Chapter 13
Global Social Governance and Health Protection for Forced Migrants

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Abbreviations

CRSR	Convention Relating to the Status of Refugees
GFMD	Global Forum on Migration and Development
HFA	"Health for All"
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labour Organisation
IOM	International Organisation on Migration
OECD	Organisation for Economic Cooperation and Development
PHAME	WHO Public Health Aspects of Migration in Europe
PHC	Primary Health Care
R202	ILO's Social Protection Floors Recommendation
SDGs	Sustainable Development Goals
UN	United Nations
UHC	Universal Health Coverage
UNHCR	UN High Commissioner on Refugees
UN GA	United Nations General Assembly
WHA	World Health Assembly
WHO	World Health Organization

Introduction

The distinction between different groups of migrants, though morally or normatively irrelevant, does matter regarding the access to national and local systems of social protection and, thus, also to health services. Migrants entering a host country as family members of national citizens or residents usually face a much more regu-

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lated and clearer situation of access. Newly arriving labour migrants are treated under specific immigration regulations that usually also include defining access to social protection and health protection. Forced migrants are those who leave their countries because of conflict; because they are threatened based on their religion, sexual orientation, political opinion and so on; or because of natural disasters. Thus, this group of migrants often does not have the time and opportunity to prepare for migration. They usually do not have a job or work permit of the country they arrive in, nor do they have access to social and health services as relative of a person covered by social protection. What is provided to these groups of people in a situation of forced migration is somewhere between humanitarian aid, asylum rights and rights to health. The right to health is often characterised by restricted entitlements except for particular groups such as women giving births, newborns or unaccompanied minors. This also creates a situation of incomplete and insecure protection in case of illness and injury for forced migrants.

In general, the need for proper health systems to ensure universal access to health care has a long history and is supported by a number of global actors. For migrants without citizenship of the host country, in particular, there are even additional issues in terms of accessing health care. There are specific demands on health systems to make sure everybody can enjoy his or her rights to health and social security. One of the challenges regarding access to health care in the context of migration is that it is often two or more countries' health systems that matter regarding rights to, and levels of, health care. There are numerous and complex situations connected to the place of origin that is usually characterised by a breakdown of existing protection arrangements (be it personal, family, state, religious and the like), in addition to a general destruction of infrastructure, and situations of mental distress and trauma (Gostin and Roberts 2015). Neighbouring countries, the most likely target destination of refugees, often face similar situations or are characterised by limited resources and infrastructure to provide health care for large numbers of additional people. The risk of epidemics as well as of other health and social risks increases for people living in refugee camps under uncertain conditions. Moreover, the affected people often also lack knowledge of their rights in the respective host country (Gostin and Roberts 2015).

This chapter discusses issues of social and health policy for people in a situation of forced migration from a global social policy and governance perspective. It draws on global social policy scholarship that is positioned between international, comparative social policy analysis and development studies. It also engages with transnational forms of regulation and human rights, international relations and global governance. Such a global perspective to tackling health issues of migrants is important as the scope of national regulation and legislation to solve global problems is limited. Furthermore, drawing on global social policy literature is particularly useful in this context as it allows combining analytical with normative positions on appropriate and transformative social policies.

Global Social Policy, Social Rights and Migrants' Rights to Health

Social policymaking, including health policymaking, happens at multiple levels of governance. This is even more true when it concerns groups of people migrating between countries. It is relevant with regard to rights to health and social security in home, transit and host countries alike.

"Global social policies" describe ideas, processes and provisions of social policy that happen at global scales. Their making includes intergovernmental negotiations, the involvement and interactions of international and supranational agencies and the formulation and enforcement of transnational norms and rules (Kaasch and Martens 2015). Global social policy literature commonly distinguishes two main types: one being social policy prescriptions to national governments by international actors. This may include policy recommendations not only on appropriate health system reform but also appropriate treatment of non-nationals in a host country. The other one is a "truly" global social policy in the sense of global social redistribution, regulation and rights (Deacon 2007). Here, we can think about the emergence of human rights on social protection, responding to different social needs, as well as the human right to health. At the same time, regulation on migration, trade and labour may also form transnational systems of social and health policy. Global redistribution, though of a different form and quality to what we know from national welfare states, includes not only development aid and emergency aid but also remittances all of which with an impact on people migrating.

