Chapter 7
Health Security in the Context of Forced Migration

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Abbreviations

ECDC	European Centre for Disease Prevention and Control
GHS	Global health security
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
IHR	International health regulations
NCD	Non-communicable disease
SDG	Sustainable Development Goal
UHC	Universal health coverage
UK	United Kingdom
UNDP	United Nations Development Program
US	United States
WHA	World Health Assembly
WHO	World Health Organization

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Introduction

Rising numbers of migration to high-income countries and events of large-scale migration have triggered security concerns related to foreigners and disease. In the public debate, immigrants are frequently perceived, conceptualised, or framed as a threat. Such debates are often dominated by security concerns through health issues, resonating through public media in an "alarmist" way (Box 7.1) and implying that immediate (unexceptional) political action is required to reverse the threat.

Box 7.1: Quotes from the Media Related to Health and Security Concerns in the Context of (Forced) Migration

> The Democrats […] do NOT want Border Security. They want Open Borders for anyone to come in. This brings large scale crime and disease […](Tweet by Donald J. Trump, Dec 11, 2018).
>
> Latin America's Zika virus is the latest undocumented immigrant to hit our shores (The National Review 2016).
>
> Risk of infection? Medical doctor fears danger of tuberculosis due to the massive influx of refugees – an expert disagrees (FOCUS 2016).

This process is known as "securitisation" and represents the opening up of the area of traditional security studies to the relatively new area of nontraditional or non-military security studies (Buzan et al. 1998). Its growing importance is attributed to the intellectual and policy space for non-military threats, which originated with the end of the Cold War (Lo Yuk-ping and Thomas 2010). The process of securitisation describes an extreme variant of politicisation by which a subject is identified as a threat to security, especially the security of a nation state. Through a more rational perspective, the securitised issue may not necessarily be the most urgent or threatening to survival but receives a disproportionate amount of attention and resources and broadens the political scope of action (Buzan et al. 1998). Issues of concern in the security agenda include climate change, natural disasters, and migration but also health aspects, such as infectious diseases. Security concerns in the context of health are reflected in the term "health security", which has become a prominent concept in global health policy. However, the tensions exist with other prominent global concepts, such as universal health coverage (UHC).

UHC means that all people receive the promotive, preventive, curative, rehabilitative, and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship (World Health Organization et al. 2010). Almost all definitions of UHC include three dimensions: universality (the whole population is included), access to services driven by demand, and protection from financial hardship when utilising the specified services. The concept is rooted in the human right to health,

which is enshrined in international law as part of the International Covenant on Economic, Cultural, and Social Rights (UN Committee on Economic, Social and Cultural Rights 2000). The right to health regards inequalities in entitlements and access to health services based on, for example, race, ethnicity, nationality, or residence status as an undue violation of human rights. The right to health further requests that nation states refrain from actions that interfere with achieving the highest attainable state of health for individuals within their territory.

Countries have agreed to aim for achieving UHC by the year 2030 as part of the Agenda 2030 and the third Sustainable Development Goal (SDG 3) to "ensure health and well-being for all, at all ages; and in all settings, including humanitarian and fragile" (High Level Political Forum on Sustainable Development 2017). Conceptually, UHC focuses on reducing inequalities in health service provision and therefore tackles universal access for all people. It focuses on results and financing and takes the social determinants of health and population-level interventions into account.

As UHC and health security are prominent global health concepts which shape global health agendas and communities, debates have emerged whether the concepts collide or function synergistically with each other. While some policymakers and scholars have argued that promoting one agenda could benefit the other (Ooms et al. 2017), others have warned of the opposite effect: that promoting health security may limit and undermine UHC (Erondu et al. 2018).

One reason is that UHC is often considered a horizontal, comprehensive approach while health security is seen as a vertical, disease- or event-specific approach (Nicogossian et al. 2017). It has also been argued that health security is driven by political interests of governments of high-income countries and their national security concerns, while UHC is driven by civil society movements rooted in a sense of cosmopolitism (Ooms et al. 2017). UHC demands a bottom-up approach which assesses local needs, whereas health security is led by top-down interests (Ng and Ruger 2011). Additionally, in underfunded health systems with limited operational capacities, efforts towards UHC may conflict with the health security approach and vice versa (Ooms et al. 2017). This could be the case, for example, when investing in universal health-care access is pawned off against investing in infectious disease surveillance and control. Others have argued, however, that the health security agenda could raise awareness and as such additional funds for issues otherwise neglected, as was the case in the global HIV/AIDS epidemic at the turn of the millennium (Feldbaum et al. 2006).

This chapter provides an in-depth analysis of how health and security have been linked in the global debate and in the area of forced migration. Discussions around the meaning of global health security are commonly held by the global health community and in international relations, while health aspects of forced migrants tend to be addressed by domestic policies. Nevertheless, we argue both have been politicised and to some extent securitised, with important consequences for health policies among forced migrants. We start by examining the rising prominence of the concept of "global health security" and how it has come to be interpreted narrowly as "global infectious disease control". We then argue that through a similar process,

health issues in the context of migration, especially among forced migrants, have been securitised. We provide examples from various countries and time periods, outlining how and why global infectious disease control and migrant health have been framed as security concerns. We proceed to analyse the consequences of the securitisation process in migrant health. The final section addresses the necessary political and conceptual changes required to make use of the benefits that come with the access of migrants to universal health care and infectious disease control for both the host population and forced migrants.

