:

- information sources *mushroom* at a hardly traceable speed
- areas, issues and processes affecting individuals *amplify*
- globalisation, sustainable and human development and well-being concepts *go beyond* the global economic interrelations and resource management
- knowledge on diverse developments is relevant to *assess* sustainability, trends in globalisation and human well-being

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Why projects like GlobalStat?

Collecting, structuring and presenting data:

- as independent information sources *deserve promotion*
- to *inform* public debate and decision-making
- to *improve* the *quality* of knowledge and decision-making
- are *essential* to analyse the core concepts and key interrelations in modern politics
- only *slowly* become *more visible* in public domain
- *clarity* and *speed of data access* need to be improved

Data gateways and research projects like GLOBALSTAT are vital to support the public and academic debate

www.globalstat.eu

Motivations

Migration and international mobility are **key challenges** for the modern societies and, together with the adaptation of welfare and, in particular of the health systems, to its new needs, need to be extensively investigated.

Worldwide around **70% of people** still lack social protection coverage (ILO, 2014) and about **400 million people** do not have access to health services (WHO and WB, 2015): among them the most vulnerable result being migrants (OECD, 2017).

In the EU (28 MS), almost 54.4 million citizens reside outside their country of origin, counting for **10.7%** of the total population, equal to approximately 510.3 million people on 1 January 2016, in turn composed for 35.5% of intra-EU migrants and for 64.5% of foreign-born (EPRS&GlobalStat, 2017).

To this we should add the so-called "**refugees crisis**": in the last three years 2014-2016 about 1.8 million people (IOM, 2017), mainly through the Mediterranean and the Western Balkans route, entered the EU ports in an irregular manner.

Health inequalities and migration in Europe

The classic *Economics of Migration*: the European welfare works as magnet as theorized by Borjas (1994,1999) vs Pedersen *et al.* (2008) and Gubert&Senne (2016).

The economic analysis focused on the health needs complexity and the social exclusion formulating the health inequalities and the socioeconomic determinants of health (CSDH, 2008; Marmot Review, 2010).

The **Healthy Migrant Effect** (HME): self-selection and health comparative advantage – time travellers (Razum, 2000; Acevedo-Garcia *et al.*, 2007, 2010).

The **Exhausted Migrant Effect** (Devillanova e Frattini, 2016): goes in the same direction of the *salmon bias effect* (Razum, 2006) and l'*unhealthy re-migration effect* (Razum *et al.*, 2000).

The **acculturation theory** (Jayaweera e Quigley, 2010; Brand *et al.*, 2017): who is a "migrant" (Grosser *et al.*, 2016)?

The European welfare systems

The health coverage granted by the country of residence, together with other factors, contributes to determine the individual **health status**.

The famous division made by Esping-Andersen (1990) among countries on the basis of their welfare systems and mechanism to health systems financing is still central (Thomson *et al.*, 2009):

Country	Anglo-Saxon (liberal)	Bismarckian (conservative)	Southern (family oriented)	Eastern (post-socialist)	Scandinavian (social democratic)
National Health Service (NHS)	IE e UK		ES, IT, MT e PT		DK, FI, NO e SE
Social Health Insurance (SHI)		AT, BE, CH, FR, DE, LU, NL		CZ, HR, EE, HU, LT, PO, RO, SK and SL	
Out-of-pocket payment (OOP)			CY e EL	BG e LV	

Source: Guidi and Petretto (2018, forthcoming)

Relevance of choice of **data & indicators** → The total health expenditure (% GDP) has increased over the past decades in most EU countries – from 7.3% in 2000 to 8.7% in 2016 - while the share of OOP out of THE presents high variability among MS (OECD&WB, 2017).

