

The refugee crisis challenges national health care systems

Countries accepting large numbers of refugees are struggling to meet their health care needs, which range from infectious to chronic diseases to mental illnesses

Philip Hunter

One aspect of the current refugee crisis that receives little media coverage is the health care need of refugees and migrants and the concomitant public health challenges faced by the various countries along their road to safety. These problems are substantial in particular for countries that have had to deal with large numbers of refugees. Lebanon is the most extreme case: its population has increased by about 25% to almost 6 million at the start of 2016 owing to the influx of refugees, which includes around 1.1 million Syrians, according to the United Nations High Commissioner for Refugees. Many refugees suffer not only from infectious, communicable, non-communicable or chronic diseases, but also from severe mental health problems owing to stress and traumatic experiences.

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And yet, the full health effects of the greatest mass migration since World War II will only become clear many years down the line, according to Anders Tarnell, from The Public Health Agency of Sweden, which, along with Germany, has admitted a majority of the refugees reaching Western Europe. Tarnell added that it would also take time

even to assess the relative fates of different migrant groups according to their origin, experiences and destination. Studies of past migrations confirm Tarnell's view: the traumas and hardships experienced by migrants often have an impact years later, reflected in higher incidences of non-communicable, chronic diseases such as type 2 diabetes. A recent study based on 1,550 households comprising at least one refugee registered with UNHCR showed that more than half of Syrian refugee households in Jordan reported a member with a non-communicable disease [1]. A total of 780 households reported one or more members previously diagnosed by a health provider with one of the five non-communicable diseases included in the survey, hypertension, cardiovascular disease, diabetes, chronic respiratory diseases and arthritis. No overall comparison is given with all-Jordanian households that do not have any refugees, but the study indicated that in 2015, 15% of Jordanians suffered from hypertension and 8% from diabetes, while the corresponding figures for refugees are 29.9% and 18.3%. The clear implication was that NCDs are significantly more prevalent among refugees.

Among adult refugees, hypertension was the most common NCD, followed by arthritis, diabetes, chronic respiratory diseases and cardiovascular disease. This reflects the results of other studies of past large-scale movements of people, including one looking at immigrants from Cambodia to the USA, which found that health outcomes are also shaped by the environmental factors in the destination countries, along with the cultural dislocation [2].

That same Cambodian study also found widespread mental health problems—with a 41% incidence of depression—which has been mirrored in other findings from the mass migrations in the Middle East and Europe. The full scale of the mental health problem has only recently been recognized in Germany, where at least half of all refugees suffer from some form of definable mental illness according to a report by the Federal Chamber of Psychotherapists (BPTK) in September 2015 [3]. Of these, 40–50% suffer from post-traumatic stress disorder (PTSD) and 50% from depression, frequently both. One in five children suffers from PTSD. Psychotherapy had so far been given to only 4% of all mentally ill refugees, which provoked BPTK president Dietrich Munz to call on psychotherapists to lobby for expanding treatment for refugees in need.

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Nonetheless, migration by itself is not a major risk factor for mental illness, according to Santino Severoni, Coordinator of Public Health and Migration at the WHO Regional Office for Europe. “Evidence shows that the very fact of being a refugee is not the

most significant criterion for the potential risk of mental disorders”, he said. “However, refugees can be exposed to various stress factors throughout the journey that may negatively impact their mental health status, including pre-migration factors such as persecution and economic hardship, migration factors like physical danger and separation, as well as post-migration factors including detention, hostility and uncertainty. For these reasons, the most important strategy for reducing the risk of mental disorders among refugees once they have arrived in the host country is the provision of general support in order to meet their basic needs, ensure safety, acceptance and social integration. Inclusion into the national education system is especially important for refugee children and adolescents”.

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If untreated, mental health problems can pre-empt physical health issues, especially chronic inflammatory conditions and NCDs. This was shown, albeit indirectly, in a study of Iraqi refugees that found a higher-than-average incidence of neurological disorders, especially among those who had been tortured [4]. Another more recent study of immigrants in the Czech Republic supported the general conclusion that factors associated with mental well-being led to a progressive deterioration in the health of migrants [5]. Severoni commented that it is therefore essential to take measures that improve the quality of life for refugees in the longer term after they have settled in their eventual destination. “Despite responding to the short-term public health implications with strengthened epidemiological surveillance capacity, reinforced health information collection systems, appropriate immunization programmes, proper evidence-based public information, and so on, the broader social and economic issues related to employment, inclusion and well-being over time must also be addressed”, he said.

