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Migrants in Latin America: Disparities in Health Status and in Access to Healthcare¹

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Abstract

The large magnitude and sudden nature of recent migration flows in Latin America and the Caribbean (LAC) impose challenges to receiving countries' health systems, which have to provide care to a larger population. These challenges are magnified by the fact that recent waves of migrants are particularly vulnerable to health risks in LAC and may not have full access to healthcare. In this paper, we revise the literature on the disparities in the health profile of migrants compared to natives and we identify which are the main sources of disparities in migrants' access to healthcare presenting, when available, evidence of these disparities and their sources in LAC. Based on this evidence, we provide policy recommendations aimed at alleviating migrants' health disparities in LAC.

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Introduction

The migrant population of Latin America and the Caribbean (LAC) has been growing during the past few years at an unprecedented pace in recent history. Since 2015, over 5 million Venezuelans have left their country and 80 percent of them have settled in other LAC countries. Besides them, Haitians are also migrating across the continent with, for example, 275,000 visas granted to them by Chile in the past 10 years; and 12 percent of Belize's population are Central American immigrants. The large magnitude and sudden nature of some of these flows of people impose several challenges to receiving countries, especially to their healthcare systems, which have to provide care to a larger population.

These recent waves of migrants in LAC are particularly vulnerable to health risks for various reasons. They are likely to live in precarious conditions, have unstable jobs, and take long journeys in which they are exposed to food insecurity, lack of shelter, and the risk of human trafficking. Many of them leave their countries of origin with pre-existing health conditions and lack of vaccination, which together with the hazards they face on the road, contribute to a deteriorated health profile upon their arrival to destination countries. In addition, their access to healthcare services is limited, especially if they are undocumented. These vulnerabilities are exacerbated in the current context of the Covid-19 pandemic, as migrants are less able to isolate, are more likely to live in overcrowded conditions, and have less access to water and sanitation than the native population.

In this paper, we study the disparities in the health profile and in the health care access of immigrants. First, we revise the literature on the disparities in their health status relative to natives', distinguishing between economic and forced migrants. We then present evidence of these disparities between immigrants and natives in LAC. Second, we identify which are the main sources of disparities in migrants' access to healthcare studied in the literature presenting, when available, evidence of these disparities in LAC. Third, based on the evidence we gather, we provide policy recommendations to alleviate migrants' health disparities in LAC. Finally, we conclude by identifying areas where more research is needed in the region and ways in which the statistics on migrants' health could be improved.

1. Health disparities between migrants and natives

a) The health profile of economic migrants

In the case of economic migrants, there is a (positive) "health selection" as healthier individuals (relative to the representative person in the sending country) are more likely to migrate for economic motives (Jasso et al., 2004).² Therefore, upon their arrival, these migrants tend to be healthier than natives in receiving countries, even when the latter are developed nations. For instance, this has been observed in the United States, where

² Economic migrants are the people who choose to move to another country to improve their lives by finding work, or due to other motives such as education or family reunification (UNHCR, 2016).

disparities between health profiles of the native population and economic migrants upon their arrival, seem to favor the latter (Antecol and Bedard, 2006, Bennett et al., 2007).

As migrants spend more time in their host countries, the evidence on the evolution of disparities is mixed. On the one hand, mortality rates have been found to be lower among migrants than the native population. This could be due to poorer and less healthy migrants returning to their home countries and not reporting their death in the host community (“salmon bias” effect) or due to the fact that the “health selection” effect of migration prevails over time.³ On the other hand, there is also evidence that migrants’ health outcomes converge to natives’ levels over time and that their health problems end up being similar (Giuntella et al., 2018, WHO, 2019). In fact, the evidence in the “negative acculturation” literature documents a deterioration of migrants’ health over time, which is due to the fact that as time passes on, migrants take on the less healthy habits of the hosting population (Riosmena et al., 2017; Bennett et al., 2007, Cabassa, 2003).

b) The health profile of forced migrants

The selection effect observed in economic migrants works in the opposite direction for forced migrants or refugees (those fleeing the collapse of their country’s economy and institutions, armed conflicts or persecution). Upon their arrival, the health of forced migrants is normally in poorer condition compared to the host population and also compared to non-forced migrants, as forced migrants have gone through more hardships.

