Migration, health, and ethics

Migration is not a new phenomenon and has always occurred throughout human history. The last two decades have seen a marked increase in international migration, however, in 2017 there were an estimated 258 million international migrants. Armed conflicts, for example in Syria, have spurred migratory movements, with about 66 million people being forcibly displaced worldwide in 2016. Other factors might also have impacted migration rates, for example the European Union (EU) regulations that grant EU citizens the right to move and choose their place of work freely in combination with the eastern enlargement of the EU in 2004 and 2007. Migration is accordingly one of the defining features of our world today.

As patients and healthcare providers, migrants interact with and shape healthcare systems. Migration thereby impacts healthcare provision and poses several ethical challenges. Societies receiving migrants will have to ask themselves how to conduct migration-sensitive health research and public health surveillance as the basis for effective health programs without promoting stereotypes. Another key issue is what level of healthcare should be granted to different migrant groups. It is also unclear how to deal with value differences, especially at the end of life: Migrant families might want to protect patients from bad news (and negative emotional reactions), for example, while physicians see it as their duty to inform patients fully.

The above-mentioned issues have an ethical dimension because they concern the well-being and self-determination of patients and providers, and pose questions concerning the just distribution of healthcare resources and how to deal with value conflicts in pluralistic healthcare contexts. Yet, while in other disciplines research on migration, culture, and health has increased in the last decade, bioethicists have only engaged with the topic to a very limited degree. Based on this observation, the authors organized a week-long workshop on ethical challenges in the healthcare provision for migrants in March 2016. The workshop gave early-career researchers and experts the opportunity to share and critically discuss their ideas and arguments.

When the authors were asked to edit this special issue following from the workshop, the call was intentionally kept broad, allowing workshop participants to share their ideas with a wider audience and more researchers to join the debate. Accordingly, the articles in this issue explore a variety of questions and draw on different discourses. Some contributions ground their analyses on concepts from global health ethics such as cosmopolitanism, others make use of concepts from medical sociology such as health-related deservingness, and still others draw on legal debates. At the same time, the articles center around two topics: Access to healthcare and the accommodation of diverse (presumably culturally formed) needs, beliefs, and wishes in healthcare provision.

Access to healthcare has so far received the most wide-spread attention among bioethicists. This topic may have been of particular interest because the exclusion of some migrant groups from healthcare is a political reality in many destination countries—a re-

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1United Nations, Department of Economic and Social Affairs, Population Division. (2017). International migration report 2017. Retrieved May 5, 2018, from http://www.un.org/en/development/desa/population/migration/publications/migrationreport/docs/MigrationReport2017.pdf
2UNHCR. (2017). Global trends: Forced displacement in 2016. Retrieved May 5, 2018, from http://www.unhcr.org/5943e3a34.pdf
3While source countries of migrants also face intricate ethical dilemmas—for example, the medical brain drain—this special issue focuses on the challenges that arise in destination countries.
4Knipper, M., & Bilgin, Y. (2010). Medizin und ethnisch kulturelle Vielfalt: Migration und andere Hintergründe. Dtsch Arztebl, 107, A76–A79.
5Ilticic, I. (2008). Kulturelle Aspekte bei ethischen Entscheidungen am Lebensende und interkultureller Kompetenz. Bundesgesundheitsbl, 51, 857–864; Wiener, L., McConnell, D. G., Latella, L., & Ludi, E. (2013). Cultural and religious considerations in pediatric palliative care. Palliat Support Care, 11, 47–67.
6We understand bioethics as an overarching term including clinical ethics, public health ethics, global health ethics and possibly further sub-fields.
7Wild, V., Zion, D., & Ashcroft, R. (2015). Health of migrants: Approaches from a public health ethics perspective. Public Health Ethics, 8, 107–109.
8For a detailed overview of the questions discussed during the workshop see: West-Oram, P. G. N., & Gottlieb, N. (2017). International workshop: Healthcare provision for migrants: Comparing approaches to ethical challenges in Germany and the United Kingdom. Clinical Ethics, 12, 76–81.
9Brock, G. (2015). Global justice, cosmopolitan duties and duties to compatriots: The case of healthcare. Public Health Ethics, 8, 110–120.
10Willen, S. (2012). Migration, “illegality,” and health: Mapping embodied vulnerability and debating health-related deservingness. Social Science & Medicine, 74, 805–811.
11See, for example, Cole, P. (2007). Human rights and the national interest: Migrants, healthcare and social justice. Journal of Medical Ethics, 33, 269–272; Dwyer, J. (2015). On taking responsibility for undocumented migrants. Public Health Ethics, 8, 139–147; Hall, M. A., & Perrin, J. (2015). Irregular migrant access to care: Mapping the public policy rati
12Cuadra, C. B. (2012). Right of access to health care for undocumented migrants in EU: A comparative study of national policies. The European Journal of Public Health, 22, 267–271.
ality presumably perceived as painfully unjust by the majority of researchers. In Germany, for example, access to healthcare is limited for groups such as asylum seekers, undocumented migrants and even certain EU citizens. Patients belonging to these groups are generally only eligible for public health services in cases of acute diseases or painful conditions. For undocumented migrants, treatment is de facto limited to emergency care. All health care provided outside of emergency hospital departments needs to be approved by social welfare offices, which have a duty to pass patients’ data on to relevant authorities. Patients accordingly risk deportation when seeking approval. These regulations produce appalling human tragedies, as documented by non-governmental organizations that provide care for those that fall through the cracks of healthcare systems.