Looking at global social rights more specifically, we think of those rights associated with what a person needs to live her or his life and take part in society (Dean 2007). Furthermore, they relate to situations in which a person cannot fully care for her- or himself and thus needs financial support, personal care, health care and the like (Maciejczyk Jaron 2009). We can distinguish between social rights that are connected to a particular group of (vulnerable) people, the so-called rights *of*, and those related to a specific social need or problem, the so-called rights *to* (for a discussion, see Kaasch 2016). Understanding the specific situation and social needs of migrants in a context of health requires a combination between the two forms, namely, the right to health and the (social) rights of people under forced migration. Regarding the right to health, various international agreements and treaties formulate that, at the very minimum, primary and basic health care should be free and accessible to every human being. This is based on Article 25 of the Universal Declaration of Human Rights. The Alma-Ata Declaration (1978) and Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) are more specific and concrete of what this right is supposed to include and imply, but there is no internationally common understanding of what is required to realise the right to health (see also Chap. 7). Looking at the "rights of" migrants, in the case of this chapter, we can see that particularly refugee rights are dealt with in the Convention Relating to the Status of Refugees (CRSR) from 1951. In general, group-related rights also include the right to health, applied to a specific group. The idea and reasoning behind is one

of equal treatment and non-discrimination. These rights often "represent an advocacy and adjustment tool for claiming and improving the situation of particular groups of people" (Kaasch 2016, p. 79).

The meaning of the human right to health, as included in the Universal Declaration of Human Rights, provides a set of standards regarding health systems (and beyond). Looking from the individual's level, when we think about the right to health, we associate the right of everybody to enjoy the highest attainable standard of health, which is part of many international treaties dealing with specific groups and social problems. As all countries have ratified one or more international treaty that is binding, we can indeed speak of a global social right representing an internationally shared norm and connected to certain mechanisms to enforce it. Nevertheless, it is basically the responsibility of national governments to realise the right to health through functioning health systems (Backman et al. 2008; Tarantola 2008).

Health systems are, at the same time, considered to be part of systems of social protection and, therefore, also matter in the context of rights to social security and global concepts of social protection floors (most prominently the ILO's Social Protection Floors Recommendation (R202) from 2012). The right to social security as such is subject to the ICESCR's Article 9, saying that "The State Parties to represent the Covenant recognize the right of everyone to social security, including health insurance". The ILO's social security standards go more into detail with this right by setting social security standards and recommendations on the establishment of social security systems. Most comprehensively, this has been tackled in the ILO Social Protection Floors Recommendation (R202) from 2012 (Hujo et al. 2017). Scheil-Adlung (2013, p. 147) emphasises how that is important making health policies more effective and efficient and for coordinating them with socio-economic policies. That would facilitate progress on universal health coverage. She further explains that R202 provides guidance to states in setting up social protection floors in the sense of basic social security guarantees to ensure that—including other provisions—access to essential health care and basic income is provided over the life cycle. This includes the expectation for national governments to create systems that combine preventive, promotional and active measures; that establish appropriate benefits and social services; and that promote economic activity and formal employment. It should also be coordinated with other relevant policies (Scheil-Adlung 2013, p. 161). Accordingly, social protection in the field of health care implies guarantees for "essential health benefits", which includes preventive and maternal care, provided to everybody and with adequate quality (universal health care) (Scheil-Adlung 2013, p. 162).

When it concerns coverage regarding at least basic health services, the problems are usually at the level of inequities in access to health care, caused by a variety of factors, including affordability and availability (Scheil-Adlung 2013, p. 167). Underlying factors contributing to inequitable access to health care are commonly related to poverty, work status and formal lack of access to institutions, services and benefits of social security. When we look at the specific group of migrants under forced migration, many of these determinants are structurally linked with citizenship status and the right to work (and by that way get access to national systems of

social protection). As Hennebry (2014) says, social protection floors initiatives are often focused on national strategies and models to protect a country's citizens, with a particular emphasis on poor countries. Initiatives for migrants, even formal migrant workers, have not been in focus (Hennebry 2014, p. 381). At the same time, there is no unified system that regulates or governs migration from a transnational level. Migrants thus lack strong national agencies to secure their human rights in many countries (Ratel et al. 2013, pp. 2–3).

