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MIGRATION-RELATED HEALTH RISKS

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Abstract. In the countries receiving migrants, their health problems have been paid attention to for a long time. On the one hand, their good state of health has been emphasized (in general, migrants are young and healthy), on the other hand, immigrant population has higher rates of mental health problems than both the population of the host country and the population of the country of origin. In this paper we present selected health problems characteristic of the migration process and behaviour strategies of migrants in case of illness: self-medication, limited contact with the health service in the country of residence and the use of health care in the country of origin. The mass scale of migration indicates the need to include its impact on the overall analysis of public health.

Key words: migration, health risks, public health, health of migrants, migrants' behaviour in disease.

«It's more stressful to be abroad. You think all the time [...] that you can't get sick»
(Czapka, 2010)

1. Health in migration context

Mobility, the movement of large masses of people causes many changes in the lives and functioning of not only communities which they leave and where they settle temporarily or permanently, but also change the functioning of many social structures, causing unpredictable and uncontrollable social processes. This is why John Urry thinks that, in a sense, migration processes set new research tasks and change the existing research preferences, but also generate new problems of social character. According to him, «... *basically, it is the mobility itself, rather than the society that should be at the centre of our attention*...» (Urry 2009: 287). It should be emphasized that the issue of migration and the consequences of migration on health have not yet been analysed according to the space they occupy in the life of whole societies, communities, families and individual actors of social life.

At the same time it should be emphasized that the scale of the phenomenon and the types of movement of population groups in the world

(economic migration, exile, human trafficking) have never had such a global nature, as it has been seen in the last few decades. Currently, there are 244 million migrants in the world (an increase by 71 million / 41% compared to 2000). Nearly 2/3 of all migrants live in Europe (76 million) (Population Facts 2015). It is important that the number of migrants has been increasing rapidly for the last 5 years. Therefore, it is understandable that migration is becoming the area of interest for many research disciplines, which focus on different aspects of migration.

Among the problems of the analysis of migration processes, especially in the cost-profit analysis, public health and the well-being of individual categories of the population, as well as the factors affecting this state have been more and more often the subject of analysis. Unfortunately, in the literature and the analysis of health, the category of people characterised by a high level of mobility, both internal and external migrants is frequently ignored. Although migration processes (emigration, immigration, returns) are observed in varying degrees and recorded in the statistical yearbooks of individual countries, the variable «migration» — is not taken into account in the many available health statistics, including Polish ones.[1] Meanwhile, as it is indicated in the literature devoted mainly to foreign migration, there is a clear relationship between migration and migrants' health, and consequently the health of the population (Migration and Health. 2009). Such analyses include only statistical data and describe the health status of various immigrant groups, but often compare the indicators describing the state of immigrants' health with the health indicators of the whole population of the host country (Harley. 2005), as well as to the population of the country of origin. They are usually conducted in each country (Dunn 2000; Waldstein 2008: 96), but also include larger populations or their individual parts — including the health of migrants in the European Union (Sole-Auro, Crimmins 2008), as well as the health of children and the youth involved in migration (Gonneke, Vollebergh 2008). There are also analyses taking a particular disease and morbidity among migrants and non-migrants into account. (e. g. diabetes, mental health, etc.) (Migration and Health, 2009). There are also individual studies, which undertake the analysis of health including large groups of migrants and refugees, including their origin from different regions of the world (Asia and Oceania, Europe and the Commonwealth of Independent States, Africa and Middle East) and the host country (the United States, United Kingdom, Canada, Australia, New Zealand, and others), gender and age

[1] Poland is not present among European countries, which are active in Migration Health Department in Geneva, although even countries such as Belarus, Bulgaria, Serbia and Ukraine participate. Comp. Migration Health. Annual Report 2006. The International Organization for Migration. p. 10.

(Migration Health 2006: 15). The statistics take cardiovascular diseases, neurological diseases or even multi-diseases into account (Migration Health 2006: 20), but also tuberculosis, HIV / AIDS and chronic diseases, which, according to the researchers, could lead to immigrants' exclusion in the host country (Migration Health 2006: 18). All the cited studies justify a conclusion that migration is a risk factor for health, insufficiently recognised by either migrants' host or sending countries. It should be noted that in many countries, conducting representative epidemiological studies on the health of migrants is impossible due to the lack of full records of migrants or because of the lack of summary records of the population with medical records.