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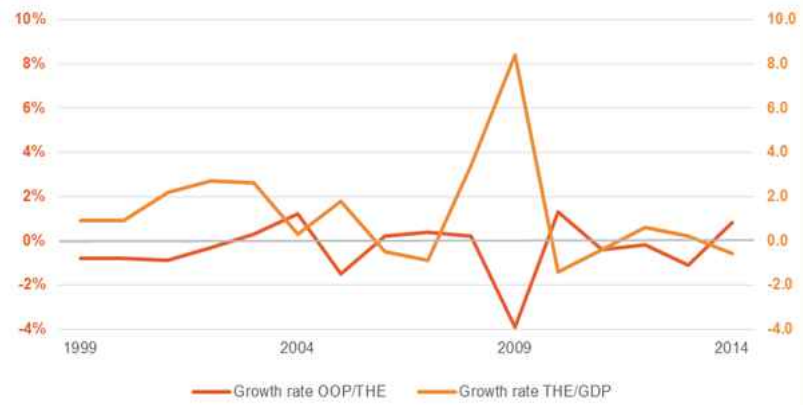
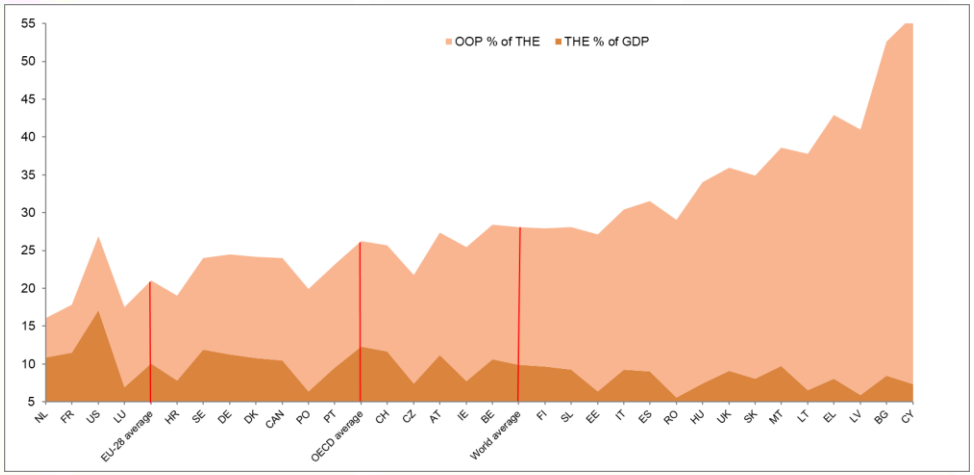
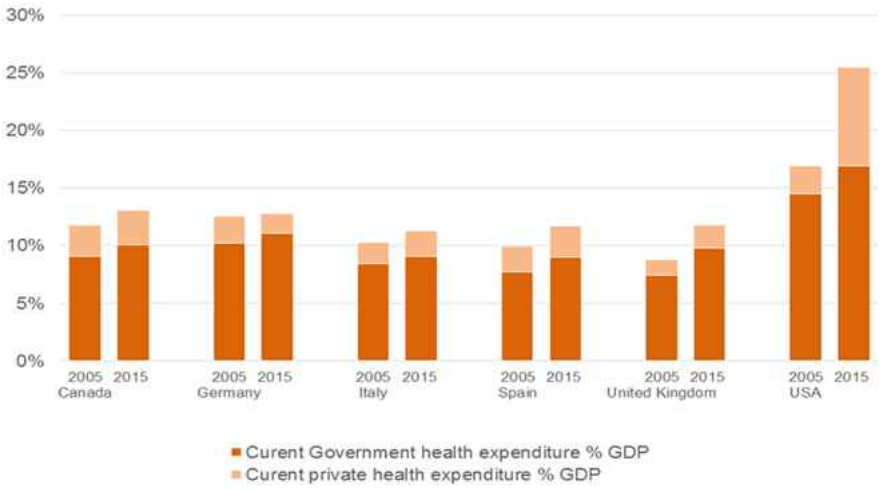
Trends of health expenditure