Overall, while there has been significant advancement at the level of global norms and recommendations on social health protection, setting up appropriate protection in health for people under forced migration remains a major challenge. In the following sections, the focus is on what international agencies are key players with regard to this specific issue, as well as on ideational and discursive developments in global social and health policies since the so-called refugee crisis.

Global Social Policy Actors in the Field of Health Systems and Migration

Global social policy and governance in general is characterised by multiple actors, overlapping agencies and competing ideas on appropriate social policies. This also applies to the field of health systems. There are several international organisations claiming to have a say on appropriate health systems (as well as a broad range of specific public health issues) and at the same time a rather small group of global health experts within these international organisations coming with an encompassing, systems view. The field is broad and complex, and it is characterised by deficiencies. More concretely, when we look at the global governance of health-care systems, we can identify a multilayered, polyarchic and pluralistic institutional architecture. The positions of specific organisations change over time and new actors emerge, which leads to varying configurations of relevant actors (Kaasch 2015, p. 3).

Looking at the issue of the social situation and needs of migrants in their host countries, we focus on a combination of social policy prescriptions by international organisations to national governments in issues of providing at least basic social protection to migrants and global social rights. We do not focus on a particular country or world region but rather turn our view to the global social policy arena in terms of mandates, positions and discourse on the subject matter. The emerging picture may be used as a frame for social and health policymaking on migrants at other policy levels.

The international community, including a number of international organisations inside and outside the UN system, holds implicit and explicit mandates to engage with issues of social rights, the right to health and migrants and refugees. Regarding the field of health systems with a focus on the social health protection of people under forced migration, we can distinguish those actors with a focus on migration issues and those concerned with health policies. Common actors—here with a focus

on international (governmental) organisations—in the field of global health governance are the World Health Organization (WHO) and the World Bank. To a lesser degree, also, the International Labour Organisation (ILO) and the Organisation for Economic Cooperation and Development (OECD) come into the picture (Kaasch 2015). Looking at migration governance, the picture is more diverse (for a discussion on the character and shape of migration governance, see, for example, Betts (2010), but the major international organisations include not only the International Migration Organisation (IOM) and the UN High Commissioner on Refugees (UNHCR) but also organisations like the ILO.

The UN High Commissioner for Refugees (UNHCR) office was established in 1950, in a context of large-scale migration from and within the European region following the World War II. It supports states and migrants in situations of major migration streams. It aims at ensuring that all refugees have access to life-saving and essential health care. The focus is less on health systems in a comprehensive sense but more on the identification of specific health issues (e.g. HIV/AIDS-related health care and prevention, reproductive health or specific communicable diseases like measles) and health determinants (e.g. food, nutrition, water, sanitation, hygiene). According to its website, UNHCR provides assistance in refugee camps and other places where forced migrants stay. The mandate is connected to the 1951 Refugee Convention and requests access to health services for refugees equivalent to that of the host population (UNHCR 1951). Whatever goes beyond emergency care, the emphasis is on primary health care (PHC) and secondary hospital care. UNHCR provides a number of guidance documents that relate to health care and associated issues of migrants and refugees in particular. In 2012, UNHCR issued "A Guidance Note on Health Insurance Schemes for Refugees and other Persons of Concern to UNHCR" (UNHCR 2012). While making recommendations and stating to provide guidance, this document does not demonstrate a profound understanding of how health systems work and what are mechanisms of integrating groups of populations into different types of health systems in order to ensure or improve their health care. The document advocates for basic primary health care and emergency services to be provided to refugees in emergency situations. It also refers to specific vaccinations and preventive measures related to what is considered to be the major life threats in the context of forced migration. The recommendations also claim not to make differences between national and non-nationals in the provision of health care. Overall, the guidance is not really coherent but rather reflects considerations from different sources that do not necessarily speak a common language. Nevertheless, the UNHCR is committed and also to some extent resourced to support migrants and refugees to access health care in different ways: claiming inclusion (though not speaking a right-based language), providing resources for paying insurance fees and reflecting upon different health systems and the challenges to include refugees. It advocates public health systems in a more general way; other documents and guiding principles are rather focused on specific diseases or health risks. Furthermore, the Principles and Guidance for Referral Health Care for Refugees and Other Persons of Concern (UNHCR 2009) reflects the organisation's emergency focus and Primary Health Care approach.