Previous studies on migrants' health, as noted in (Migration Health 2006: 4), are focused on separate diseases rather than on the analysis of their conditions, such as environment, behaviour, socioeconomic status, stage of migration process. However, this does not mean that such variables are completely overlooked. Studies conducted recently in Norway took factors determining migrants' health into account, e. g. the level of education, discrimination experience (at work, school, health care, parallel in many areas of life), as well as age, gender, belonging to migrant and ethnic groups (Migration and Health 2009: 21–25).

Migrants' behaviour in case of illness is a separate issue. However, this is a narrow aspect of the reach area of health aspects of migration and health that is presented in the literature (Carballo, Divino, Zeric. 1998;.Czapka 2010. Hughes. 2007; Zamojski 1995: 30–31). These issues were also reflected in the authors' research (Kawczyńska-Butrym 2008; 2009; 2010 Czapka, 2012). It is particularly worth to note two already cited studies showing the health problem of migrants as a global problem (Migration Health 2006; Migration and Health 2009).

2. Health in the migration context — review of research

Decisions about leaving the country in search of work are usually made by healthy people who are positive about the possibility of investing their physical and intellectual potential to achieve economic success. If you look at the problem from the perspective of migrants' families, you can see that the decisions of migration are made by these family members or those who are delegated by the family who have the greatest potential to find a job in the labour market in a foreign country — e. g. language proficiency, professional competence and also health. This is emphasized by local leaders who express the view that it is most often young active, confident of the success and strong peo-

ple that leave their area.[1] People who choose to emigrate are usually young, relatively healthy, often statistically healthier than both members of the sending and receiving society. It is therefore assumed that the first stage of their stay abroad does not cause major health problems (healthy migrant effect).

On the other hand, as it is shown by numerous studies, migration poses health risks. With the increase of the length of stay abroad, the situation is reversed, and causes the phenomenon known in the literature as «exhausted migrant effect». Moreover, migrants are prone to different stressors, which may result in serious health problems in case of limited access to health care services (Weishaar, 2008). Statistics Norway has found that immigrants are overrepresented in works that pose health risks (Bloom, 2008). Furthermore, immigrants state more frequently than others that they are exposed to accidents at work (Ministry of Labour, 2011).

The earliest results of the health of migrants, who I have contacted, come from the 1940's. The study was conducted in North America, where numerous waves of economic migrants came. Studies have shown that migration is a serious risk of mental health problems. (Minas 1990: 251). The results of many subsequent studies conducted in different countries and in relation to migrants of various origins, including Polish migrants in Australia, confirms this conclusion (Kulmatycki, Łazowski 2005). Also, recent studies indicate that the most common problem associated with migration are mental disorders, including depression symptoms. In addition, it should be emphasized that the frequency of disorders vary, depending on the origin and cause of migration (refugees, especially refugees' children) (Migration and Health 2009: 54). In Sweden, from 1994 to 2001, research on mental health of migrants from former Soviet Bloc showed that their self-reported mental health was worse than native-born Swedes' and that they had higher hospitalisation hazard ratio due to mental diseases (Blomstedt, Johannson, Sundquist 2007). Based on unpublished data from the Polish Embassy in London which reported that 50 of 250 deaths of Poles in 2007 were due to suicide, Lakasing and Mirza stated that post-accession migrants constitute «a community much more vulnerable than first imagined» (Lakasing, Mirza 2009: 138). In subsequent years there was reported a high number of suicides among Polish migrants in England. According to the data obtained from the Consular Section of the Embassy of the Republic of Poland in London, from 2009 to 2012 there were 67 cases in the south of England alone (Smoleń 2013). It must be

[1] The results of the interviews conducted by the author in the Lublin province, 2010. (In preparation)

added that data concerning suicides are often inaccurate and the actual number of suicides can be higher due to incorrect classification of death cases.

The second type of risk applies to somatic health and the loss of physical fitness. The array of health problems is vast, as mentioned earlier. The most drastic events are accident, which have always happened to labour migrants. They have already been described by Polish peasants of America (Thomas, Znaniecki vol. II: 179–180). Indirectly, we also find information on Polish agricultural workers before the First World War. Studies show that during this period not-paying accident insurance for migrants or death benefits for their families was a serious problem. (Plewko, 2010: 38). A huge body of research has documented that post-accession labour migrants experience more accidents at work than nationals (McKay, Craw, Chopra 2006; Connel et al. 2007). Consequently, they tend to occupy low-qualified and high risks jobs (Agudelo-Suárez et. al. 2011). As Schenker argues, migrants' higher rates of occupational injuries could be explained by both difficult working conditions and lack of experience of context that may differ from the ones in their home countries (Schenker 2008).

