CONSENSUS CONFERENCE for establishing a European level Migration Health Database

Pécs, 07-08 October 2019

Drawing together the strands of a consensus on data for migrant health

David Ingleby
University of Amsterdam

General points

General points

- Requirements are changing

Collecting data on migrant health, 1920

General points

- Requirements are changing
- Leaving no-one behind

General points

- Views are changing
- Leaving no-one behind
- Research is as important as data

General points

- Views are changing
- Leaving no-one behind
- Research is as important as data
- What could go into a ‘European database’?

Individual-level (‘raw’) versus aggregated data

- Individual level can be personalised or anonymised
- Aggregate level is always anonymous; summarises individual-level data in various ways
- But this is already ‘research’
- Could be collected in a global/regional level database

Health data	Health-related data
State of health - mortality - diagnoses of illness - self-rated health - well-being - resilience	**Individual characteristics** - type of migration - age - sex - civil state - education - income - occupation
Contacts with health services - utilisation - drop-out - adherence - unmet needs - ‘supply-side’ and ‘demand-side’ barriers to access	**Contextual factors** - migrants’ social position and other social determinants of health - policies inside and outside the health sector

Need for an intersectional approach

- Migrants are not a separate species but a cross-section of humanity.
- Simply being able to disaggregate migrants is unlikely to be sufficient for generating useful research results.
- It may mask important differences, or generate artefactual ones due to confounding by other variables .
- Interactions can be as important as main effects – or even more important.

To link or not to link?

- Is it better to insert health-related information into a database containing health data, or to link the database to a different one?
- The answer depends on financial, legal and practical limitations.
- Linkage allows flexibility in the choice of variables.

Background data on migrants

- To be able to relate migrants’ health status to their living conditions (SDH) requires more than just statistical information.
- It needs an understanding of migrants’ place in the country’s history, why the main groups arrived and when, how their relations with the native-born have developed, etc.
- **Qualitative** data are important for this

Migrant health or **migration** health?

Studying only the health of migrants ignores the effect of migration on other groups, for example:

- Children, grandchildren, etc. born in the destination country (often classified as “ethnic minorities”)
- Family members of migrants left behind in the sending country
- Impact of migration on health service workforce

Are we “leaving no-one behind?