The Evolution of "Global Health Security"

The term "health security" is now widely used by both health-related security actors and the public health community. It has been introduced quite recently, but in order to fully grasp its history and the different meanings that have been attributed to it, we have to take into account the history of transborder security of infectious disease control.

In 1851, triggered by widespread cholera epidemics in Europe, the first international sanitary conference was the starting point for international health cooperation (Brown et al. 2006) and eventually led to the formation of the WHO. Since then, legally binding agreements in the form of "international health regulations" (IHR) (previously "international sanitary regulations") have been in place to combat the spread of a few infectious diseases.

The landmark document for the establishment of the term "health security" was the 1994 Human Development Report (United Nations Development Program (UNDP) 1994). It was themed around "human security" and identified seven dimensions of human security, health security being one. Overall, the report called for a transition from national security, with the nation state at its core, to a people-centred concept of protecting individuals. Based on the premise that security and peace are tied to development and human rights, the report describes health security as comprising two aspects: firstly, *collective* health security to reduce the vulnerability of societies to threats from cross-border health issues and secondly *individual* health security to promote access to safe and effective health services and medicines. This duality of addressing both individual and collective health aspects strongly characterises the comprehensive understanding advocated by UNDP. It explicitly includes anything relevant to individual health, both communicable and non-communicable disease, and links disease to poverty and vulnerability. However, the concept described in the report differs from the implementation of health security policies.

The understanding of health security has since been taken forward and changed by many actors, one of the most noteworthy being the World Health Organization (WHO). In 2001, the World Health Assembly (WHA) adopted a resolution on "Global Health Security: Epidemics Alert and Response" (WHA 2001). This was later described as the first step towards understanding global health security as compliance with the IHR (Aldis 2008) and called for a complete revision of the IHR. Subsequently, a comprehensive reform was undertaken in 2005, and one of the

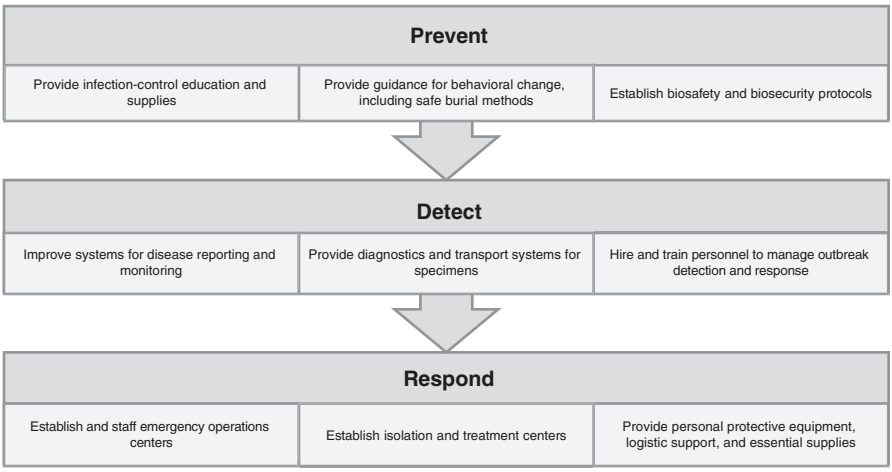


Fig. 7.1 Functions of the International Health Regulations (own illustration)

major changes was the abandonment of specifying diseases under the IHR (formerly yellow fever, cholera, and plague). While the revision broadened the scope using an all-risk approach, it neglected health inequalities and the social determinants of health. The IHR's scope now is to prevent, detect, and respond to the international spread of diseases that impose a risk to public health (see Fig. 7.1). Countries are compelled to notify the WHO in the case of infectious disease outbreaks with either serious public health impact, risk of international spread, or the possibility of travel and trade restrictions. The WHO can then proclaim a public health emergency of international concern ("PHEIC") and quickly initiate a coordinated global response in order to contain an outbreak where it occurs, minimising unnecessary interference on travel or trade (WHO 2008). Ever since the IHR revision, it has had an effect on the governance of health issues in the context of infectious diseases at the international, European, and national levels, by setting rules, norms, and mandates to react and respond to health threats.

The prominence of the concept of "health security" was further strengthened by the 2007 World Health Report. It confirms the necessity of compliance with the IHR in order to ensure global health security (Aldis 2008) but defines health security more broadly "as the activities required, both proactive and reactive, to minimise vulnerability to acute public health events that endanger the collective health of populations living across geographical regions and international boundaries" (WHO 2007). In addition to infectious disease, it also addresses issues such as poverty, violence, and chemical, biological, and nuclear attacks or accidents as important threats to achieving global health security.

In 2014, immediately preceding the 2014–2016 Ebola epidemic, the Global Health Security Agenda (GHSA) was launched as a new partnership in the global health security debate. Comprising over 64 states, international organisations and non-governmental organisations, it aims to support capacity building to prevent,

detect, and respond to infectious disease outbreaks in humans and animals. It further aims to "[…] elevate global health security as a national and global priority" (Global Health Security Agenda 2019). Norm-setting organisations such as the WHO, the Food and Agriculture Organization, and the World Organization for Animal Health serve as advisors to the GHSA member states. Endorsed by the G7 in 2014 and ever since highly driven by the USA, the GHSA developed 11 action packages such as action on zoonotic diseases, real-time surveillance, and workforce development. GHSA's vision reveals their narrow scope in global health security: "a world safe and secure from global health threats posed by infectious diseases, whether natural, deliberate, or accidental"(Global Health Security Agenda 2019).