The bioethics articles on this topic have dissected the arguments for and against limiting healthcare. A variety of theoretical approaches ranging from global public goods over social responsibility and human rights frameworks to cosmopolitanism were used to argue (mostly) for broadening access to healthcare for different migrant groups. In this issue, three articles are devoted to this topic, building on previous theoretical work.

Ariane Shahvisi’s article brings together the discourses on access to healthcare for migrant patients and the brain drain of medical personnel from the Global South to the Global North. She thereby provides yet another argument for granting migrants equal access to healthcare. Using the UK as an exemplary destination country, she shows first how the National Health Service (NHS) increasingly restricts healthcare entitlements of specific migrant groups for questionable reasons such as incremental savings and political gain. In a second step, she describes the NHS’ reliance on foreign-trained care workers. She also points out what is morally troubling about the current situation: The losses of severely needed health personnel and of financial investments for strained source countries. She then discusses various measures proposed to address the medical brain drain and rejects them as inadequate. By dissecting the NHS’ approaches to these two different migrant groups, she uncovers the inconsistency of upholding a cosmopolitan position that is indifferent toward nationality only with regard to medical personnel. She argues that this partial cosmopolitanism is unfair as it reaps the benefits without realizing the duties that a cosmopolitan approach would entail. Consequently, a more consistent policy that grants (at least) all those living in the UK equal access to healthcare should be installed.

Peter West-Oram’s paper attempts to show how to derive solidarity with refugees from self-interest. He starts from the observation that refugees are often not granted (full) access to healthcare for self-interested reasons: The fear that providing healthcare to refugees (or migrants in general) will increase costs and thereby adversely impact the care of citizens of the receiving nation. He explains that some have proposed motivating people to expand health services for migrants by using arguments that cater for these parochial interests. One example is the epidemiological (or public goods) argument, which points out that health risks for all citizens increase if refugees are not adequately treated. These arguments will, however, only justify access to a rather limited number of healthcare services, such as treatment for infectious diseases. If people were instead to act in solidarity with refugees (understood as a commitment to carry costs for others with whom relevant similarities are recognized), this would result in an adequate expansion of healthcare services. He argues that people buying into the self-interested arguments mentioned above already recognize relevant similarities (health-related vulnerabilities). By acknowledging and emphasizing these similarities in public discourse, health policy-makers can use parochial interests as catalysts for solidarity. He illustrates that such shifts from self-interest to solidarity are indeed possible using policy responses to antimicrobial resistance as examples.

In her contribution, Nora Gottlieb empirically examines the rationales that are invoked to justify the exclusionary policies with regard to healthcare in two exemplary states: Germany and Israel. She shows that it is not just practical concerns such as the costs of healthcare that underlie these policies, but also ethical concepts of health-related deservingness. While Israel grounds deservingness in ethno-national belonging, in the German context membership and contribution to a mutually supportive community is central for deservingness. These moral convictions clash with those that hold that migrants should have equal access to healthcare, often stipulated in human rights or public health ethics discourses. In attempting to move the debate about access to healthcare forwards, this fundamental clash of moral values notwithstanding, Gottlieb provides the following four suggestions for a more constructive dialogue. (1) Acknowledge that different (arguably justifiable) ethical positions may be at play and not simply discard the other’s position as implausible or vile. (2) Make more effort to explain and ground one’s own claims (including seeking the debate with practitioners to tap into their practical moral knowledge). (3) Distinguish clearly between factual and ethical claims. (4) Finally, be aware what role one (as researcher, policy-maker, ethicist etc.) can and should play in the dialog: While researchers can help to clarify factual claims, ethical questions cannot be answered by ethicists alone, but rely on public debate involving all affected by planned actions as members of a political community.