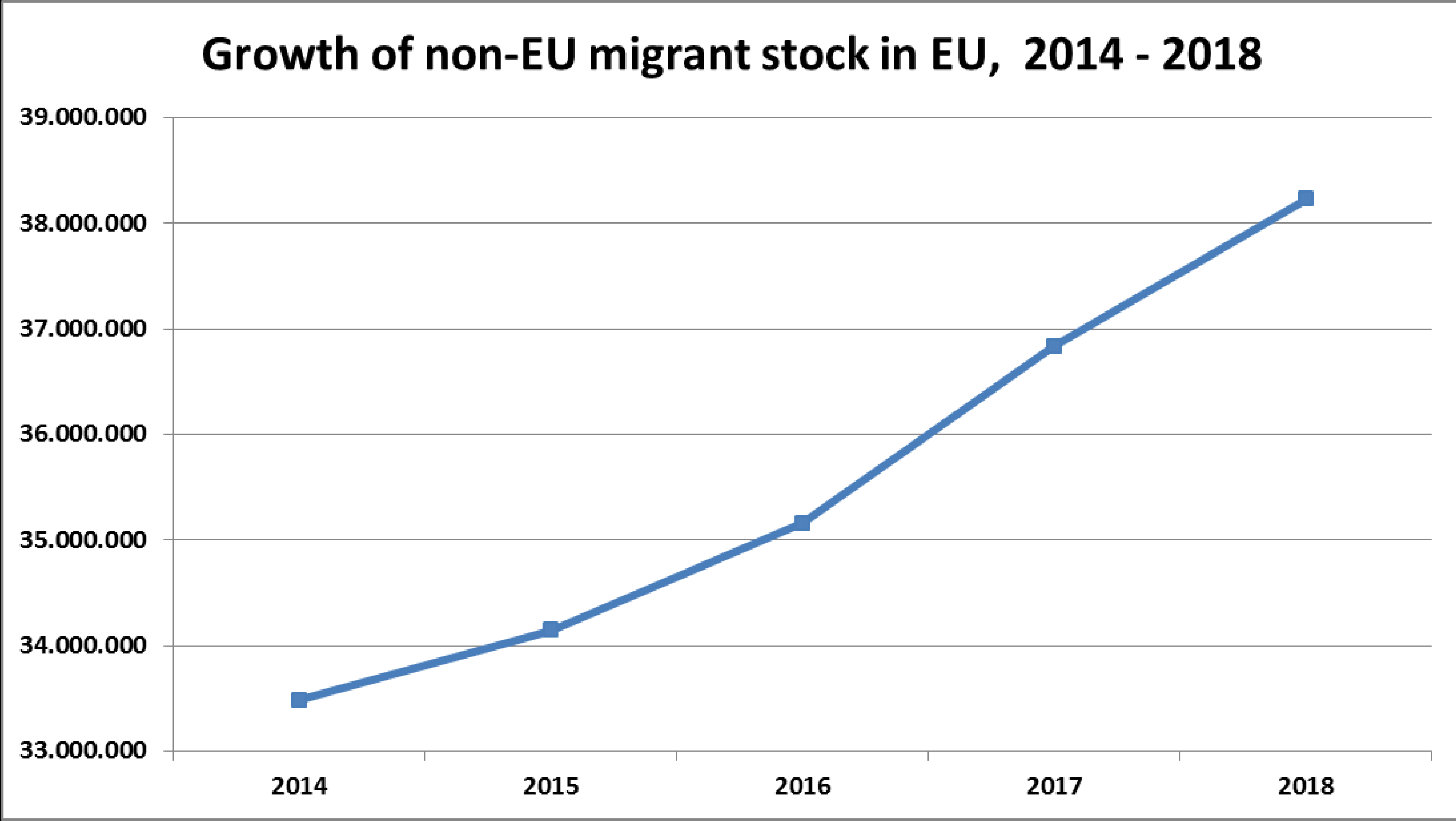
Different types of individual-level database

- ‘Dynamic’ health data for real-time use by health service providers (**medical records**);
- More ‘static’ health data for use by researchers or managers (may be updated periodically).