This narrow understanding is also mirrored in recent developments in global health debates. At the first conference on global health security in 2019, experts in the field of health security consented on health security being "[…] a state of freedom from the scourge of infectious disease, irrespective of origin or source" (Global Health Security Conference 2019).

Two polarising understandings of health security can be outlined: On the one hand, it has been described as addressing all possible threats to human health, both individually and collectively (UNDP definition). On the other hand, health security has been understood as freedom from those infectious diseases that may spread rapidly and therefore interfere with travel and trade.

These conflicting definitions have been addressed by scholars as "narrow" and "broad" definitions of health security (Ooms et al. 2017) or, with a slightly different connotation, as "statist" vs "global" (Rushton 2011). However, as in the case of the World Health Report 2007, definitions do not always fall neatly into these opposing categories, further complicating the discussion.

The term "health security", in its first interpretation by the UNDP, was promoted as "securing health" of individuals. It has then been used to refer to global infectious disease control and the international health regulations, coinciding with a complete reform of the international health regulations. It has been argued that through this shift "the dominant health security discourse captures only a very small proportion of the issues that threaten individual and population health worldwide—those which are of concern to the west" (Rushton 2011). High-income countries have therefore been identified as main actors in the process of securitising infectious disease control (Hwenda et al. 2011). Health security is now understood as security from ill health (as a threat mainly to high-income countries) instead of protecting individuals worldwide.

Securitisation of Health in the Context of Forced Migration

The growing emphasis on securing collective health over individual health needs, and the exclusive narrative of health security as security of selected populations, can also be identified in approaches to health among forced migrants. The securitisation of health in the context of forced migration, i.e. the process of considering migrants a threat to national public health, has a long history. This section provides a historical example (Box 7.2) to outline how forced migrants' health has been identified

Box 7.2: The Case of Ellis Island: Systematic Exclusion of Persons Assumed to Suffer from Illness or Inability to "Make a Living"

Immigrants to late nineteenth-century USA, many of which were forced to leave their countries of origin due to fears of religious or political persecution, had to pass through the infamous "line" at Ellis Island. The "line" referred to a series of "gated pathways resembling cattle pens", where thousands of immigrants were examined rapidly by public health officials (Bateman-House and Fairchild 2008). Even though this procedure originally aimed at the detection of infectious disease, the responsible public health officers conducted a rather broad medical examination, focusing on the exclusion and classification of those who "would not make good citizens" (Bateman-House and Fairchild 2008).

Classification was realised in two categories: Those classified as A were either "dangerous contagious" (including, e.g. tuberculosis and syphilis) or suffering from a "loathsome disease" (including, e.g. "insane persons", "idiots", "feeble-minded", and "imbeciles") and denied entry. Category B consisted of conditions interfering with the ability to "earn a living", such as debility, senility, pregnancy, and "poor physique", and exclusion was up to the discretion of the responsible public health official (Fairchild 2003). When denied entry to the USA, migrants were either held captive in isolation on Ellis Island or deported directly. Some were granted hospital treatment, but on their own expenses. Often, this resulted in deportation due to pending medical bills (Bateman-House and Fairchild 2008).

Despite all restrictions, only a fraction of prospective migrants was effectively denied entry as demand for cheap labour force was high in the industrial era. Eventually, however, the labour market saturated and immigration procedures became more restrictive. In 1924, obligatory and privately paid medical examinations were introduced and had to be completed prior to departure (Bateman-House and Fairchild 2008). This so-called pre-entry screening is still in place, although the evidence suggests that only a small fraction of tuberculosis cases is identified pre-entry (Aldridge et al. 2016), and similar screening procedures are applied by many other high-income countries (e.g. Canada, Australia; see also Chap. 10). Remarkably, immigration regulations have not changed drastically since the nineteenth century: Prospective migrants to the USA are still categorized A or B, A implying infectious pulmonary tuberculosis and impeding admission to the country. Furthermore, current US law still lists under "inadmissible aliens on health-related grounds": anyone determined to have a communicable disease of public health significance and anyone with "a physical or mental disorder […] that may pose, or has posed, a threat to the property, safety, or welfare of the alien or others".

and treated as a threat to the security of host populations over time. We argue that this not only happened in terms of infectious disease control but also included mental health and the public costs of disease. We continue to examine whether these approaches are still of importance today.

The example from Ellis Island (Box 7.2) serves as a particularly vivid case for the securitisation of migrants' health for three reasons: Firstly, it shows that contemporary screening programmes are often historically rooted and tend to persist. Secondly, it shows that the scrutiny of the screening depends on the political willingness to accept migrants. Thirdly, it illustrates the threats associated with the (ill) health of forced migrants: It is seen as a threat to population health through the importation and spread of infectious disease from high-endemic to low-endemic countries, a threat to overall security through mental illness, and a threat to prosperity and state budget through costly diseases. The significance of all three arguments and their (implicit or explicit) reflection in contemporary policy and practice will be examined briefly in the succeeding sections. To this end, we focus on current screening programmes, especially for tuberculosis, and discuss cost-containment policies and two case studies from Germany on mental health and vaccination among asylum seekers and refugees.

