

THE RIGHT TO HEALTH OF LOW SKILLED MIGRANT WORKERS



BACKGROUND

The social and economic characteristics of low skilled migrant workers are the most significant determinants of their health. The poor and unequal conditions under which they migrate, live, work and age have a fundamental impact on their health. Migrant Forum in Asia (MFA) has been advocating for the protection and promotion of migrants rights for many years to address rights violations, which are largely responsible for the conditions that create and contribute to their ill health. MFA began specifically calling for action to address migrant workers health under the rubric of Right to Health in 2002.¹

Migrant workers and their families, like every human being, have a fundamental right to enjoy the highest attainable standard of health. Achieving this requires a human rights approach to health identified by the International Covenant on Civil and Political Rights as reframing basic health needs as health rights. Thus becoming healthy and sustaining it is not merely a medical, technical or economic problem. Rather a question of social justice and concrete governmental obligations to individuals within their jurisdiction concerning maternal, child and reproductive health; healthy workplace environments; prevention treatment and control of diseases; and health facilities, goods and services.²

The right to health is enshrined in a number of international human rights covenants.³ Many of the provisions are recognised as applicable to all migrants, regardless of legal status. The right to health contains a broader concept of health apparent in the preamble of constitution of the World Health Organisation (WHO), which conceptualizes health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. The right to health concept of health includes both the right to timely preventative, curative and rehabilitative healthcare and the right to a

standard of living adequate for health. The latter corresponds with the public health principle that health status is influenced by a number of socio-economic factors that are generally accepted as falling outside the confines of clinical curative medicine. Healthcare alone is inadequate for improving migrant workers health given the importance of social economic and political factors in influencing their health outcomes i.e. the social determinants of health. Migrant workers’ right to health thus encompasses and is dependant on realisation of economic, social, cultural, civil and political rights.

Where migrant workers are situated in the social structure of sending and receiving countries in terms of class, institutional racism, discrimination, exploitation, power, wealth and sexism is responsible for the social injustice that contributes

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to their unequal patterns of illness, disability and premature death. E.g. high skilled migrant workers have greater access to healthcare than low skilled workers. Domestic workers are excluded from occupational health and safety legislation.

The Commission on Social Determinants of Health (CSDH) was established to support countries and global health partners in addressing the social factors leading to ill health and inequities (2005 –2008), largely neglected migrant workers. Despite their growth in number and the substantial contributions made by labour migrants to both countries of origin and destination, migrants health rights are often overlooked and marginalised leading to health inequity. This was recog-

nised by the Sixty-First World Health Assembly Resolution on the Health of Migrants (2008), which called upon participating nations to “promote migrant inclusive health policies and promote equitable access to health promotion and care for migrants”. However it did not emphasise the importance of addressing underlying health determinants.

The progressive realisation of the right to health for low skilled migrant workers requires:

1. Their inclusion in healthcare services without discrimination in both countries of origin and destination through equitable and timely access to affordable quality healthcare and safe essential medicines⁴. Also the development of continuity of care across borders and social protection towards enabling them to enjoy the highest attainable standard of health.
2. Participation of low skilled migrant workers is fundamental in setting priorities and developing procedures and policies for their right to health.
3. Advocacy for the promotion and protection of migrant worker rights is essential for their right to health. Migrant workers health inequities are often beyond their control as individuals being largely a systemic problem. Thus education and access to information about their main health problems, including methods of prevention and control will have limited impact on their health. Also low skilled migrant workers often lack sufficient autonomy over their lifestyle to enable them to make choices and necessary changes to improve their health.
4. Ensuring rights associated with the underlying social determinants of health are upheld. These were identified by the Committee on Economic, Social and Cultural Rights (CESCR) General Comment No.14 (2000) as: access to safe and potable water and adequate sanitation, an adequate supply of safe food, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. Tackling health inequities of migrant workers requires an even broader view that also includes considering the ways in which education, social inclusion, gender equity and political power influences their health.
5. Migrant workers must be integrated into healthcare systems and their health concerns included in global and national health policies in sending and receiving countries. Migrants and their families right to health must be considered during pre departure, transit, residency in the receiving country; when detained and stranded in crises and when reintegrated into the country of origin. Migrant workers right to health must also be mainstreamed through policies and laws across a variety of sectors as a cross cutting issue with monitoring and enforcement by states.