Source: Guidi and Petretto (2018, forthcoming)

The European welfare systems

Given the **intersectionality of migrants disadvantages**, central are the different integration models adopted - based on the *Migrant Integration Policy Index* - MIPEX (Meuleman and Reeksen, 2008):

Countries	National Health Service (NHS)	Social Health Insurance (SHI)	Out-of-pocket payment (OOP)
Assimilationist	IE	FR, DE, LU, CH	
Exclusionist	DK, MT	AT, CZ, EE, HU, LT, PO, RO, SL, SI	BU, CY, EL, LV
Multicultural	ES, FI, IT, NO, PT, SE, UK	BE	

Source: Guidi and Petretto (2018, forthcoming)

Countries with OOP and exclusionist policies have lower % public HE and ethnic minorities can suffer major health problems: higher risk of mortality and lower level of well-being.

Countries with NHS and multicultural policies, ask to their citizens lower % of OOP taxes contribution granting wider depth of health coverage.

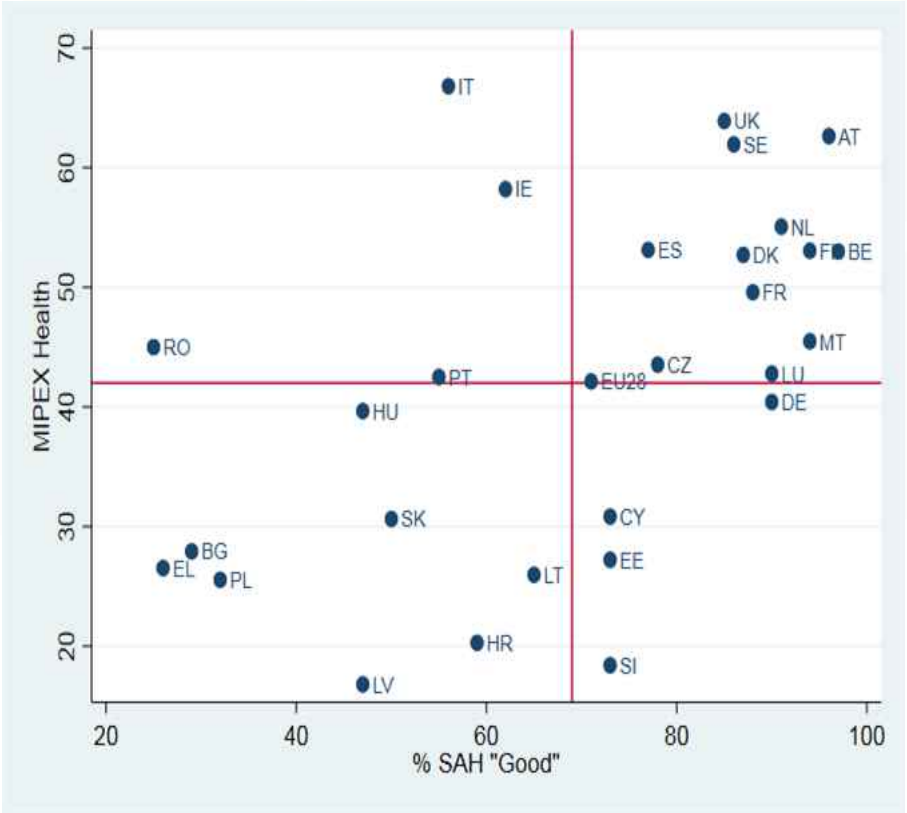
Assimilationist countries, irrespectefully of their health system, suffer health discrimination (poorer health outcome) for the first generation of migrants, but non among their descendants.

The European welfare systems

Common to all:

On the vertical axis the health policies supporting or not the migrants in EU MS are reported (MIPEX Health strand), while on the horizontal axis the % of people that in the same countries replied "*Good"*to the question "*How do you evaluate the overall quality of your healthcare system?*".