Screening for Infectious Disease: Security for Whom?

Besides the USA, many high-income countries screen asylum seekers for infectious disease through pre-entry screenings (e.g. Australia, Canada), directly at arrival, or in the scope of registration for the asylum process (e.g. Germany). Diseases screened for include tuberculosis, hepatitis B/C, and HIV (Kunst et al. 2017; ECDC 2018; see also Chap. 10 "Assessing the Health of Persons Experiencing Forced Migration: Current Practices for Health Service Organisations").

While the overall aim of screening programmes is to control infectious diseases, end transmission, and prevent infections, it remains unclear who or what they primarily intend to protect: migrants from the consequences of disease, migrants from other migrants in shared accommodation centres, native populations from migrants, or publicly financed health systems from costly treatments.

Public opinion tends to focus on protecting host populations (e.g. Die 2018). Nonetheless, most evidence shows that transmission of communicable disease rarely occurs between foreign-born and native-born populations. For tuberculosis, for example, molecular epidemiological studies show that even though in low-endemic settings migrant populations make up a relevant proportion of tuberculosis cases, transmission between foreign-born and native-born populations rarely occurs (Lillebaek et al. 2002; Sandgren et al. 2014). Migration may therefore be associated with rising incidence of tuberculosis in low-endemic countries, but the rising incidence stems from the reactivation of disease in migrants and not from transmission to the host population. Several studies even suggest that foreign-born patients with tuberculosis cases are less likely to transmit disease compared to native-born tuber-

culosis patients (Chin et al. 1998; Fok et al. 2008). If disease transmission does occur, this is far more likely to happen within migrant communities than to native populations (Sandgren et al. 2014). The same is true for many other infectious diseases, as is shown by the case example of disease outbreaks in shared housing facilities in Germany (Box 7.3). Better housing conditions, improved hygiene in reception centres (Bozorgmehr et al. 2016), social integration, and good access to primary care are measures to prevent such outbreaks. Although the evidence shows that structural factors and supply-side factors of the health system are the drivers of outbreaks and potential vaccination gaps, national policy responses have securitised the issue by passing legislation for mandatory vaccination programmes linked to financial penalties (Box 7.3).

Box 7.3: Gaps in Vaccination Coverage: A Demand-Side or a Supply-Side/Structural Problem?

A review of 10 years of infectious disease outbreaks for all shared housing facilities of asylum seekers in Germany (2004–2014) showed that outbreaks were related to vaccine-preventable and diarrhoeal disease (varicella, measles, scabies, rotavirus, influenza, salmonella, and norovirus) and in very few cases to tuberculosis. Only in 2 of 117 outbreaks over 10 years a transmission occurred to the population outside of the shelter. Both events were cases of measles (Kuehne et al. 2015).

These outbreaks are preventable through structural and individual preventive interventions, such as better vaccination services, which have been shown to be insufficient and poorly managed in the context of refugee shelters (Bozorgmehr et al. 2016). Experience from practitioners in refugee shelters, and evaluations of outreach vaccination programmes, shows that vaccination uptake is very high among asylum seekers and refugees (Brockmann et al. 2016). The evidence hence clearly shows that gaps in vaccination coverage among asylum seekers and refugees are a supply-side, rather than a demand-side, problem. Despite these facts, national legislation will be passed in 2019 making measles vaccination mandatory for asylum seekers and refugees in reception centres and shared accommodation facilities. Non-compliance will be penalised by high fines. The act of securitisation here addresses migrants' presumed denial of vaccinations, requiring the extraordinary measure of making vaccinations for asylum seekers mandatory.

If the rationale of screening was the protection of the individual from disease, we would expect to find the detection and treatment of disease to be consistent with the needs of forced migrants. Data about burden of disease of forced migrants is difficult to obtain due to intra-group heterogeneity, lack of reporting, and differences of social determinants in host countries (World Health Organisation Regional Office 2018). Despite these difficulties and uncertainties, however, overall trends show that

even though migrants tend to have somewhat higher morbidity and mortality ratios for infectious disease than host populations (Aldridge et al. 2018), morbidity and mortality for non-communicable diseases (NCDs) are significantly higher: NCDs account for 86% of deaths and 77% of disease burden among migrants in the European region (World Health Organisation Regional Office 2018). Hence, from a population health perspective, the focus on screening for and treatment of infectious disease in forced migrants does not target the most important health needs of this very heterogeneous population. Nevertheless, forced migrants from countries with high prevalence of tuberculosis are at a higher risk of suffering from tuberculosis or being asymptomatically infected with the disease. Equally, extra-pulmonary tuberculosis poses a high risk (WHO 2018) but is not addressed by public health measures because it is not as infectious. An evidence-informed and needs-based rationale to screening for tuberculosis would therefore be (a) to explicitly target those at higher risk of having and developing tuberculosis (Bozorgmehr et al. 2019), (b) to take extra-pulmonary disease into consideration, and (c) to include screening for latent tuberculosis infection and offer treatment to those at risk of developing active tuberculosis (WHO 2018).