Unique health-risk factors for Migrant Workers

Low skilled migrant workers in every stage of the migration process are particularly vulnerable to violations of their right to health. Migration in itself is not a risk factor for health. However, individually or collectively, the process of migration can result in vulnerability to physical and psychosocial health problems, depending on the conditions to which migrating persons are exposed.⁵ Research indicates that migrants from the same country develop different diseases dependant on which country they migrate to⁶ and that there is variation in health risks based on migrant worker typologies. Given that they largely arrive healthy in receiving countries it is important to identify the conditions, which are proving detrimental to their health. Clearly the nature of their employment and working conditions usually in ‘3D’ (dirty, demeaning, dangerous) jobs makes them specifically vulnerable to health inequities in injuries, ill health, chronic conditions and death.

Examples of the specific risks to low skilled migrant workers’ health include the following:

The cumulative adverse effects of systematic health discrimination may lead to preventable diseases, chronic conditions and disability rendering migrants more vulnerable; particularly given the likelihood of repatriation and lack of support for returnee migrants.

- Anecdotal evidence from the MFA network suggests migrant workers are developing health problems at an earlier age than what is common. E.g. A young man contracting tuberculosis caused by poor immunity due to a combination of excessive work, exhaustion and malnutrition.
- Occupational health and safety for migrants is often neglected, particularly in the case of undocumented workers; with a large proportion of all reported occupational diseases and accidents occurring amongst migrating persons. E.g. migrant workers in the Gulf countries maybe required to work in the heat of the day at temperatures as high as 40 Celsius. This leads to hospital admissions for heat exhaustion, which carries the ultimate risk of death.
- Occupational accidents render migrant workers more vulnerable to disability as they are largely denied access to rehabilitation.
- Unscrupulous behaviour of employers. Examples include: reports of medical falsification of diagnosis of occupational accidents, such as a fall being labelled a cardiac arrest. Some employers have been known to exert pressure on health professionals to deny ill workers sick leave or rest; limit treatment to underplay the extent of an occupational injury and send the worker back to their country to protect their health and safety record. Some employers make deductions from their workers salary during sick leave.
- Labour exploitation is a crucial factor affecting low skilled migrant workers health; such as being made to work excessive hours. Regularly working in excess of 48 hours per week significantly increases the risk of mental health problems. More than 60 hours per week increases the risk of cardiovascular disease. ⁷ E.g. masons, carpenters and domestic workers excessive work over several years at a pace that does not allow for recovery, due to the absence of adequate breaks, can result in joint injury, osteoarthritis and chronic fatigue syndrome. Additionally, without leisure time they are denied the opportunity for social support or activities essential for stress management and general well being.
- Migrant workers, and in particular undocumented migrant workers often accept these dangerous working conditions as they know that they can easily be dismissed and sent home if they refuse to undertake work that they think could harm their health or safety.
- Contract substitution results in migrant workers being placed in jobs for which they may lack the skills leading to the risk of occupational accidents and stress.
- Insufficient wages for both living and sending remittances home may lead to poor nutrition. E.g. A worker based in Korea became ill whilst attempting to live on instant noodles to save money.
- Lack of autonomy over their lifestyle if living in a labour camp or employed as a live-in domestic worker. E.g. If they have diabetes they cannot maintain a low carbohydrate, low sugar diet necessary to stay well. Domestic workers who are denied sufficient food by their employer or not provided with culturally appropriate food are at risk of malnutrition.
- Low skilled migrant workers' squalid living conditions undermine their health status. E.g. poor sanitation and overcrowding in labour camps.
- Women migrant workers often suffer from inequalities that threaten their health. ⁸ The UN Convention on the Elimination of All Forms of Discrimination against Women (Article 12, CEDAW) requires states to eliminate discrimination against women in health care in order to ensure...access to health care services, including those related to family planning, pregnancy and post-natal care. Yet sexual and reproductive health rights are often violated and access to quality reproductive health services denied as evidenced by the lack of maternity protection for pregnant migrant workers.
- Well documented high rates of physical, sexual, and psychological abuse and labour exploitation impact fundamentally on the health of women migrant domestic workers. Sexual assault by employers may lead to sexually transmitted diseases, infection with HIV/AIDS,