Some **country clusters** are emerging: according to the economic and financial peculiarities of their health systems, we show the empirical evidence in adapting to the new health questions of migrant citizens, bringing the empirical evidence of some case studies (Germany, Italy, UK and Spain in the EU vs. USA, Canada).



Source: Guidi and Petretto (2018, forthcoming)

Disentangling the data narratives: UK case of study

Population: 64 mil. of habitants,
12.5% foreign-born population

Public perception vs **reality**: 2/3 of British interviews believed there should be greater restrictions on free movement of EU citizens. Those who wanted more restriction on free movement of EU citizens, ¾ mentioned pressure on public services and six in ten cite people coming to claim benefits as their reason for *Brexit* (IPSOS Mori poll, Oct. 2015).

Beyond the former PM, Cameron, also Boris Johnson (Conservative Party) and Nigel Farage (UKIP) – both "Leave" campaigners - claimed for too much pressures on public services, waiting lists in hospitals and in schools due to migrants.

Despite the fact that it was effect of austerity measures, the majority of people voted for ***Brexit*** attributing the daily cuts to public spending for public services affecting the healthcare provision and hospitals performance to migrant presence and the European Union robbery to UK.

Disentangling the data narratives: UK case of study

How to analyse the real impact of migrants on (British) **health sector** (Rowthorn, 2008)**?**

- Fertility and mortality rates: in 2014 27% (1 in 3) of all babies were born to foreign-born mothers (Office for National Statistics), while in 1996 they were 13%
- Age pyramid and aging process: migrants are mostly concentrated in the working age
- The degree of integration into the labor market: the National Audit Office found (2014) there was a shortfall of 50,000 clinically trained staff, that migrants helped fill
- The length of time spent in the country

Empirical evidence:

- the **cost-benefit ratio** of all migrant groups is higher than that of UK natives (Dustmann e Frattini, 2010, 2014) and migrants have thus largely support the local public finances (Alfano *et al.*, 2016, Wadsworth *et al.*, 2016) but the healthcare rights are based on the **residence status**
- the use of di the use of **specialist**, **outpatient** and **hospital** medicine appears to be lower among ethnic minorities than in equivalent white groups (Steventon e Bardsley, 2011; Wadsworth, 2013) – but not consistent by gender, age, or job specialization (Jayaweera, 2013). Very low the effect on **NHS waiting times**– emergency and outpatient (Giuntella *et al.* 2015, 2016)
- despite these studies don't distinguish between intra-EU and non-EU migrants, on average intra-EU migrants are younger than third country nationals so less likely to use health services (Wadsworth *et al.*, 2016)

Possible path for evidence-based policy making

Openness to public scrutiny and contestation: narratives and power structures emerge from the use of statistics and evidence in politics → the 'post-factual' reality and the risk of politicization.

Development of the institutional capacity to select, evaluate and process evidence: as part of knowledge production process through data warehouse and qualified evidence-based research.

"*Closing the doors of the welfare state*" (Boeri and Brücker, 2005) should never be a solution for European countries. The closure of health sector could generate pandemic emergencies of preventable diseases and create marginalized and excluded individuals, by definition, from health coverage (WHO, 2017).

Institutional requirements to guarantee neutrality of the access to evidence: there is no evidence that in Europe legal migrants, especially the highly qualified ones, are net beneficiaries of social transfers by the state, even though there is a "residual dependence" on transferring to non-contributory character and self-selection of migrants more likely to approach countries with more generous welfare systems (Preston, 2014; Boeri, 2009, *et al.*, 2002).

Moreover, according to Preston (2014), the economic and fiscal equilibrium between the different effects depends, inter alia, on the nature of fiscal and expenditure rules, the pressures of selection processes on the composition of migrants and from the stages of the economic cycle. There aren't "**one size fits all**" conclusions applicable to all countries proofing that immigration is totally beneficial to public finances.

Thanks for your attention!

Comments and observations are welcome to:
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