13For elaborations on the healthcare rights of asylum seekers, see Kaltenborn, M. (2015). Die Neufassung des Asylbewerberleistungsgesetzes und das Recht auf Gesundheit. Neue Zeitschrift für Sozialrecht, 24, 161-166. For legal limitations in access to healthcare for EU citizens, see Section 23 Sozialgesetzbuch—Zwölftes Buch (SGB XII). Access issues for EU citizens generally arise when they are not and have not been employed in Germany.

14On the other hand, social welfare offices do not have to pass on data that is submitted by healthcare providers, e.g. for the sake of payment. In these cases, an extension of medical confidentiality to welfare offices is assumed. This allows undocumented migrants to at least access emergency care (which was not the case before 2009 when a new regulation was introduced). See also: Platform for International Cooperation on Undocumented Migrants (PICUM). (2016). Undocumented migrants and the Europe 2020 Strategy: Making social inclusion a reality for all migrants in Germany. Retrieved May 5, 2018, from http://picum.org/wp-content/uploads/2017/11/UndocumentedMigrantsandEurope2020StrategyinGermany_EN.pdf; Husek, S. (2010). Versorgung von Menschen ohne Papiere: "Den Letzten beißen die Hunde". Deutsches Ärzteblatt, 107, 34-35, A1620-A1624.

15European Network to Reduce Vulnerability in Health & Doctors of the World International Network. (2017). Falling through the cracks: The failure of universal healthcare coverage in Europe. Retrieved May 5, 2018, from https://www.aerztederwelt.org/presse-und-publikationen/publikationen/2017/11/08/falling-through-cracks-european-observatory-report-2017

16Prainsack, B., & Buyx, A. (2017). Solidarity in biomedicine and beyond. Cambridge: Cambridge University Press.

17Although one is not labelled as such in her paper.
The second thematic focus is on cultural diversity and the challenges associated with it in healthcare provision. Language barriers and the cultural insensitivity of healthcare providers and hospital policies (among other factors) have been described as barriers to adequate healthcare for various migrant groups, resulting in worse health outcomes. Using Germany again as an example, little has been done at a national level to reduce known informal barriers. Within the German healthcare system, for instance, responsibility for financing and/or organizing translation to support those with limited language abilities generally rests with the (often migrant) patient. Consequently, it is mostly lay people who do the translating more or less appropriately, risking adverse health effects for vulnerable patients. From the perspective of the physician, ensuring informed consent in such situations is nearly impossible. Some initiatives have developed to increase the provision of culturally sensitive and competent care in hospitals, but these are sparse, pushed by a few dedicated individuals and have so far not evolved into political programs or regulations.

One of the most basic normative questions that warrants discussion is whether the receiving society has a duty to accommodate cultural differences, for example by providing translation services. This question has been discussed more thoroughly in philosophy (e.g., with reference to multilingual ballots or exemptions from legal rules) than in bioethics. In bioethics discourses, such a duty is often tacitly assumed, and debates center on how such accommodation should take place. Accordingly, concepts such as culture as a lens to view certain situations, cultural competence and cultural engagement are critically discussed. It is, for example, questioned whether they really further the interests of migrants or risk additional stereotyping and discrimination. The two articles by Yeal Peled and Jo Samanta & colleagues contribute to this growing discussion.

Yeal Peled’s article is concerned with the prominent issue of language barriers and their potentially detrimental effects regarding the quality and equity of healthcare. While language barriers affect healthcare not only for foreigners but for all linguistic minorities, addressing these issues becomes even more pressing against the backdrop of contemporary migration flows. Rendering the often monolingual approach of modern healthcare systems as linguistic epistemic injustice, Peled makes a case for a language-sensitive approach of linguistic epistemic humility and makes suggestions for its implementation in practice. She argues that because the concept of intercultural competence presupposes a substantial familiarity with the patient’s culture (including language), linguistic epistemic humility is a more useful approach. It allows assessment of and response to the health needs of increasingly diverse populations while acknowledging existing uncertainty in healthcare across language barriers.