unwanted pregnancies, unsafe abortions and longterm psychosocial health problems. Attempts to escape abuse such as jumping from a building can result in injury and possible permanent disability.

- Some migrant workers may choose suicide as a tragic reaction to their stressful life situations without protection from exploitation and abuse, access to justice and the absence of psychosocial support and healthcare.
- Absence of family reunification policies violates migrant workers right to family unity and renders migrants isolated without an adequate support system due to the lengthy separation from the family. It carries an increased risk of marital problems and stress associated with unrealistic family expectations created by the distance.
- Detention health care is frequently inadequate, often unethical, regularly damaging to health and can be lethal. Some migrant workers maybe at risk of contracting communicable diseases as conditions in the centres where undocumented migrants are detained may be conducive to the spread of diseases. Migrants are sometimes detained in unacceptable substandard conditions and victims of violence, including sexual violence and abuse. Pregnant women migrants are often detained. Detention can be particularly damaging to vulnerable categories of migrants, including victims of torture, unaccompanied older persons, persons with a mental or physical disability, and persons living with HIV/AIDS.
- Migrant workers may be more prone to risky sexual behaviour owing to their vulnerable situation, far away from their families and their exclusion from major prevention and care programmes on sexually transmitted diseases and HIV/AIDS. Their situation is therefore conducive to the rapid spread of these diseases.
- Discriminatory policies that lead to automatic detention and deportation and lifetime bans if diagnosed with a communicable disease such as HIV/AIDS, tuberculosis or a mental health problem inhibits migrant workers from seeking treatment even if they have access to free healthcare. This exacerbates their condition with adverse health outcomes.
- Immediate termination of employment if ill health is disclosed without compensatory

benefits. Coupled with fear of termination of employment and deportation means workers frequently continue to work whilst ill, or conceal a diagnosed condition risking a long-term adverse impact on their health. E.g. Hypertension- they do not monitor blood pressure for fear of revealing their condition, placing themselves at risk of haemorrhage. Others respond by becoming undocumented when their residency is tied to their employment risking exacerbating their health problem.

- Many undocumented migrant workers living under permanent threat of being caught and deported and economic insecurity may develop psychosocial health problems. As chronic stress wears down immune systems overtime, they also have an increased risk for disease and death.
- Denied access to healthcare undocumented workers may self medicate incorrectly or seek help from informal healthcare providers placing their health at greater risk.
- Low waged migrant workers health may deteriorate significantly without access to access to available affordable and quality medicines. E.g. Medication in the UAE is reported to be 23x higher than elsewhere. This may result in the dangerous practise of sharing of medication in migrant communities.
- Racism imposes a health burden. Migrant workers segregation, social exclusion, and human rights violations from xenophobia, anti-migrant sentiment, hate speech and hate crimes all impact negatively on their health. E.g. The increase in hate crimes against migrants in some countries such as Greece.
- Poor state monitoring and enforcement of existing laws that provide for their right to health. Lack of access to justice if denied healthcare in violation of national laws or excluded such as the case of domestic workers from labour laws.
- Mandatory medical testing repeated for a visa process may mean a migrant worker leaves their sponsor for fear of being terminated due to ill health. This exacerbates health problems as becoming undocumented places them at greater risk of rights violations and being denied access to healthcare.