The WHO has started to address the problem, at least in Lebanon, where it is working with Lebanon’s Ministry of Health to provide Psychological First Aid training at 30 primary health care centres in the country and trained 62 health care staff during 2014 (http://www.who.int/hac/crises/syr/sitreps/syria_regional_health_sitrep_january_2015.pdf). This was part of its Mental Health Gap Action Program (MHGAP), to improve diagnosis and early treatment of mental illnesses among people in low- and middle-income countries. WHO also noted that language barriers are a particular handicap for treating mental illness not only in Lebanon but also in Jordan and Turkey. Long-term rehabilitation of severely traumatized patients was a major and escalating challenge for the already-overburdened Turkish health care system; to help tackle this, WHO has been training 35 mostly Turkish fieldworkers in Arabic in collaboration with International Medical Corps, so that they can communicate better with refugees from Syria.

Understandably, though, mental health issues have been trumped by more immediate threats in Syria and the neighbouring countries, after a particular health crisis arose in Lebanon in July 2015 following the closure of the country’s main landfill and the government’s failure to find an alternative. With rubbish piling up across the country, the WHO noted an increased risk of diarrhoea and other hygiene-related infections, as well as food poisoning, all of which are likely to escalate as temperatures rise during the spring and summer of 2016. Meanwhile, there is a particularly pressing need to protect both refugees and many Lebanese from viral hepatitis, according to the WHO. Equally urgent is the need to increase access to safe drinking water.

Along their journey from war-ravaged Syria to the relative safety of refugee camps in Lebanon, Jordan or Turkey, across the Mediterranean Sea to Greece or Italy, through the Balkans to Austria and Germany and further North to Sweden, migrants face a variety of different conditions that impact on their health. Those ending their journey in Germany or Sweden are likely to be better off than the larger numbers in refugee camps in the Middle East, on the road through the Balkans or those left behind in the country of origin,

especially in the case of Syria. Thus, the starting point for addressing refugee health in the current crisis must be the countries of origin and the immediately adjacent countries that bear the brunt of the refugees. Nada Al Ward, the coordinator of the WHO’s Emergency Support Team in Amman, Jordan, has therefore called for more financial support for health care for the countries nearby and Syria itself. While funding had indeed increased, it had nonetheless failed to keep pace with the rapidly escalating needs resulting from the great numbers of people fleeing Syria and Iraq.

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According to the 2016 Humanitarian Needs Overview (HNO) compiled by UN agencies (https://www.humanitarianresponse.info/en/system/files/documents/files/2016_hrp_syrian_arab_republic.pdf), 11.5 million people in Syria are in urgent need of health care, including 4.5 million out of the 6.5 million who have been internally displaced. As Al Ward pointed out, funding was inadequate during 2015 not because there were any unexpected health requirements but because of the numbers of people involved, coupled with the difficulties of reaching people in battle zones. This shortfall was also highlighted in the WHO’s Regional Situation Report for December 2015 (http://www.emro.who.int/images/stories/syria/WHO_SitRep_December2015.pdf?ua=1), which noted that over the year only 29% of the US\$369 million requested for medical funding as part of the UN’s Regional Refugee and Resilience Plan (3RP) had been met, and only 44% of the \$317 million for the 2015 Strategic Response Plan for the Syrian Arab Republic. This is not taking account of the mental health equation, which has not been costed yet.

Among the neighbouring countries, refugees in Turkey often find better conditions and health care than those in the nearby Middle Eastern countries, although there is some dichotomy between those in camps and those living in local communities.

Turkey has the world's largest number of Syrian refugees at about 2.5 million, but only around 10% of these are in the government-run camps where access to health care is good. The country acted to reduce the gap between those in camps and those outside by making free health care available to all refugees as of September 2013. However, this did require a 20% contribution towards pharmaceuticals, which meant that in practice many could not afford the drugs for their treatment.

Many refugees, for whom Turkey is only a transit country from where to cross the Mediterranean, failed to reach their destination and have been detained on route, often ending up in substantially worse conditions. In 2014, migrants detained in Greek detention centres suffered as a result of poor conditions associated with prolonged detention, according to Médecins Sans Frontières (MSF) (http://www.msf.org.uk/sites/uk/files/invisible_suffering_2014.pdf). This resulted in high incidence of various respiratory, gastrointestinal, dermatological and musculoskeletal diseases, as well as anxiety and depression; about a year later, Greece began to close these centres. Ironically though, the UK, France and Germany called on the EU to re-establish migrant detention centres in Greece and Italy in September 2015 to stem the tide of migrants by separating supposedly genuine refugees—who would be allowed to stay—from economic migrants—who would be returned home. At the same time, the EU was negotiating its controversial agreement with Turkey, concluding in November 2015 (<http://www.euractiv.com/sections/global-europe/eu-and-turkey-agree-eu3-billion-refugee-deal-319929>) with a deal under which Turkey agreed to take measures to stem the flow of refugees to Europe in return for unfreezing Turkey's EU accession negotiations and a €3 billion down payment, with the understanding that more money would follow.