The International Organisation on Migration (IOM) was established around the same time and has over 170 member states. The IOM's website describes its mandate as to promote humane and orderly migration for the benefit of all by providing services and advices to governments and migrants alike. Its mandate comprises migration and development, regulating migration and forced migration, as well as the promotion of protection of migrants' rights and migration health. The IOM includes a Migration Health Division through which it provides comprehensive, preventive and curative health programmes to address migrants' needs. One focus of its work—though in collaboration with WHO—is on migrant sensitive health systems. Similar to the UNHCR, the focus of IOM is on supporting migrants and countries to improve health coverage for migrants through technical support, information and promotion. Activities include the strengthening of national health systems—with the aim of "the strengthening of migrant-friendly and migrant inclusive health systems which benefit migrants and the communities in which they live" (IOM 2019).

WHO is the UN agency mandated with health issues of all kinds. This includes ensuring appropriate structure and functioning of health system, so that they cover different vulnerable groups, different countries and world regions and different sorts of health problems, illnesses or diseases. WHO's work on refugee and migrant health links prominently and explicitly to the right to health while describing the problem as a lack of access to health services and protection for refugees and migrants. Furthermore, WHO's work on the issue is guided by the aim to achieve universal health coverage (UHC) and equitable access to quality health services (WHO 2019). Compared to the other two actors, WHO has produced "soft law" on the issue of migrants' health. In 2017, the World Health Assembly endorsed the Resolution "Promoting the Health of Refugees and Migrants", setting plans for international engagement for improving refugees' situations (WHA 2017). It lists guiding principles including the right to health, the principles of equality and non-discrimination, equitable access to health services, people-centred and refugee- and migrant-sensitive health systems, and whole of government approaches (see also WHO 2015).

In conclusion, there are three main actors involved in global health policy and governance for forced migrants. It is striking that WHO has the leading role, while the financial means to support migrants is rather with the two other actors. Furthermore, WHO does not have a migrant health division except for WHO EURO. In the following section, the focus will be on the general global policy development with regard to migrants and refugee health, which commonly brings these three actors (with other actors) together on pushing the agenda on social protection in health and migration.

Evolving Global Health Governance on Social Health Protection for Migrants

The Alma-Ata Declaration of the 1970s provided a framework of Primary Health Care (PHC) and "Health for All" (HFA). Since then, international organisations have provided reports providing more in-depth analysis and understanding on the

meanings and functions of health systems in different types of countries. There has been increasing consensus emerging about the general importance of health-care systems. Nevertheless, there are differences on priorities and strategies of different global actors on how to develop and improve health-care systems. The need for universal health care, meanwhile, is increasingly acknowledged in the global health community (Kaasch 2015).

There are several international organisations engaging with issues of global migration governance. However, in contrast to global health governance, for a long time, there has not been a UN migration organization (Betts 2011, p. 1). In the meantime, the IOM has been given such a status. Nevertheless, we cannot speak of a truly international migration regime. However, asylum seekers are supported by the 1951 Convention on the Status of Refugees and the UNHCR. The Global Forum on Migration and Development (GFMD) has met on a regular basis since 2007; it also has an important role as a forum to discuss issues of migration. Even more than for health systems, though, decisions on the regulation of migration and the local rights of migrants are taken by national policymaking.

Nevertheless, combining key components of global migration and health governance, the normative claim would be straightforward: as human beings, forced migrants do have a right to health, and therefore, national governments have to do their best to guarantee this right, regardless of migration status. That was also part of the 1951 Refugee Convention and its 1967 Protocol that obliges national governments to provide appropriate social security and health care for injuries, maternity, sickness and disability (Gostin and Roberts 2015).