Different kinds of lethal diseases were also a problem for migrants. It was noted in the case of diseases typical for different climate — what resulted in diseases unknown to European immigrants — which caused a lot of deaths. This was emphasized by the writers of the late nineteenth and early twentieth century, describing a mass exodus to South America called «Brazilian fever» (Motsyk, 2005). Maria Konopnicka in «Pan Balcer in Brazil» signalled that the problem of health risks among Polish emigrants «because the fever is here caustic and vicious, and swept away more than a thousand of our people.» Even in the host country, the health of immigrant children was disturbing. For example, the Ministry of Foreign Affairs of the German Reich stated in the official data of 1928 that in Germany there were about 26 thousand Polish immigrant children under the age of 14. They suffered from diseases and 25–30% of children died by the aged of 2 (Fiedor. 1968).

Currently, the state of health of migrants can be partly explained by the existing barriers in the access to health services, language comprehension, lack of information or financial difficulties, which are recently the subject of a lot of research and attempts are made to mitigate them (Mladovsky 2007). The existing barriers in access to health services are also reflected in research conducted among health care professionals in 16 European states. (Priebe, Sandhu, Dias, et al., 2011). Doctors and nurses often experience those two barriers during their appointments with migrant patients. Studies show that economic aspect plays a sig-

nificant role in the decisions of visiting the doctor for migrants. During the talks with immigrants, especially those whose families remained in the country, it turned out that they do not go to the doctor's and despite being ill, they do not take days-off because they are afraid of losing overtime, for which they receive a significant financial equivalent. «*Here, as you are on a sick leave you are indeed paid 100%, but you do not go home or you don't get overtime hours*.» Therefore, they do not use the right to «be ill.» «*It's more stressful to be abroad. You think all the time [...] that you can't get sick*. (Czapka 2010). This situation leads to the deterioration of health.

The complexity of the situation involving health of migrants is also paid attention to by other authors. Based on their research, you can mention: poor eating habits that lead to a «*digestive problems*,» (Wites 2005), passivity in making the treatment, using self-medication based on the cultural traditions of the country of origin (mainly by women), which may be due to the distance to the culture of the host country. (Nagi, Haavio-Mannila 2008: 96).

Observations and research conducted, among others, among 300 Polish re-migrants indicate, on the one hand, that in connection with work abroad their health condition worsened (11.7%), and that they will not return to work there, because «*there is no need for sick people*» (Kawczyńska 2010/1), on the other hand, that women restrict contact with health care facilities at the time of migration. This is confirmed by their declarations, which indicate that re-migrants were less likely to benefit from medical programs aimed at women during their stay abroad (5%) than after returning to the country (15.8%). (Bryk 2010).

3. Main coping strategies in a state of illness

Even this fairly simplified analysis of migrants behaviour during disease can determine a general scheme of their behaviour in a disease that includes three strategies: self-medication, limiting contact with the health service in the country of residence and the use of health care in the country of origin.

The basic strategy is self-medication, understood as independent efforts to fight the disease in order to eliminate its symptoms. We see in fact that self-treatment is mostly symptomatic, (increased temperature, rash, swelling, diarrhoea, insomnia, pain, etc.). Self-medication is a common, planned before leaving behaviour undertaken by migrants who «just in case», buy different medicines — mostly painkillers, anti-inflammatory, antibiotics and those that are the result of their previous experience of diseases.

The strategy of limited contact with the health service in the country of residence is the result of the impact of a number of interrelated factors. The source of these restrictions may apply to different actors — migrant, the employer, the state.

On the part of the immigrant — some are related to underestimating the symptoms also because of the high concentration on the objective of migration — earnings; others — in the legislative sphere and information: no permission to use care in accordance with international guarantees (e. g. unregistered migrants), or lack of knowledge about their rights, awareness of the high cost of health care, and lack of language knowledge. Many of these barriers are minimized with the passage of time and the stabilization of the immigrant to stay in the host country. It is even observed that the process of integration in the new country is beneficial for health. In addition, it is worth to note the factors limiting the contact of human trafficking victims with medical care. The dominant factor is the isolation of trafficking victims by the perpetrator.