Unlike economic migrants, for whom there is evidence of convergence in disparities relative to the native population, refugees’ health disadvantage seems to persist over time (Giuntella et al., 2018). Although refugees’ health disadvantage is strong enough to expect health improvements over time (Reed and Barbosa, 2017), there is also evidence of “negative acculturation” and poorer health outcomes especially in terms of chronic conditions such as diabetes (Cuhane-Pera et al., 2007) and obesity and hypertension (Dookeran et al., 2010). For example, the health disadvantage of refugees in the United States seems to manifest more prominently in chronic conditions, functional limitations, and overall health status (Reed and Barbosa, 2017). Migrants’ subjective wellbeing has been found to be lower than that of natives (Chen et al., 2019) which indicates that mental health may be playing an important role in explaining the persistence of health disparities.

c) Migrants’ health in Latin American and the Caribbean

In addition to the health selection effect, age works in favor of migrants’ health outcomes. The migrant population normally tends to be more concentrated in younger working-age groups, who are less likely to fall ill or suffer chronic conditions. Migrants in Latin American countries are no exception to this pattern. For example, in Chile, in 2018, near 60% of the migrant population was concentrated in the 20-39 age group, while in Peru in 2018, near 72% of the Venezuelan population was in the 18-44 age group. Then, it is not surprising that in Chile,

³ See Abraido-Lanza et al (1999) for an analysis in the United States, Malmusi et al. (2010) in Spain, Lu and Qin (2014) in China and Puschmann et al. (2017) in the Netherlands.

according to the 2016-2017 National Health Survey (ENS), the percentage of individuals reporting health conditions such as diabetes and hypertension was lower within the migrant population (4% and 16% respectively) than within the native population (11% and 27% respectively). In Peru, according to the 2018 Survey of Venezuelan Migrants (ENPOVE), only 1 in 10 Venezuelan migrants interviewed reported having a chronic condition.

Despite its youth, the migrant population is not immune to health concerns once they settle in their destinations. For instance, nearly half of the Venezuelan migrants surveyed in Peru's 2018 ENPOVE have fallen ill or had a medical concern since their arrival. Regarding mental health, the stress and trauma that migrants are exposed to, due to the precariousness of their living and working conditions, takes a toll on their well-being. In Chile, 45% of surveyed migrants in the 2016-2017 ENS reported suffering depression and nearly 30% reported anxiety.

Although these figures are indicative of existing disparities in the health profile of the migrant population relative to the native population, a more precise analysis of such disparities would require the use of information based on samples that are representative of the migrant population in a given country. Unfortunately, the main sources of available information to assess migrants' health profiles are (household or health) surveys that are based on samples that do not have such representation and thus could generate biased figures; or hospitalization registries where selection is a problem (we only observe the health profile of only those who request medical attention). Surveys specifically dedicated to the migrant population would alleviate these concerns.

Finally, with over 4 million Venezuelan migrants displaced throughout LAC, the potential transmission of infectious diseases has become a topic of concern. The collapse of the healthcare system in Venezuela has led to the re-emergence of previously controlled or eliminated infectious diseases: outbreaks of vaccine-preventable diseases such as measles and diphtheria have been reported as well as an increase in the incidence of vector-borne diseases such as malaria, and a resurgence in HIV and tuberculosis (Tuite et al., 2018). In Colombia, larger inflows of Venezuelan migrants have been found to be associated with an increase in the incidence of vaccine-preventable diseases—chickenpox and tuberculosis—as well as sexually transmitted diseases—AIDS and syphilis—but not with increases in vector-borne diseases (Ibañez and Rozo, 2020).