It seems reasonable to conclude that current programmes primarily serve to prevent the spread of disease in shared housing and migrant communities, therefore primarily protecting forced migrants themselves. However, it is not guaranteed that screening is accordingly perceived by migrants as being implemented for their own protection or that the aim of screening is communicated accordingly by public health authorities. Defining the target population is furthermore relevant for evaluating the effectiveness and cost-effectiveness of public health screening programmes (Wilson and Jungner 1968; Andermann 2008). A survey on screening measures for asylum seekers implemented in 28 European countries concluded that few experts considered the structure and implementation of screening measures in their countries to be sufficiently well executed (Kärki et al. 2014). The screening programmes in some regions of Germany, for example, have been criticised for being irrational, as screening is mandatory for very rare diseases, leading to low yields, a high number needed to screen, and high costs (Bozorgmehr et al. 2017).

We argue that these irrational and costly screening practices are the result of securitisation in the context of forced migration. As these investments are unlikely to translate into improved population health (of forced migrants or residents), they can be attributed as costs to suit the "security concerns" of authorities. What is more, parallel to the debate of "global health security", we see a strong focus on public health and collective security over ensuring the health of the individual. This is illustrated by more recent developments in the context of screening for and addressing mental diseases among asylum seekers and refugees (Box 7.4). While screening for mental illness, such as depression, has the potential to be cost-effective given appropriate follow-up care processes (Biddle et al. 2019), there are severe gaps in access to appropriate services (Satinsky et al. 2019). In Germany, these shortcomings can be attributed to limited capacities of the mental health-care system, but also to a lack of prioritisation in terms of health planning and budget allocation by policymakers. Well-intended attempts to raise awareness of this issue also

Box 7.4: Addressing Mental Illness Among Forced Migrants: Individual Need or Threat to Society?

Calls for addressing the mental health of forced migrants have been generally based upon a needs-based discourse, linking to human rights and equity arguments in providing psychosocial care for refugees or asylum seekers with a high burden of mental illness. Recently, however, a shift of the discourse towards securitisation can be observed. In a recent report on traumatised refugees, the National Academy of Sciences in Germany (Leopoldina) called for rapid measures to address the mental health needs of refugees in Germany. One of the main lines of argument is that a failure to address mental illness could pose a threat to German society, as refugees with untreated illness could potentially have a lower threshold for violence and aggression (Leopoldina - Nationale Akademie der Wissenschaften 2018). While the intention of this argument is to facilitate access and raise awareness among policymakers with regard to the potential consequences of untreated mental illness, the securitisation poses a slippery slope, potentially leading to a consideration of refugees themselves as a risk, motivating policymakers to impose even more restrictive immigration policies. This is particularly dangerous, as emerging evidence suggests that restrictive policies (i.e. securitisation of immigration) may increase mental illness among migrants (see Chap. 8 "Security over Health: The Effect of Security Policies on Migrant Mental Health in the UK").

make use of securitisation arguments in addition to needs-based ones, aiming to mobilise resources for identification and treatment of mental conditions (Box 7.4).

Even though in practice the aim of screening programmes is to protect the collective health of migrant and asylum-seeking populations, the public and medical debate seems to focus on the host population, a phenomenon which is described in more detail in Chap. 10 "Assessing the Health of Persons Experiencing Forced Migration: Current Practices for Health Service Organisations".

Restriction of Entitlements to Health-Care Services for Forced Migrants

Restriction of entitlements to health care for forced migrants are in place in many countries (International Organisation for Migration 2016). The act of restricting health-care entitlements for a certain population group is not commonly framed in the classic narrative of security theory because health-care utilisation is rarely explicitly named as threat to security. In this section, however, we argue that restrictions to health-care entitlements can actually be explained by classic security theory or by the resulting process of framing migrants themselves as a threat to society.

For refugees, the "Convention Relating to the Status of Refugees and its Protocol" explicitly guarantees the "same treatment with respect to public relief and assistance as is accorded with nationals" (United Nations High Commissioner for Refugees 2010). Nonetheless, national laws do not always endorse and respect international laws. Even though many countries, including all countries of the European Union, commit to UHC, this is often not realised for forced migrants (see also Chap. 5). For asylum seekers and especially irregular migrants, access is governed even more restrictively (Abubakar et al. 2018).

The reasoning behind restricting access is rarely stated explicitly by legislative authorities or bodies. However, there are two common readings, which may contribute to varying degrees to the decision to limit health-care entitlements: first, to protect the national health system from rising costs and, second, to discourage "health seeking migration", assuming that forced migrants may choose their destination based on considerations of where they might receive the best health care.

With respect to the first argument, the protection of the health system from costs arising as a result of disease treatment may be an especially relevant consideration for countries with premigration screening programmes. In the USA, for example, prospective migrants—including refugees—are required to complete screening and treatment for pulmonary tuberculosis at migrants' own expense before departure (Liu and Painter 2009). In Australia, applications for residency can be denied if "an applicant has a health condition for which treatment is likely to result in significant health care […] costs to the Australian community" (Migration Regulations 1994 as cited by Abubakar et al. 2018). In Taiwan, migrants have been deported upon the detection of tuberculosis. This practice has recently been restricted to multidrug tuberculosis, which entails significantly longer—and therefore costlier—treatments (Kuan 2018).