Meanwhile, the exodus into Europe continued almost unabated during the winter of 2015/16. At least 55,652 migrants and refugees arrived in Europe by land and sea routes during the first 27 days of 2016 (https://www.iom.int/sites/default/files/situation_reports/file/europe-mediterranean-migration-crisis-response-situation-report-28-January-2016.pdf), according to the International Organization for Migration (IOM). This included 45,361

crossing into Greece by sea. Large numbers have continued moving northwards into Europe; the former Yugoslav Republic of Macedonia registered a total of 436,607 migrants and refugees between 19 June 2015 and 27 January 2016. As of 27 January, 619,847 migrants and refugees had been registered in Serbia, arriving at an average rate of 1,628 during the early days of 2016. In Croatia, 611,972 migrants and refugees were counted entering between 16 September 2015 and 27 January 2016.

This has naturally strained health services in those countries, according to the IOM, which has provided among other measures interpreters to assist during medical interventions. Because of unmatched demand for this service, IOM has had to hire additional Arabic speakers to assist. Similar cultural issues have been faced in the wealthier nations where many refugees have found asylum, such as Germany and Sweden. As Peter Daneryd, a co-director of the Swedish Forum for Health Policy, noted, shortage of professional interpreters has impaired provision of health care there. An additional issue has been the attitude of politicians, who according to Daneryd have acted in denial and refused to acknowledge the scale of the health care challenge. "Too many politicians fear to bring up the issue as they fear the reaction from the nationalistic party", he said. "Many of us thought leaders from the medical profession that are not politically involved think this political behaviour is unethical".

Of course, Europe has plenty of past experience of migrations it can call on, including some studies on health care impact. The difference, though, is the unprecedented rate of migration this time, which has tempered the initial optimism over the continent's ability to absorb refugees harmoniously and humanely. Indeed, mounting concern over providing adequate health care for the fast-growing numbers of migrants triggered an Expert Opinion from the European Centre for Disease Prevention and Control (ECDC) in September 2015, just a month after it had been requested by the EU (<http://ecdc.europa.eu/en/publications/Publications/Expert-opinion-irregular-migrants-public-health-needs-Sept-2015.pdf>). This left little time for new research or feedback from the field, so the recommendations were largely general, including disease surveillance, vaccination and hygiene. The Expert Opinion also included syndromic surveillance

looking for signs such as bloody or watery diarrhoea indicative of a specific disease, which can then provoke further assessment. Soon after that major assessment, the ECDC was compelled into producing an emergency report at even shorter notice by a case of malaria in Sweden (<http://ecdc.europa.eu/en/publications/Publications/risk-malaria-vector-borne-diseases-associated-with-migrants-october-2015.pdf>). This report suggested that there were bound to be more cases of malaria among European migrants and that surveillance should therefore be stepped up, particularly in southern countries during the summer, where the potential for onward spread by vectors is greatest.

One lesson of past migrations is that regardless of your moral position, restricting health care is economically counterproductive. During the 1990s, Germany tried restricting access to health care for refugees from the Balkans in an attempt to reduce their numbers. This did not work out well according to a recent study of migration into the country over the two decades from 1994 to 2013 [6]. The study found that annual health care costs were substantially higher—on average by €375 per person per year—among migrants with delayed access to health care than those who had immediate access. The obvious conclusion was that the cost of treating conditions as a result of delayed access outweighed the savings made by not providing immediate access.

Another clear if rather obvious lesson from the past—and one acknowledged in the ECDC's Expert Opinion—is that migrants should not be lumped together from a health care perspective. Another report from the US Centers for Disease Control and Prevention noted that Iraqis, for example, are more prone to type 2 diabetes than other groups, so it may be worth screening migrants from that area more thoroughly for general signs of metabolic disorder. Iraqis are also more susceptible to hypertension (<http://www.cdc.gov/immigrantrefugeehealth/pdf/iraqi-refugee-health-profile.pdf>). This may reflect epigenetic factors associated with their recent history rather than inherent genetic dispositions, but either way should be taken into account.

There are other risks for migrants who have safely arrived and settled in their destination country including the prevalence and

temptation of less healthy habits, such as heavier alcohol consumption, smoking or unhealthy nutrition. For large numbers of migrants, though, facing such long-term risks in a developed European nation might be seen as a sort of luxury. For the immediate future, any solution to the whole migrant crisis must address the political dimension, which will achieve more than anything WHO, MSF or any other NGO can do on their own. The greatest efforts however are not needed for European countries but to create safe havens either in Syria itself or over the border in Turkey, Lebanon and Jordan. Even if a political solution emerges, providing adequate health care for millions of refugees all over the Middle East and Europe will remain a major challenge for many countries where large numbers of

migrants have settled after their long and arduous journeys.

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