Jo Samanta and her colleagues argue that the expression of faith-based values and their recognition by healthcare providers within a public healthcare system is a moral right. The authors use a hybrid methodology for their article, attempting to integrate socio-empirical and normative methods. They focus in their analysis on the end-of-life context and draw on an empirical study in which they explored the faith-based values of migrants from South Asia of Muslim or Hindu belief and of their descendants. Participants were asked how they and their loved ones would want to be treated in hospitals at the end of life. With various quotes, the authors illustrate that their participants expected that their religious values and rituals would be respected by healthcare personnel in hospitals. Then, the authors proposed an ethical framework for accommodating faith-based values and needs in end-of-life care for migrants. The framework refers to inclusiveness, integration and embedding as key principles in a national strategy for culture-sensitive healthcare. The terms differ with regard to the levels at which action is supposed to take place. Inclusiveness demands the recognition of diverse religious and faith-based values by healthcare providers. Integration refers to the incorporation of religious and faith-based values into organizational processes. For this step, educational programs, additional resources and alterations in hospital procedures are required. With embedding, the authors demand

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22To give just a few examples from the UK and German context: Razum, O., Zeich, H., Meesmann, U., Schenk, L., Bredehorst, M., Brozoska, P.,... Ulrich, R. (2008). Migration and Gesundheit. Schwerpunkterichter der Gesundheitsberichterstattung des Bundes. Berlin: Robert Koch-Institut; Brozoska, P., Sauzet, O., Yilmaz-Aslan, Y., Widera, T., & Razum, O. (2016). Self-rated treatment outcomes in medical rehabilitation among German and non-German nationals residing in Germany: An exploratory cross-sectional study. BMC Health Services Research, 16, 105; Bachmann, V., Völkner, M., Bösner, S., & Donner-Banzhoff, N. (2014). The experiences of experienced-speaking migrants in primary care consultations. Dtsch Arztebl Int, 111, 871–876; Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T., & de Visser, R. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: A qualitative study in Southeast England. BMJ Open, 4, e012337; Rhodes, P., Nocon, A., & Wright, J. (2010). Access to diabetes services: The experiences of Bangladesh people in Bradford, UK. Ethn Health, 8, 171–188; Jayaweera, H., & Quigley, M. (2010). Health status, health behaviour and healthcare use among migrants in the UK: Evidence from mothers in the Millennium cohort study. Social Science & Medicine, 71, 1002-1010.

23Wissenschaftliche Dienste des Deutschen Bundestages. (2017). Dolmetscher im Rahmen der gesundheitlichen Versorgung: Anspruch und Kostenübernahme. Sachstand. Aktenzeichen: pp. 1–9. Retrieved May 5, 2018, from https://www.bundestag.de/blob/514142/0d03782b88d8d292a2ed12cffd271fde0b/wd-9-021-17-pdf-data.pdf; Spickhoff, A. (2010). Spezielle Patientenrechte für Migranten? Juristische und rechtsethische Überlegungen. In Deutscher Ethikrat (Ed.), Tagungsdokumentation Migration und Gesundheit – Kulturelle Vielfalt als Herausforderung für die medizinische Versorgung (pp. 59–77). Berlin: Deutscher Ethikrat. Retrieved May 5, 2018, from www.ethikrat.org/dateien/pdf/tagungsdokumentation-migration-und-gesundheit.pdf.

24Flores, G., Laws, M. G., Mayo, S. J., Zuckerman, B., Abreu, M., Medina, L., & Hardt, E. J. (2003). Errors in medical interpretation and their potential clinical consequences in pediatric encounters. Pediatrics, 111, 6–14.

25Droste, M., Gön, A. K., Kiefer, H., Koch, E., Naimi, I., Reinecke, H.,..., Wesselman, E. (2015). Das kultursensible Krankenhaus: Ansätze zur interkulturellen Offnung (pp. 1–100). Berlin: Beauftragte der Bundesregierung für Migration, Flüchtlinge und Integration. Retrieved May 5, 2018, from https://www.bundesregierung.de/Content/Infomaterial/BPA/IB/Das_kultursensible_Krankenhaus_09-02-2015.html?view=trackDownload.

26Song, S. (2016). Multiculturalism. In The Stanford encyclopedia of philosophy. Retrieved May 5, 2018, from https://plato.stanford.edu/archives/spr2017/entries/multiculturalism/
the recognition of religious and faith-based values at all levels, especially at the European and national policy levels.

Contributions in this special issue discuss many important questions, but some pressing questions remain unaddressed. While migrant patients are receiving increasing attention from bioethicists, not much has been written on migrant health personnel. To be precise: There are articles discussing the medical brain drain, but there is a lack of articles reflecting on how migrant physicians are to be received and integrated into the healthcare systems of destination countries. This is unfortunate, as empirical studies have shown that migrant physicians as well as the receiving care teams may face many struggles. Furthermore, the question of how to conduct migration-sensitive research has so far not been addressed sufficiently. Social scientists have shown that choosing certain categories (e.g., race or ethnicity) is not normatively neutral. Bioethical work could support health researchers in better reflecting on the design of their studies and how this design affects the circulation of stereotypes and discrimination in particular. While much work still needs to be done, we hope that the five contributions included in this special issue will help to advance the academic debate and also inform political deliberations.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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