In response to the significant increases in refugees/migrants, particularly into European and other high-income countries, there were additional human-right-focused measures taken at the UN level. In September 2016, the UN General Assembly adopted the New York Declaration for Refugees and Migrants (UN GA 2016). This called upon member states to take international cooperation seriously, as well as the protection of migrants. Regarding health, it alerts states to "address the vulnerabilities to HIV and the specific health-care needs experienced by […] refugees and crisis-affected populations" (section 30). Furthermore, the states commit themselves to provide access to sexual and reproductive health-care services (section 31). More generally, in section 39, the states announce to "take measures to improve [refugees] […] integration and inclusion, as appropriate, and with particular reference to access to […], health care, …". Regarding migrant children, the commitment to provide access to basic health care is also emphasised (section 59). With regard to refugees, in particular, the Declaration states the commitment to humanitarian assistance, including in the field of health care (section 80). But most explicitly, section 83 says "We will work to ensure that the basic health needs of refugee communities are met and that women and girls have access to essential health-care services. We commit to providing host countries with support in this regard. We will also develop national strategies for the protection of refugees within the framework of national social protection systems, as appropriate".

The New York Declaration for Refugees and Migrants was also meant to start a process towards two separate global compacts: one to deal with refugees in particu-

lar and the other one on the so-called "safe, orderly and regular" migration. The idea driving the process of setting up the compacts was not to invent new international policies on migrants but to "improve how the world responds to the needs of refugees as defined in the 1951 Refugee Convention and its 1967 Protocol" (Thomas and Yarnell 2018). In this context, the focus is on the refugee compact and within that on its health component. Within the programme of action, there are defined areas in need of support, including a section on health (section III B 2.3). The statement on health system basically says that resources and expertise will be provided to whatever health system is in place at the place where refugees need to be supported. This should help to facilitate inclusion or refugees into national health systems. Furthermore, it hints at particularly vulnerable groups and lists some of the principles to be met, e.g. "affordable and equitable access to adequate quantities of medicines, medical supplies, vaccines, diagnostics, and preventive commodities".

The UNHCR was the responsible global agency for the compact, holding numerous consultations with various stakeholders, including the so-called High Commissioner's Dialogue on Protection Challenges. In 2018, the process of drafting the compact took place; formal consultation happened in summer 2018; the final draft was then presented at the UN General Assembly in September 2018. Despite a number of states opting out in advance of the conference, in December 2018, both compacts got adopted. The Global Compact on Refugees got more support (perhaps because of the humanitarian aspect of refugee crises). It was adopted by the UN General Assembly by a recorded vote of 181 in favour to 2 against (United States and Hungary), with three abstentions (Eritrea, Libya, Dominican Republic). Seven countries did not vote: Democratic People's Republic of Korea, Israel, Micronesia, Nauru, Poland, Tonga and Turkmenistan.

WHO, in cooperation with IOM and UNHCR, also engaged with the required health component as part of the Global Compact for Safe, Orderly and Regular Migration (WHO and IOM 2016). The reason is that, looking beyond the concrete plans for such a compact and considering the common vision of the Sustainable Development Goals (SDGs), health rights and needs of migrants need to be adequately addressed. It is argued that global and national health policies, strategies and plans have not sufficiently considered the implications of large-scale migration. That concerns not only information and data systems but also health policies and public health interventions. The emphasis in the report is on the right to the enjoyment of the highest attainable standard of physical and mental health for all; equality and non-discrimination through comprehensive laws and health policies and practices; equitable access to people-centred, migrant- and gender-sensitive, and age-responsive health services; non-restrictive health practices based on health conditions; and whole-of-government and whole-of-society approaches. This implies the goals of realising health rights as part of international human rights, addressing the social determinants of health and improving migrants' access to health services. Among the actionable commitments and means of implementation, point 5 is on providing UHC and right-based and inclusive health services and more specifically "ensuring that the necessary health services are delivered to migrants in line with human rights standards and in a people-centred, gender-responsive, cultur-

ally and linguistically appropriate way, without any kind of discrimination and stigmatization; providing access to quality health services to migrants, …; identifying and/or developing sustainable models of health care financing to cover migrant health". There is now the need to develop, reinforce and implement occupational, primary health and safety services and health insurance as social protection for migrant workers and their families in response to WHA resolutions (WHA60.26 and WHA70.15) and ILO conventions and protocols.