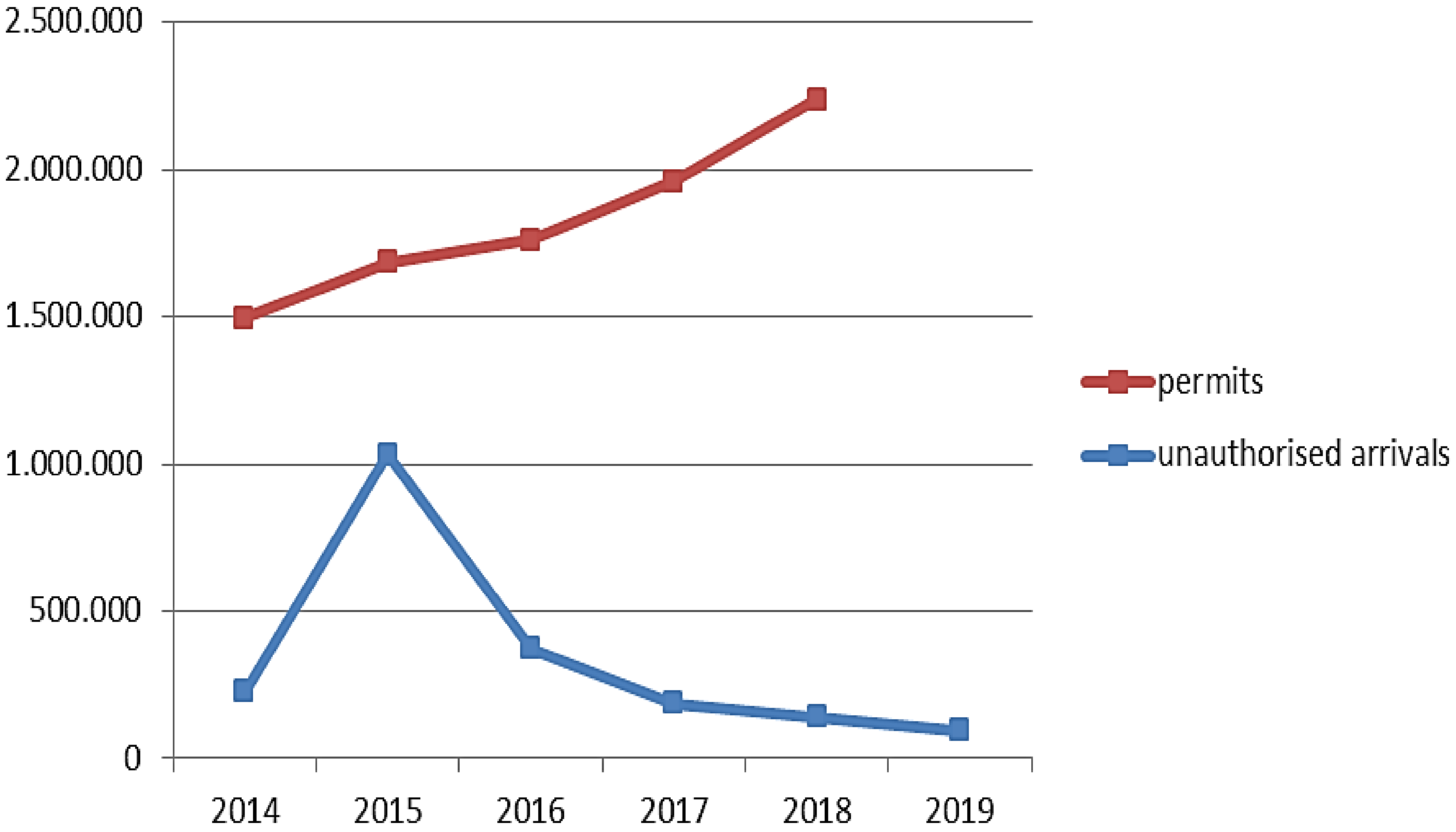
Medical records

- Vital for ensuring safe and joined-up care
- Added value of European database? Harmonisation certainly valuable
- Portable or trans-national records for migrants "on the move" (e.g. IOM's Re-Health project)
- Mainly useful for migrants moving irregularly, but how large a group is this?