2. Sources of disparities in migrants' access to and use of healthcare services

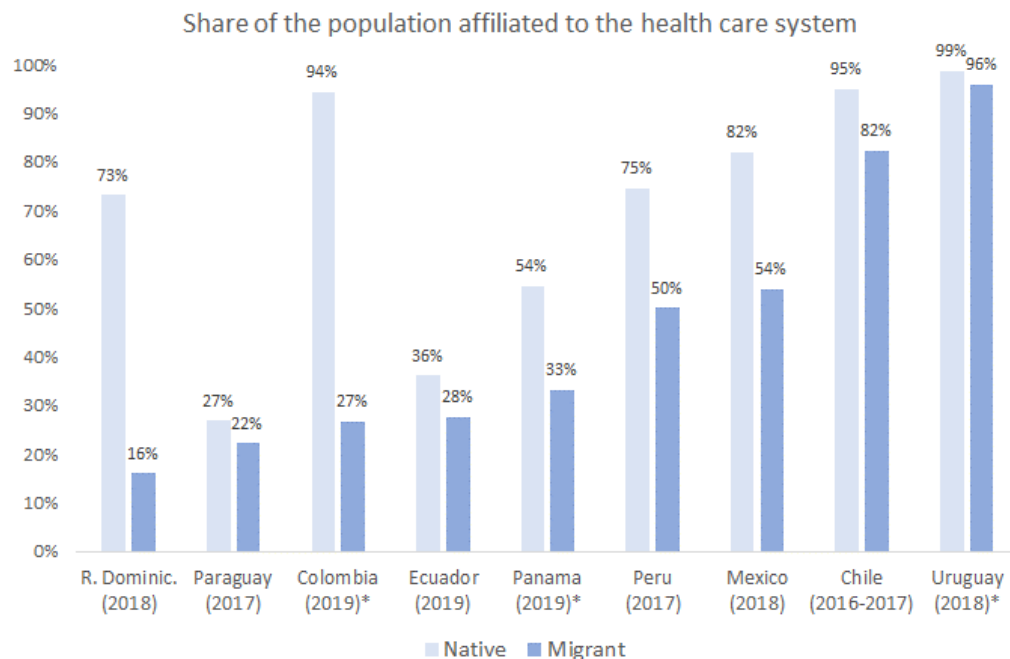
a) Lack of coverage

In most countries, the legal status of immigrants determines the type of access to healthcare services they have. When immigrants do not have legal status or they have temporary status under a work visa, they generally have fewer rights to access healthcare than a native. A large body of literature for the United States, shows that lack of health insurance is a major

barrier in access to health care, particularly for immigrants and minorities (see Institute of Medicine, 2009 and Perez-Escamilla, 2010 for evidence on Hispanic and Latinos in the US).

In the case of LAC, where a non-negligible share of recent migrant population could be undocumented, policies vary across countries.⁴ Migrants in Argentina, for example, have access—regardless of their migratory status—to the universal and public healthcare system (Hadler, 2015). In Colombia, all Venezuelan migrants have free access to emergency and preventive health services, independent of their migratory status, however, full access to the healthcare system is restricted to migrants with a legal status (Ibañez and Roza, 2020). In terms of strict affiliation (full access) to health care systems (whether public or private), the gap between the affiliation rates of immigrants and of natives varies across hosting countries in the region (Figure 1). This gap is particularly large in Colombia (68 percentage points, pp) and in the Dominican Republic (57 pp), followed by Mexico (28 pp), Peru (25 pp), and Panama (21 pp).

Figure 1



Source: Authors' calculations based on National Household Surveys, except in Chile (National Health Survey) and Mexico (National Health and Nutrition Survey).

The figures on migrants' access should be considered indicative. The Household surveys are not designed to be representative of the migrant population.

*Affiliation to the public health care system only. In all other countries figures include affiliation to both public and private health care systems.

However, even when migrants have legal access to healthcare services, they may not use them with the same intensity as natives. For example, migrants in the US, even when insured,

⁴ The share of undocumented migrant population can vary from 15% in Peru to 90% in Dominican Republic (Abuelafia, 2020).

use fewer services and have lower medical expenses than US-born individuals (Ku 2009). In Colombia, based on information from the 2018 Census, 36% of migrants report having a medical need yet not seeking any medical help, while the percentage is 16% for Colombian-born individuals. This implies that there may be barriers other than lack of coverage that prevent migrants' full use of these services (see next subsections) such as: discrimination, linguistic and cultural barriers, and lack of information or fear deportation in the case of undocumented migrants.

Given the lack of coverage in healthcare services, migrants have to rely on alternative sources for medical help. Pharmacies or drug stores are one of them. In Latin America, it has been observed that 55% of migrants in Peru and 11% in Ecuador seek medical help in these establishments. Medical care centers (other than hospitals and clinics) have also been visited by migrants especially when sick children are involved (Abuelafia, 2020).

b) Discrimination, prejudice, and stereotyping

Discrimination is a potentially important determinant of health disparities between natives and migrants. It can, in principle, affect migrants' health through two channels (Johnston and Lordan, 2012). First, the experience itself of discrimination can induce physiological and psychological effects, which can have a detrimental impact on health. Second, differential treatment by health workers towards migrant groups may lead to poorer quality of care. A doctor's differential treatment towards a minority group such as migrants can have multiple sources (Balsa and McGuire, 2003): prejudice of doctors that manifests as a lower willingness to treat and interact with minority patients (taste-based discrimination), doctors' differential interpretation of symptoms from minority patients (clinical uncertainty), or doctor's distinct priors across racial or ethnic groups about their health status and their health-related behavior (statistical discrimination).