The WHO Regional Office for Europe came up with considerations on how to handle health issues in the context of migration and the increase in refugees to Europe. Their report calls for "evidence-based public health interventions to address the health needs of migrants that could save a significant number of lives and reduce suffering and ill health" (WHO Regional Office for Europe 2016, p. v). The WHO Public Health Aspects of Migration in Europe (PHAME) project focused on migrant health and host populations with the aim to "assist Member States in responding adequately to the public health challenges of migration" (WHO Regional Office for Europe 2016, p. v), applying the Health 2020 strategy. This could be "a basis for the preparation of migrant-sensitive health systems and makes a strong case for investment and action through whole-of-governments and whole-of-society approaches. It gives national ministries of health the opportunity to lead a multisectoral collaboration to optimize their health system preparedness and capacity" (WHO Regional Office for Europe 2016, p. v). "Migrant-sensitive health systems" is a concept that at a more general level, and already in 2008, the WHA had called upon member states to adopt (WHA 2008). In 2010, a Global Consultation on Migrant Health followed, "which asks Member States to take action on migrant-sensitive health policies and practices, and directs WHO to promote migrant health on the international agenda, in collaboration with other relevant organizations and sectors" (WHO 2010, p. 4). The considerations here are primarily on the implementation of national health policies for equal access to health services for migrants, inclusion in social protection schemes in the field of health and the general improvement of social security for migrants (WHO 2010, p. 4). Among the arguments reflected in the report are that the main responsibility for setting up institutions to facilitate access to health facilities, goods and services for migrants is with the member states' governments. If required, multilateral cooperation could assist government in attempts to including migrants (WHO 2010, p. 12–13). Explicit connections to human rights are also made (WHO 2010, p. 13).

Meanwhile, the Declaration on Primary Health Care (WHO and UNICEF 2018) attempts to revive the PHC spirit of Alma-Ata (1978) and links to the 2030 Agenda for Sustainable Development and health for all. The vision is on strong and accessible health systems and links to the right to health "without distinction of any kind". There are also explicit links to migrants but mostly to health personnel migrating and the risk of brain drain to developing countries. A civil society document to the Astana conference, though, called for "inclusive access and utilization of health services as well as prevent discrimination, addressing first those most in need, including … refugees and migrants …" (Civil Society Engagement Mechanism for UCH2030 2018, p. 4). Furthermore, at a side event at the Global Conference on

Primary Health Care (Astana, Kazakhstan, October 2018), the IOM's Migration Health Division Director, Jacqueline Weekers, said: "High costs are often cited by governments as the main reason to not include migrants in health systems. Meanwhile, migrants contribute more in taxes than they receive in benefits, send remittances to home communities and fill labour market gaps in host societies. Equitable access for migrants to low cost primary health care can reduce health expenditures, improve social cohesion and enable migrants to contribute substantially towards the development" (IOM 2018).

Conclusions

This chapter discussed some of the roles and activities of global social policy and governance actors on the issue of social health protection for people in the situation of forced migration. Despite a group of international organisations mandated to act on migration and health, what has developed in terms of global regulations is fairly limited (see also Chap. 2).

Addressing the needs of forced migrants is complex and increasingly politicised. This has made it difficult to implement meaningful transnational mechanisms to support their needs. As a result, major developments in the definition and promotion of human rights including the right to health, and developments on health systems, social protection floors and UHC, have not yet sufficiently benefited forced migrants in transit or in a host country. Regional, rather than global, efforts may offer means of improving transnational social policies, including the social protection in health for migrant populations (see also Chap. 5). Particularly for WHO, this would require, though, even greater leadership and investment on health and migration.

As long as international processes primarily happen as intergovernmental struggles on how to distribute irregular migrants, the potential for global social policy and governance to strengthen the right to health remains underdeveloped. Particularly regarding forced migrants, the critical issues are more about the weakness of international organisations than about a lack of knowledge or already formulated global rights.

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