On the part of employers — sending migrants to unpaid holidays in order to make foreign workers use healthcare in the country of origin and re-employing them, after recovering and returning.

On the part of the country of residence — no institutions are prepared to support immigrants (knowledge of the language of larger groups of immigrants — it is compensated employing doctors from their country of origin, the availability of interpreter), restrictions on «foreign», as well as lack of knowledge of and compliance with their culture. For this reason, in the years 2002–2005 in twelve hospitals in several countries bad practices in this area were analysed. Their experiences became the basis of the EU-funded program «Migrant Friendly Hospitals in ethnically diverse Europe. (Migration and Health. 2009: 37) The development and financing of the program indicates that many governments, especially in countries with increased migration realize the consequences of negligence in the treatment of immigrants, especially those who remain in the country permanently. To assure continuity of the MFH movement, a Task Force on Migrant Friendly Hospitals has been established in the framework of the WHO Network on Health Promoting Hospitals. Six working groups have been created: service quality and policy development, staff training and development, intercultural communication, patient and community empowerment, research and evaluation and trans-cultural psychiatry.

Another strategy is to seek health care in the country of origin. The strategy of contact with the health service in the country of origin includes arrivals for the purposes of treatment, rehabilitation and prevention. Polish studies show that migrants from the newly admitted EU

countries «*generally do not benefit from health services in the host country. They repair their health in the intervals between successive stays or after returning from migration.*» (Golinowska 2008: 21). However, this applies to those migrants who have not stabilized their situation in the host country and those for whom the distance to the origin country is not associated with high costs.

Research confirms that stay and work abroad change the behaviour of migrants associated with disease/malaise. Research conducted among Poles in Norway showed a change of behaviour in the country of residence compared to the behaviour of the country of origin (Czapka 2010).

Table 1.

Coping strategies in case of malaise (in percent)

Behaviour	In Poland	In Norway
Go to GP	50	18
I cope myself	58	67
Ask friends	14	18
Wait until I get better	20	28

During their stay abroad more often than in Poland people declared such behaviour as: waiting until the person gets better and independent coping with the disease. This is illustrated in another Polish migrant's statement: «*It happened to me only once here to be ill, I had a backache, but I spread some ointments and went to work anyway*.» However, the largest change concerns the cancellation of visits to the doctor, which is due to the existing barriers in access to health services. With 50% of respondents who declare reporting to a doctor in Poland, in Norway only 18% of patients declared visiting a doctor in case of illness (Czapka 2010). According to international conventions, migrants who are covered by health insurance in one Member State have the right to use the health services in the public system of medical care in other countries which have concluded the agreement, «adequately to the state of health», in which they are. (Czyżewska 2008: 35).

Departures from the country of origin to countries with a mild climate for the purpose of raising the quality of life in retirement is a separate, but a notable aspect of migration processes from the point of view of public health. With time, the country of «sunny climate» hosting wealthy retired foreigners faces challenges for the local health system and care institutions for chronically ill. It is exemplified by the data stating that in 2007, Spain recorded 15,630 immigrants from Norway and that many of them needed health and care services (Migration and Health 2009: 78).

According to Norwegian estimates the number may be even twice as high. Norwegians' seasonal trips to Spain, Turkey and Thailand is compared to the migration of the birds, which migrate to the warm countries in order to survive winter and return in spring. The social situation and the health of this category of migrants is generally more favourable than the situation of the inhabitants of the country of immigration. The strategy of wealthy residents' trips of Western European countries to «warm countries» is not a new phenomenon. Retirees migrated in order to improve their quality of life to attractive places in terms of climate even before the era of railroads (Warnes, Williams, 2006). There are many papers devoted to the migration of retired British (King, Warnes, Williams, 2000). For example, in the province of Alicante, in a 20-thousand town of Alfaz del Pi, over 50% of the population are foreigners, most of whom are immigrants from the UK, followed by the Netherlands and Norway.

4. Conclusion

The paper allowed identifying the areas of health threats for migrants. Special attention should be paid to mental health, which is emphasised by a number of authors. Hard work below one's qualifications, especially in case of post-accession migrants, separation from the family and social isolation contribute to the development of mental disorders such as depression, which translates to overuse of alcohol and other disease units, which may trigger suicidal attempts.

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