Going back to the process of securitisation described by Buzan et al. (1998), they argue that the framing of an issue as threat to security serves not only to allocate an extraordinary budget but also *to use extraordinary measures* to respond to them: "to break the normal political rules of the game" or by "placing limitations on otherwise inviolable rights". This might be the reasoning behind restricting health care for specific groups, e.g. asylum seekers, despite committing to UHC, or behind infringing on the right to health despite having ratified the right to health. If the protection of public funds is the underlying motivation for entitlement restrictions as "extraordinary measure", adequate supranational health financing policies may help to overcome the security logic (see also Chap. 5).

In the case of the second argument, restricting health care is used as a political instrument to discourage migration. The same mechanism is applied, for example, in the UK, where "voluntary" repatriation is enforced by denying or charging for health services (United Nations High Commissioner for Refugees 2010) or when medical staff is required to report undocumented migrants (Abubakar et al. 2018). In these cases, health and access to care is used as an element of political control. In these processes, the object of securitisation is not migrants' health but the migrants themselves. These measures are thus repercussions of a broader context in which migrants have been securitised and the restrictions, denial, and charging for medical services are used as "extraordinary" mechanisms to respond to the threat migration poses to society (see also Chap. 8).

Negative Consequences of Securitising the Health of Forced Migrants

We have shown that forced migrants may be identified as a threat to population health by framing them as carriers of infectious disease, as a potential threat to security if (mentally) ill, and as causing costs rather than contributing to state-funded welfare systems. Reducing migrant health to infectious disease concerns has been called "the maybe most pervasive and powerful myth related to migrants and health throughout history" (Abubakar et al. 2018). We now examine three consequences of these security-based approaches on migrants' access to care and healthcare provision.

The first consequence of securitisation is the effect on the allocation of resources. Budget allocation is directed towards those infectious diseases identified as threat to community health in host countries rather than the identification of needs and vulnerabilities of the individuals. While screening programmes for infectious disease are implemented in many high-income countries (ECDC 2018), very few have successfully implemented vulnerability assessments (despite existing legislative framework; see also Chap. 10). Another example is that access to vaccination against infectious disease is commonly recommended and provided for forced migrants, whereas, e.g. in Germany, vaccination against the human papilloma virus is not part of the package recommended for asylum seekers in reception centres (Robert Koch Institute 2015). Other potentially more important causes of disease to the individual, such as non-communicable diseases, may also be neglected.

The second consequence is the process of identifying the disease itself as threat, which may lead to discrimination and stigmatisation for the identified carrier of the disease. This process (shown for tuberculosis by Abarca Tomás et al. 2013) may cause asylum seekers to negate or deny symptoms of (infectious) disease or avoid accessing health services out of fear of negative repercussions for the asylum process. This can lead to the creation of additional barriers for migrants to access health services and may also dramatically undermine measures of effective disease control (see Chap. 11). This may result in the deterioration of health status and potentially avoidable health emergencies and hospitalisations (Lichtl et al. 2016).

The third consequence is that restriction of entitlements to health care may lead to difficulties in accessing UHC in all three of the dimensions mentioned previously: universality, services, and financial protection. Tying entitlements to health care to legal status and/or nationality clearly contradicts the concept of universality. Even though some countries generally grant access to health care for documented migrants, many countries limit them in their scope, granting access only to certain services, e.g. emergency care, acute conditions, or maternal services (see also Chap. 5). Financial protection, the third dimension, is also not guaranteed in many situations: with missing legal entitlements, as is often the case for undocumented migrants or transiting migrants, health expenses and necessary medication may need to be paid out of pocket or require co-payments (Abubakar et al. 2018). Furthermore, restricting health services to acute and urgent conditions has been