- Dual loyalty of health care professionals may result in reporting to authorities being prioritised over the right to confidentiality and health of the migrant worker.
- Health vulnerability based on their ability to adapt to changes in weather, lifestyle, language barriers and culture in the receiving country.
- Stranded migrants are often denied access to healthcare, provided with inadequate or poor quality healthcare and/ or denied the right type of healthcare they require.

Barriers to Migrant Workers Access to Healthcare and Information

Limited or denial of timely access to affordable quality healthcare services is one of the major health risks for low skilled migrant workers. Barriers to accessing healthcare means migrant workers do not seek help until their conditions are serious; increasing susceptibility to preventable diseases, disability and death. Ultimately this also exacerbates their financial burden contributing to poverty for workers and their families; undermining their goal of a better life and health.

Civil society benevolent intervention to address this gap is valuable though unfortunately is not sustainable, nor comprehensive. When offering healthcare it may place migrant workers in a position of dependency as a welfare recipient rather than a person with a right to health. The creation of vulnerable parallel migrant health care systems undermines their basic human right of equality in accessing health care services and the role of health in promoting social inclusion.

Migrant workers are part of the society in which they live and have an equal right to access healthcare. Inequities in health status and in access to preventive, curative and palliative health services; between migrating and host populations is evident in several countries in the world. National health-care plans often discriminate against temporary migrants and especially undocumented ones by making only emergency care available for non-citizens. This forces migrants to wait until they feel their condition has deteriorated to justify going to emergency clinics placing their health at great risk and increasing the cost of healthcare. Despite well-documented cases of abuse and labour exploitation by employers, migrant workers have negligible access to psychosocial¹⁰ healthcare with those qualified to treat problems including trauma, in a language known to them.

[Migrant worker] accessibility to the highest attainable standard of health has been identified by General Comment No.14 (2000) as having four overlapping dimensions: Non-discrimination, Physical accessibility, Economic accessibility¹¹ and Information accessibility which should be weighed against international standards rather than other states healthcare provision. There is a need to advocate for their right to healthcare by calling for Universal Health Coverage¹²: ensuring equitable access to quality health services for all, whilst ensuring people do not suffer financial hardship. MFA calls for states to assume responsibility to provide universal access to healthcare for all, including migrant workers.

Low skilled migrant workers face several barriers in accessing health services including the following:

High costs of healthcare and medical services; language and cultural differences; administrative issues; lack of information or inability to access health insurance schemes; and lack of information about entitlements or legal status. Health professionals discriminating against migrants, means that they are denied, delayed or inappropriately charged for healthcare.¹³

Undocumented migrant workers dare not access health care for fear that health providers may denounce them to immigration authorities leading to arrest, detention and deportation; violating their rights including a right to patient confidentiality. Violation of migrant workers' right to freedom of movement inhibits their ability to access healthcare e.g. even with healthcare coverage, migrant domestic workers access to healthcare facilities maybe denied because of physical and social confinement in their workplace.

Low skilled migrant workers subordinated in the relationship with their employer leads to decision making about access to health being dependant on the attitude and arbitrary response of the employer; particularly under the Kafala (sponsorship) system. The sponsor may exercise power over the employee as a 'gatekeeper' to healthcare deciding whether or not they believe the employee has a 'need' for treatment rather than it being their right. E.g. migrant domestic workers report that their employers frequently decide when they complain of knee pain that it does not warrant clinical intervention and instead dispense over the counter medicine. This may mask the problem in the short term leading to permanent knee injury as they continue working with an injured joint. If they agree to accessing healthcare the employer or broker often choose the clinic and the doctor for the medical checkup and act as the interpreter in the clinic; thus seriously compromising the migrant workers healthcare.

Migrant workers access to healthcare can also be obstructed by unjust law and policies. Labour laws exclude domestic workers rendering them extremely vulnerable to denial of healthcare. Additionally, migrant workers lack access to justice when healthcare is denied in violation of labour laws. For example when a law stipulates that the employer is liable to provide healthcare coverage and provide onsite clinics at the workplace.