Evidence for South Africa shows that Zimbabwean migrants are denied care even though they have the right to it and also face verbal and physical abuse (Crush and Tawodzera, 2014). Migrants in Latin American countries may also be exposed to discriminatory behaviors when seeking medical treatment. Preliminary results from an ongoing IDB study on Venezuelan migrants' social integration in Peru, show that 1 in 4 Venezuelan migrants who participated in the survey, feel that the attention they were given when seeking medical services was not the same as the one given to a Peruvian national. More research is needed to contrast the actual quality of service received by migrants to that received by natives in LAC.

c) Linguistic and cultural barriers

Linguistic and cultural differences can also act as barriers to immigrants' access to high-quality healthcare services. Studies of Latin American immigrants in the United States (Escarce and Kapur, 2006; Flores, 2005) have shown that immigrants who only speak Spanish report less patient satisfaction than those who speak English and that immigrants who need and get a medical interpreter report better quality of care and less medical errors than those who do not get one. Therefore, linguistic competencies and culturally appropriate communication skills

are key for increasing patient satisfaction and quality of care among immigrants (Anderson et al., 2003, Betancourt et al, 2004).

Although most intra-regional immigrants in LAC speak the official language of the host country, there are important migration corridors in which this is not the case, such as: Haiti-Dominican Republic, Haiti-Chile, Venezuela-Brazil, Venezuela-Guyana, Venezuela-Trinidad and Tobago and the Northern Triangle-Belize. This is also the case for immigrants who belong to monolingual indigenous communities. More evidence is needed about the specific barriers faced by the migrant population in these corridors and by those belonging to indigenous communities.

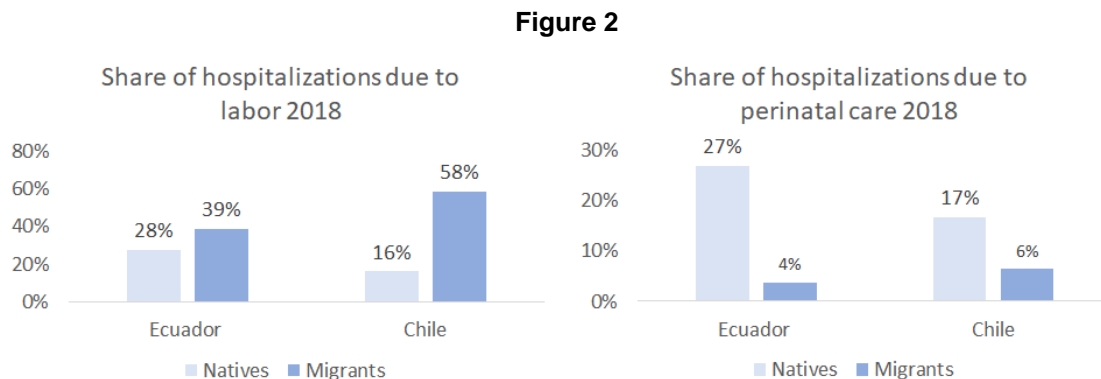
d) Lack of information and fear of deportation

Even in countries where they have access to public health regardless of their legal status, immigrants may not attend health centers due to lack of information about their rights or due to fear of being deported, if undocumented (see Box 1 for a discussion about how these factors may be particularly detrimental for women and infants). Lack of knowledge about Medicaid eligibility has been reported in the United States among African refugees (Asgary & Segar, 2011), whereas fear of deportation has been reported in developing countries such as South Africa (Crush and Tawodzera, 2014).

In the case of LAC, the 2018 ENPOVE reveals that fear due to migratory status is one of the reasons that Venezuelan migrants in Peru do not seek medical services. There is also qualitative evidence from focus groups that this may be the case in Colombia as well (Ibañez and Roza, 2020).

Box 1. Special medical concerns and barriers faced by women and children

Evidence from Canada (Sword et al. 2006) and Europe (Balaam et al., 2013) shows that migrant women face particular barriers to high quality care related to unsuccessful communication with healthcare professionals, lack of information and awareness, poor mental health (from trauma or depression related to human mobility), and lack of support from family and relationships. Lack of information in the female migrant population can be fatal. According to WHO (2019), female migrants who are not informed about the availability of reproductive healthcare services (including prenatal care and breastfeeding) may receive late diagnoses and their conditions may be life-threatening for women and their babies. This is particularly concerning given that in the region, there is a considerable demand for these health services among migrants. For example, in countries such as Chile and Ecuador in 2018, the percentage of hospitalizations due to labor is considerably higher among the migrant population than among the natives while the percentage of hospitalizations due to perinatal care is lower among the migrant population (Figure 2). This shows that migrant women are less likely than native women to seek healthcare for perinatal care, which is why the share of hospitalizations due to situations in which a hospitalization is more essential (i.e. labor) is higher.



