Restrictive migration policies in low-income and middle-income countries

Sol Pia Juárez and colleagues' analysis[1] of the effects on migrant health of non-health-related migration policies (April, 2019) strengthens the case for policy coherence and for a health-in-all-policies approach to migrant health. The scope of their discussion, however, excluded consideration of the contexts of the global south and of low-income and middle-income countries (LMICs). Aptly highlighted in the linked Comment by Kayvan Bozorgmehr and Rosa Jahn,[2] the conversation should also extend to the practical entry points for translation of evidence to influence policy change. In response to these points, we call attention to some dimensions of non-health policies in southeast Asia (to represent the global-south and LMIC contexts), and briefly suggest how national health-system actors could use current global windows of opportunity to advocate for and pursue policy change both within and beyond the health sector.

Despite burgeoning international anti-migration sentiments, now is an opportune time for migration-policy advocacy and reform. The Global Compact on Migration[3] has been signed and adopted at a global level—despite some notable opt-outs. There are continuing discussions and programme developments in migrant and refugee health policy within the World Health Assembly (WHA) and WHO. Recent developments include a WHA resolution for member states to prioritise and strengthen migrant and refugee health within national contexts, the establishment of a global framework of priorities and guiding principles (2018),[4] and a Global Action Plan,[5] presented at the WHA 2019. These initiatives promote the mainstreaming of migrant and refugee health in global, regional, and country agendas, including in the pursuit of the Sustainable Development Goals and universal health coverage, which also includes the task of addressing the influences of non-health sectors on health through intersectoral, intercountry, and inter-agency collaborations.

Although these global policy developments offer local and national actors a window of opportunity to drive necessary policy change forward, actors must also be well positioned and skilled to tactfully identify, deconflict, and balance policy dynamics across levels, sectors, and actors. Alignment of relevant socioeconomic policies—such as rights to engage in decent work and income generation, access to health care without risk of catastrophic or impoverishing financial risks through health or social insurance, and structural protection against exploitation, abuse, and harm—is integral to migrants' access to care and health outcomes. For example, in Malaysia, refugees can use public health services at subsidised out-of-pocket costs. Additionally, the Malaysian office of the UN High Commissioner for Refugees negotiated a (currently suspended) voluntary private health insurance scheme for refugees. However, both initiatives are often unaffordable for refugees because they do not have the right to engage in formal-sector work and generate income.[6] In this situation, a non-health-related policy undermines the health-sector programmes. Policy change to provide work rights to refugees is required to optimise the benefits of health access and financing arrangements.

In the global south, restrictive policies are also imposed by source countries, sometimes for positive reasons, including those of economic strategy and human security. For example, Myanmar and Cambodia have implemented gender-based restrictions on formal routes of migration as a safety measure following reports of abuse and exploitation of their female nationals in destination countries.[7] In another example, Laos bans migration for work that does not develop skills or knowledge, endangers safety and health, or contradicts traditional Laotian values. Domestic work is considered a grey area of this policy, and government officials tend to reject the applications of their country nationals who seek overseas work through formal channels.[8] Whether these policies are successful in preventing migration is debatable. For instance, in Thailand, 90% of migrant domestic workers from Myanmar are registered; by contrast, just 4% of Laotian domestic workers are registered.[9] These policy effects are likely to have implications on care-seeking and health-financing arrangements and ultimately, on health outcomes.

Further research, advocacy, and capacity-building to support policy change and coherence across sectors are required, including managing the complex broader economic and sociopolitical dynamics that lead to non-health policies that produce negative health consequences in migrants. Ultimately, health system actors need to adopt a health-in-all-policies approach and be active and responsible promoters of policy coherence across national and local levels to ensure the health of migrants. Among the many other requirements necessary to achieve reform, health-system actors cannot only use strong and objective evidence but must also be prepared to engage in the long-term process of identifying mutually beneficial incentives and outcomes across sectors and administrative levels in order to formulate joint and cohesive strategic plans and adapt the policy architecture itself.

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