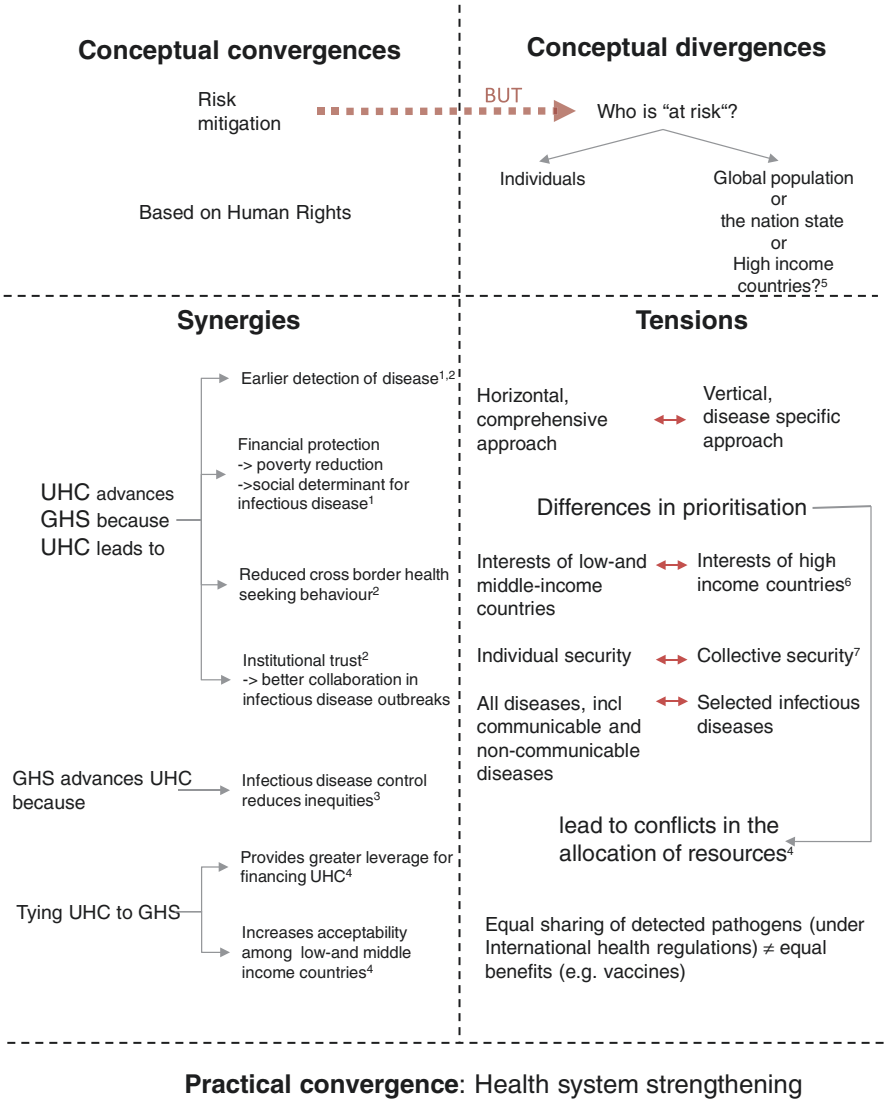
shown to create exactly the opposite of the intended effect, leading to higher health-care expenditures among forced migrants through late diagnosis, preventable hospitalisation, and a shift from primary care to tertiary care structures (Bozorgmehr et al. 2015). The consequences are even more detrimental for irregular migrants, as mandatory reporting of irregular migrant status by health-care workers may mean that health services are avoided at all costs (see also Chap. 8).

UHC for Forced Migrants: Benefits for Host Populations and Forced Migrants

Four mechanisms have been described and summarised by Wenham et al. (2019), describing the synergies of UHC and infectious disease control: Firstly, individuals suffering from disease may be detected and treated earlier under UHC (Jain and Alam, 2017). Secondly, when access to health services is assured, individuals are less likely to seek health care abroad, decreasing the risk of transnational spread of disease. Thirdly, UHC helps to build trust between citizens and (public) health institutions, an essential prerequisite for effective cooperation in the case of an epidemic (Heymann et al. 2015). Finally, UHC protects people from poverty and therefore addresses the social determinants of infectious disease (Jain and Alam 2017). Positive effects operating the other way around have also been illustrated, as effective infectious disease control reduces health inequities (Ooms et al. 2018). The conceptual convergences and divergences, synergies, and tensions are summarised in Fig. 7.2.

Even though the public health community tends to avoid the securitisation perspective, in the context of migration securitising forced migrant's health may entail some benefits for host populations and forced migrants. In many countries where health entitlements are restricted, framing infectious diseases as threat has led to free provision of diagnostics and treatment for these diseases. In the UK, for example, tuberculosis treatment is exempted from the user fees imposed upon migrants who are denied asylum (United Nations High Commissioner for Refugees 2010). However, if implemented exclusively on a security rationale, this approach may also lead to the perception of forced migrants as vectors of infectious disease and deflect attention from the fact that forced migrants are a vulnerable population with individual health needs.

Lifting restrictions on health-care entitlements and ensuring UHC for all forced migrants, no matter their legal status, may be beneficial not only for migrants themselves but also for infectious disease control. In the case of tuberculosis, data from national surveillance programmes in low-endemic countries shows that even though a growing proportion of detected cases is attributable to foreign-born patients, most of these cases cannot be detected by screening for active disease upon entry as they stem from the reactivation of latent disease and occur after migration (Aldridge et al. 2016). Avoiding stigmatisation and removing barriers to health service access contribute to a timely detection and lower cost of disease while decreasing risks for



[1]Jain and Alam, 2017; [2] Yates et al 2015; [3] Oom set al 2018; [4] Ooms et al 2017; [5] Rushton et al 2011

Fig. 7.2 Conceptual and empirical synergies and tensions between universal health coverage (UHC) and global health security (GHS), own illustration adapted from Wenham et al. (2019)

transmission (Lonnroth et al. 2017; Sreeramareddy et al. 2009). Additionally, adherence to treatment is essential in order to prevent the creation of drug-resistant bacteria. The accessibility of health information and positive experiences and interaction with health-care providers are thus of utmost importance (Abarca Tomás et al. 2013; Lonnroth et al. 2017), and this would be facilitated by providing UHC.