Source: Authors' calculations based on "Registro Estadístico de Camas y Egresos Hospitalarios", INEC in Ecuador, and "Egresos Hospitalarios del Departamento de Estadísticas e Información de Salud" in Chile.

Migrants' lack of access to healthcare is particularly detrimental for women and children, considering that they are groups vulnerable to health risks. For example, influenza can be more severe for pregnant women and children under the age of 5. The risk of this and other respiratory infections is increased when the woman or child is a migrant, given the physical and mental stress and deprivation they are exposed to due to lack of housing, food, and clean water (WHO, 2019). Their lower access to healthcare, makes the health threat by respiratory infections even more severe. The high demand for healthcare services by women and children in the region adds to the seriousness of this health concern. For example, in Colombia, according to the Individual Registry of Healthcare Services Provided (2017-2019), 70% of the services provided to migrants were requested by women, mostly related to pregnancy, and 2 in 10 patients were children under 10 years (Observatorio Proyecto Migración Venezuela, 2020).

3. Policy recommendations

Based on the evidence from the region and other countries, possible guidelines for policy makers from countries in LAC receiving large and sudden migration flows include:

- Vaccination campaigns. Given the prevalence of vaccine-preventable disease among the Venezuelan population, vaccination campaigns in regions with a high density of migrants could be a cost-effective way to prevent the spread of diseases such as chicken pox, diphtheria, and measles.
- Healthcare access for migrants. Offering migrants full access to healthcare upon their arrival, including preventative care is necessary to deal with pre-existing conditions and prevent new ones that can result from long periods on the road in precarious living conditions, including lack of access to WASH. It should be noted that if these measures are not accompanied by a regularization of their migratory status, migrants may not even use the services due to fear of deportation.
- Information campaigns. This type of campaign could be a way to reduce the lack of information, not only about healthy habits, but also about migrants' rights to healthcare services. Engaging immigrant organizations can help to adjust the tone of the message and appeal to a broader audience. The use of the appropriate social media channels could help to reach the target immigrant and host communities. Campaigns to communicate to the migrant population that they will not be deported if they seek attention, could be an example. Also campaigns about contraceptive methods (together with better access to these products), could be effective in reducing the prevalence of HIV and other STDs among migrants.
- Cultural competency programs and interpreter services. Health insurance does not guarantee a satisfactory access to healthcare. Discrimination, cultural differences, and language can become important barriers for migrants' full use of health services. It is important, therefore, that healthcare personnel are adequately trained in the cultural competencies necessary to treat migrants and that interpreter services are available, if needed. Employing immigrants in these services can help in building trust and in adapting to migrants' needs.
- Healthcare access for migrant women. Special consideration should be given to the access of migrant women to either the full healthcare system, or at least, to some types of preventative health services such as prenatal controls.
- Alternative healthcare options for migrants. Given the reliance of migrants on alternative sources of medical help when they are not covered by any health care system (e.g. pharmacies, medical care centers), efforts intended to contain the spread of infectious diseases, such as Covid-19, among migrants could include joint efforts with these type of establishments in strategic locations.

4. Conclusions

In this paper, we revise the literature on health disparities between migrant and native populations, accounting for differences between economic and forced migrants; and on the barriers that may explain such disparities. When possible, we also present indicative evidence of the prevalence of differences in both health profiles and access to healthcare services in selected Latin American countries. Finally, we provide policy recommendations for countries

receiving large migration flows, such as massive vaccination campaigns and healthcare access for migrants.

Immigrants in some Latin American countries report having less chronic conditions compared to the native population, which could be partially explained by their youth; however, they still face several health risks, both physically and mentally. As we revise the barriers that may be a source of disparities, we note that access to healthcare services is consistently lower for migrants across Latin American countries. Discrimination can also have pernicious effects on migrants' health and on the way they are treated by health professionals in the hosting country. Similarly, cultural and linguistic differences, and lack of information and fear of deportation are other constraints that may influence immigrants' health outcome negatively.

While the evidence gathered in this paper is indicative of important health disparities in the region, more exhaustive analysis of the existing gaps in health outcomes and in access to healthcare services between the migrant and the native population is needed. A meaningful first step in that direction should consider efforts to generate more comprehensive information based on samples that are representative of the migrant population. A necessary second step would be to study the prevalence of barriers in migrants' access to healthcare in LAC. More research is needed on the pervasiveness of discrimination, linguistic barriers, and information failures faced by the migrant population in the region.

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