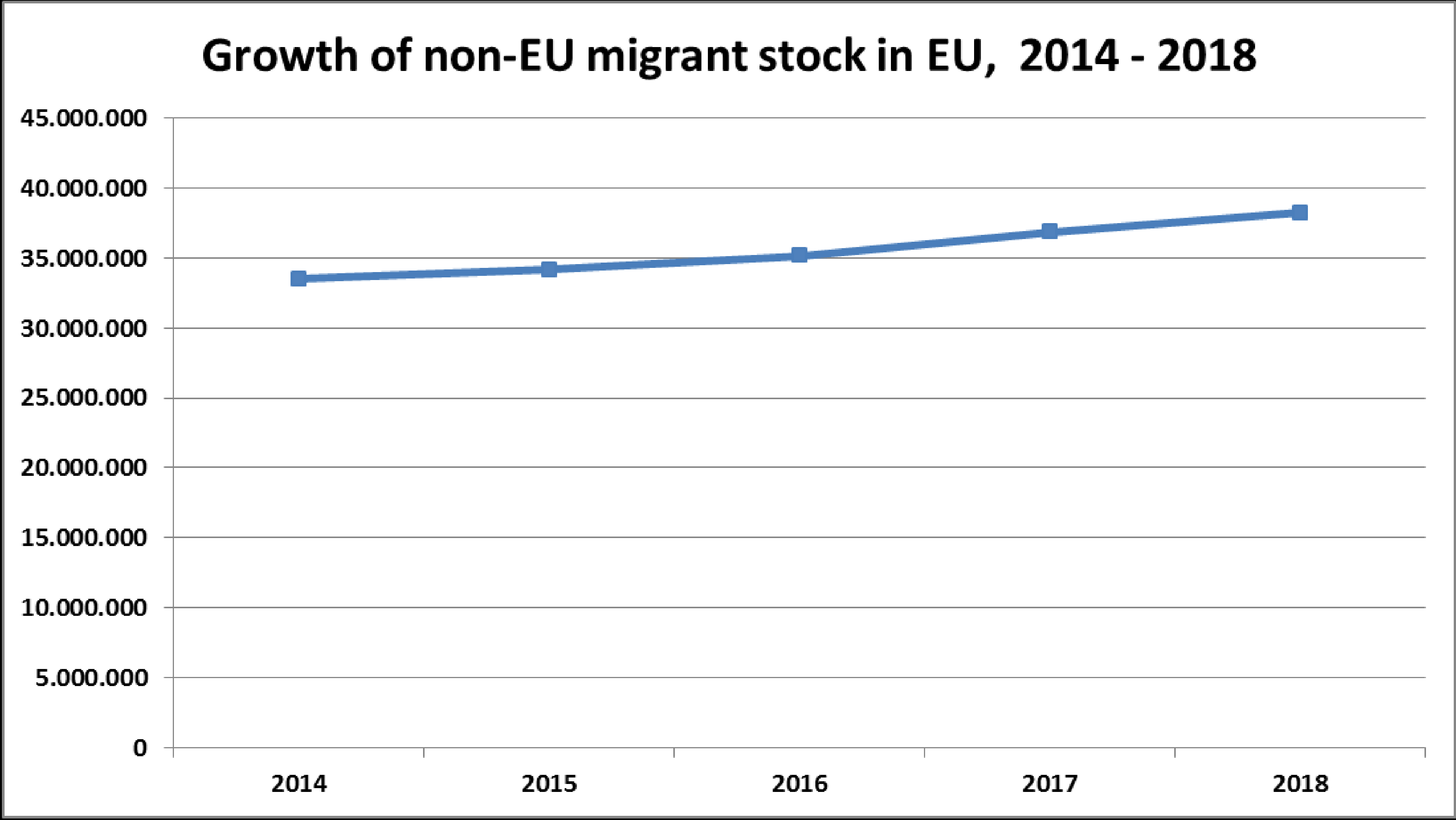
Did the 2015 influx trigger a dramatic increase in migration to the EU?



Unauthorised arrivals versus first-time residence permits issued in EU for family, work and education reasons (valid for 6 months or longer), 2014-2019



Did the 2015 influx trigger a dramatic increase in migration to the EU?



‘Static’ databases for research purposes

- Added value of European database? Harmonisation certainly valuable
- MEHO project (2008-2010) explored possibilities for combining data from different countries
- Stating the obvious: data must include whole population, not just migrants, to identify health advantages and disadvantages. (“Population-based” - see later)

Different sources of information

Based on population registers:
- “Vital statistics”
- Census data (may include questions on health)

Based on sampling of population:
- Surveys
- Data from screening programmes

Based on clinical contacts (NB selection biases):
- Disease-specific registries
- Disease surveillance and notification (DSN) systems

Global data on health and health systems

- WHO Global Health Observatory (GHO)
- WHO Global Health Expenditure Database
- HiT Reports.

All pay insufficient attention to migrants and minorities (especially regarding health status and inclusion in health system). Could a new Euro database rectify that, or should migration be mainstreamed into all WGO Global data?

Measuring inclusive policies:

- MIPEX Health strand (country level)
- TF MED Equity standards (organisational level)

Variations that need to be harmonised

- Who is a migrant?
- Ethnic minorities
- Legal and ethical restrictions
- Variations in level of attention for migrants