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Intersecting crises: migration, the economy and the right to health in Europe

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The past decade has marked a period of multiple and intersecting crises for Europe. Some of these crises—like the economic downturn starting in 2008/09 and the influx of over 1.2 million refugees in 2015—were 'fast-burning', requiring prompt action by policymakers; while others—like the gradual erosion of welfare provision—were 'slow-burning', with consequences that will take years, if not decades, to manifest.[1] Together, this web of fast- and slow-burning crises have both constrained policymaking (whether at the national or European levels) and yielded political and social counter-movements that challenge prevailing wisdoms about what is to be done.[2]

These multiple crises were perhaps nowhere as profound as in the case of Greece. Starting in 2008, the country experienced a rapid economic contraction that resulted in a reduction in output by 25% and in unemployment that peaked at 27.5% in 2013.[3] This economic disaster was—in part—brought about by ill-designed policy reforms, including excessive budget cuts and the dismantling of social policies and labour rights.[4] By the time that the influx of refugees through the Aegean sea quadrupled to 857 000 in 2015, the country's welfare system—already dysfunctional and inequitable—had suffered debilitating blows and was unable to effectively and coherently deal with the increased pressures.[5]

Unsurprisingly, Greece's multiple crises most affected those with least resources to cope. The present special issue of *EJPH* draws attention to the health of migrants, and documents a system that has failed to protect those in great need, irrespective of country of origin. After the onset of Greece's economic crisis, migrants were at higher risk of unemployment, which—in turn—would impact their ability to access public health services. Analyses of the pioneering MIGHEAL survey (conducted in 2016) show that migrants reported high levels of depressive symptoms, compared with migrants residing elsewhere in Europe, and unmet needs were an acute problem.

Although the intensity of the crises in Greece was extraordinary, the underlying dynamics are reflective of broader trends across Europe. On the economic front, the aftermath of the 2008/09 global financial crisis is still felt across the continent. Many countries scaled back entitlements and restricted health coverage, with adverse effects on access to services.[6] This phenomenon of welfare state retrenchment predated the recent crises, but since the late 2000s gathered pace. These policy changes were not merely temporary responses to short-term economic trouble (most European countries recovered from the crisis within a few years), but became permanent features of emaciated health systems.

Further, migration became a highly politically salient issue, with politicians often relying on incendiary rhetoric and fear-mongering for political gain. Old tropes about migrants 'spreading disease' re-emerged with vigour, and country commitments to universal health coverage wavered. In particular, some of the first services to face cuts or be discontinued altogether were those that specifically related to migrant health.[7,8] For example, evidence from Spain suggests that immigrants with infectious diseases were at particular risk of losing access to certain health services.[9]

Taken together, these phenomena suggest the need to adopt an intersectional approach towards studying the crises and their social aftermath. That is, rather than treating them as independent areas of policy action, we need to approach them as representing interconnected power structures.[10] Who gets to define what counts as a 'crisis', and the appropriate policy response to it? Who benefits and who loses from this response? These questions both denaturalize the policy course pursued and open up the space for alternatives. Such a re-evaluation of structural constraints on improving population health and decreasing health inequalities complements calls[11] to recognize how layers of privilege or disadvantage—e.g. due to migrant status, gender or race—prevent individuals from living healthy lives.

What is at stake? The right to health in Europe is under threat. Although overall health on the continent has been steadily improving, health inequalities have often widened.[12] A key contributor to these broadening disparities have been policies that have limited or impeded access to health and other social services, with migrants often being among the first social groups to lose coverage. Such policies are contrary to the European Union's stated commitment that "everyone has the right to timely access to affordable, preventive and curative health care of good quality."[13] But even more importantly, they hamper migrants' ability to integrate in their host countries and improve their socio-economic status. This—in turn—compounds disadvantages.

The right to health applies to all, and delivering on it is a legal obligation of states enshrined in the Universal Declaration of Human Rights of 1948. Ensuring that this right is fulfilled is not only a moral and legal obligation; it contributes to a fairer society that equips individuals to overcome disadvantage, irrespective of country of origin.

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