Ooms and Jahn (2017) state that "efforts to improve global health security contribute to global health equity, albeit only to a part of global health equity". The same is true in the context of forced migration. Combatting infectious disease in an evidence-based and cost-effective manner is in the best interest of everybody and ultimately contributes to migrants' health, despite being just one health concern among other, often more pressing issues. Acknowledging the heterogeneous nature of forced migrants requires the use of disaggregated data. This may then lead to targeted screening measures that increase effectiveness and cost-effectiveness of established screening programmes and help to tailor screening programmes to burden of disease (Bozorgmehr et al. 2019). Bringing current programmes in line with criteria for public health screening measures (see above Wilson and Jungner 1968; Andermann 2008) by explaining the procedure and consequences of outcomes and ensuring access to treatment may also increase the acceptability of screening programmes for migrants.

Tensions between individuals' rights and collective health are a classic public health dilemma and reinforce the need to carefully balance the harms to the individual against the actual benefits for the public. Beeres et al. (2018) suggest another approach to overcoming the ethical dilemma of restricting individuals' autonomy and liberty to decide whether to participate in a screening programme (Beeres et al. 2018). Using the concept of reciprocity, described as "to return good in the proportion to the good we receive, and to make reparations for the harm we have done" (Becker 2014), they argue that the participation of individuals in obligatory screening programmes creates the moral obligation of the executing institutions to assist "the individual (or the community) in the fulfilment of their health care needs, including identification of personal health needs and providing accessible treatment when needed". Such an approach, however, may be considered to collide with the notion of anchoring health services in the right to health.

How to Make Use of the Benefits: Necessary Conceptual and Political Changes

To make use of the benefits that come with migrants' access to universal health care and infectious disease control, practical and fast changes in health-care provision and policy are needed. In the following section, we provide three necessary steps for this:

Firstly, forced migrants' health needs to be de-securitised politically and in the public debate. Forced migrants do tend to have higher risks of suffering from infectious disease than the respective host populations, but transmission of infectious diseases between migrant groups and host populations rarely occurs. Rather, post-migration factors put forced migrants at higher risk of acquiring and suffering from infectious diseases. Acknowledging this and de-securitising migrants' health accordingly would help to remove associated stigma, benefitting both infectious disease control and access to services, while shifting the attention to post-migration

social determinants which may favour the spread of infectious diseases among forced migrants. The securitisation process has further led to a discourse in which the rights and needs of the individual may be disregarded in order to ensure collective security. De-securitising migrants' health would help to equalise individual versus collective health aspects.

Secondly, in line with Heymann et al. (2015), we call for the acknowledgement that individual health security is an essential element for collective global health security and that effective risk reduction needs to address all levels—the individual, national, and global level. Successful collective health security and infectious disease control are therefore tied to UHC as a means to achieve individual health security.

Thirdly, and perhaps most importantly, both health security and UHC need to be interpreted inclusively and therefore truly anchored in the human right to health. Wenham et al. (2019) have argued that convergence between the two concepts of health security and UHC could "be found through the realization of the right to health, with both UHC and global health security requiring that states address inaction or regression in realizing the right to health to the mutual benefit of both […]".

Taking into consideration that Ooms et al. (2019) have demonstrated that the right to health has historically been considered a citizens' right, granting rights to those considered a citizen under the respective governments and excluding whoever was historically considered to be "non-citizens", such as women, slaves, or non-nationals—the common anchor in an inclusively interpreted right seems to be a crucial point to the discussion. The authors further argue that the "shift from citizens' rights to human rights has not been completed yet" and that moving beyond citizens' rights towards human rights requires citizens who challenge current policy narratives and who "elect governments that prioritize human rights in domestic and foreign policy" (Ooms et al. 2019). If both concepts are sustainably anchored in the right to health, inclusive health systems can promote health security efforts that respect the right to health and UHC for all, including forced migrants.

Conclusion

Linking health and security has triggered a process of securitising health. Over the years, the concept of "global health security" has been equated with infectious disease control. It has been implemented through the international health regulations and governed, to some extent, by high-income countries driven by their national rather than by global interests. At the same time, there has been a global movement advocating for the establishment of UHC. Its aim is to improve health care by ensuring universal access, essential services, and financial risk protection.

Both agendas, achieving UHC and global health security, have been promoted and advocated for sometimes by the same actors (e.g. WHO). This has caused a comprehensive discussion about whether the agendas complement or conflict with

one another, by what means they could be aligned, and what positive or negative effects could be expected by such alignment.

The process of securitising health, especially infectious disease, has negatively affected forced migrants. Many high-income countries have installed comprehensive pre-entry screening measures for infectious diseases, while other countries have employed travel restrictions based on health status. At the same time, for reasons of containing costs or using access to health care as a political lever, forced migrants suffer from the exclusion from health systems, a limitation of services, and a lack of financial protection. Tendencies to use the denial of or charging for healthcare services as means to "disincentivise" forced migration or to enforce "voluntary" repatriation can be observed. To some extent, health security approaches have resulted in the creation of further barriers to health service access, resulting from stigmatisation and other negative repercussions of an infectious disease diagnosis.

Despite these current discrepancies, some synergetic potential for forced migration can be seen between the two seemingly contradicting agendas. We argue that a successful linkage of health security and UHC agendas to the benefit of both forced migrants and host populations is possible. However, three underlying conditions (political, practical, and conceptual) need to be fulfilled in order to achieve rational, effective, and cost-effective approaches to infectious disease control and UHC. This requires careful planning, disaggregated data, and a continuous evaluation of inclusive public health programmes which are anchored in the right to health.

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