It is beyond the scope of this policy brief to cover the issue of equal access to social security and its role in migrant workers health. Discussion on access to healthcare is often limited to a focus on health financing and social security, despite the complexity of the issues as outlined above. Social security is an important way to improve the health of low skilled migrant workers; though not only because it provides financial protection via coverage of healthcare costs. All benefits are important for the health equity of migrant workers. For example: denied paid sick leave; migrant workers with access to affordable healthcare may continue to work rather than seek help placing them at high risk of developing serious health problems.

ANALYSIS

Migrant Forum in Asia (MFA) advocates that essential to the progressive realisation of the right to health for migrant workers is the recognition and challenging of the structural drivers of their poor health and health inequity, as a matter of social justice. There is a need to reconceptualise the terms of the debate surrounding health and migration, particularly to prevent the establishment of a dominant unilateralist concept of health based only on economic criteria.

This necessitates advocating for health as a human right; universal health coverage for all including migrant workers; gender equality; development of a new inclusive discourse on migrant health; adoption of a social determinants of health perspective on migrant health and continuing

to advocate for the promotion and protection of migrants rights.

The Commercialisation of Healthcare as a Commodity, rather than a Universal Human Right.

Migrant workers exclusion or limited access to health is part of a wider global issue.

Health is increasingly being constructed as a commodity rather than a right under the neoliberal system. The cost of healthcare delivery dominates the shift of healthcare to a commodity rather than a right reducing discussions of healthcare to a narrow economic focus. Rather than a commitment to universal health coverage for all there is an

emphasis on the individual management of risk. Global market economics are replacing government obligations eroding the right to health in favour of profit.

This health inequity is being driven by global reform within the health sector; which has created a stronger role for the private sector and an emphasis on cost-effective medical interventions at the expense of addressing the underlying determinants of health. Governance regulations of the private sector to evaluate accountability in delivering an efficient, effective and equitable service are often absent. These changes have been driven by international agencies, medical groups, and commercial actors such as health insurance companies, whose power they enhance.

This is creating inequalities in access to health with a growing divide between the rich and the poor consumption of healthcare services worldwide. This exclusion not only acts to impoverish but ultimately can lead to death. This exacerbates low skilled migrant workers marginalisation with respect to healthcare; particularly as they cannot afford the prohibitive cost of private healthcare. Migrant workers have a right to a protective healthcare system and should not be pushed into poverty because of the cost of healthcare. The state should maintain an oversight function to ensure accountability for providing timely, affordable and quality healthcare for migrant workers.

The Right to Health Goes Beyond Healthcare

Migrant workers right to health must not be reduced to discussing only access to healthcare, affordability or diagnosis. This medical and technical focus does not fully address their right to health. If the social determinants of health are excluded there is a risk of medicalisation of migrant workers social conditions and a narrow conception of technical and economic efficiency when attempting to improve access to healthcare. A narrow focus on universal health coverage and health financing strategies is not sufficient for the realisation of their right to health. Universal health coverage whilst important is limited in its ability to address the complexity of factors that create and impair migrant workers health.

Traditionally societies look to the health sector to deal with the issue of health. The health status of migrant workers is largely determined by fac-

tors outside the health sector. Injustice in policies related to immigration, labour, women rights etc demand that the right to health of migrant workers be approached as an interdisciplinary issue requiring cross cutting policy and action for sustainable health. It is not just an issue of exclusion but also unequal power relations.

The right to health also requires a paradigm shift within the health field itself away from the unsustainable traditional healthcare model towards one with an emphasis on social justice to overcome inequalities. A human rights lens must be applied to health. The movement for health equity seeks to shift the focus from individuals' risk factors (the biomedical model of health) to the conditions, policies, and institutions that create or hinder opportunities for health (the socioecological model of health). This leads to a change in questions asked. E.g. Instead of asking why do migrant workers smoke? The question would be what social conditions and economic policies predispose migrant workers to the stress that encourages smoking? What is the injustice that leads onto a health problem?

Development of a new discourse on migrant workers health

The violation of migrant workers right to health is underpinned by their social and political constructions. To realise the right to health for migrant workers requires a complete reframing in the way migrant health is understood and presented. It is not possible to do justice to the complexity of this discourse here except to highlight that: traditionally migrant health has been approached from a position of exclusion leading to a focus on security, disease control and a national focus.

This discourse has contributed to the securitisation of migrant workers. It has created an emphasis on dealing with their health at national borders with mandatory medical testing and policies of deportation in response to a certain medical diagnosis. It has contributed to the development of migration health myths; such as they are a threat to public health by stereotyping them as carriers of communicable diseases and a threat to national health care resources. Despite evidence to the contrary these myths are used for justifying discriminatory restriction of access to services. The current dominant discourse on migrant health has reinforced stigmatisation, marginalisation and securitisation of migrant workers instead of

ensuring migrant workers right to health. The realisation of the Right to Health for migrant workers requires a new discourse that does not construct health as a reason to impede freedom of movement and deportation as a policy instrument instead of offering treatment.

Migrant workers are not a commodity, they have a right to health

The emphasis on economic growth and the role of remittances as a tool for development leads to commodifying migrant workers with serious risk to their health. Migrant workers are often primarily perceived and dehumanised by many governments, employers and recruitment agencies as a 'labour commodity' that can be sent home and replaced should they become ill; undermining their dignity as a person with a right

to health. Workers with temporary contracts suffer accidents more easily, and have more difficulty obtaining healthcare insurance. Competition among countries after the cheapest labour places migrant workers health at risk, as does the lack of investment in health and safety for temporary migrant workers.

The well being and health of human beings should be central to development necessitating a human rights based approach to labour migration and development. The benefits of labour migration for workers are negated if their ill health leads to poverty and workers acquire chronic health conditions, disabilities or die. Governments should be obligated to provide health protection linked to the human right to life and physical integrity for low skilled migrant workers.

ENDNOTES

¹ Migrant Forum in Asia Regional Conference on Migration, *Migration and Migrant Workers' Health and Well Being: Trends Issues and Analysis*, Dhaka, Bangladesh 2002

² CESCR General Comment No. 14: the right to the highest attainable standard of health (art. 12), 2000

³ The Universal Declaration of Human Rights (UNHR,1948) and the International Covenant on Economic, Social and Cultural Rights (ICESCR,1966) have recognized the right to health, and the core international human rights treaties referred to the right to health or to elements of it such as the right to medical care. The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW) has 8 articles related to health including article 28: "Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment."

⁵ International Organisation for Migration (IOM), *Migrant Health for All*, MC/INF/275, Geneva, 2004.

⁶ Marmot M & Wilkinson RG, Eds., *Social Determinants of Health*, Oxford, Oxford University Press, 2006.

⁷ International Labour Organisation (ILO), *Working Time and Health: Conditions of Work and Employment*, Social Protection Sector, Information sheet No.WT-1, May 2004, ILO Geneva,pg 1.

⁸ CEDAW, General Recommendation No. 26: women migrant workers, 42nd Session.,2008 at p.276.

⁹ The Office of the High Commissioner for Human Rights (OHCHR) and the World Health Organization (WHO), "The Right to Health. Fact Sheet 31." June 2008

¹⁰ Psychosocial: An approach to understanding and managing human behaviour and wellness that places equal importance on individual psychological factors and on social factors.

¹¹ General Comment No.14, The right to the highest attainable standard of health. Article 12 of the International Covenant on Economic, Social and Cultural Rights. Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds. Physical accessibility: Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas., Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues.

¹² Universal health coverage, is defined as ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services.' WHO. Accessible at:http://www.who.int/healthsystems/universal_health_coverage/en/

¹³ IOM

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