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Limitations and Consequences of Migrant and Refugee Healthcare- An Analysis of the Current State of Migrant Health

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LIMITATIONS AND CONSEQUENCES OF MIGRANT AND REFUGEE HEALTHCARE: AN ANALYSIS OF THE CURRENT STATE OF MIGRANT HEALTH

By

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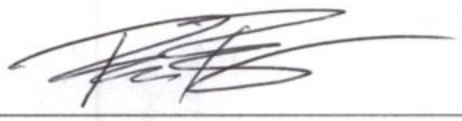

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THESIS SUMMARY

Migrants and refugees are an often-neglected specialized population in the field of healthcare, although making up over 14% of the world's population.

The following paper examines the current state of migrant healthcare, including but not limited to ease of access, quality of care, and the accompanying stigmatization of immigrants in general. It then analyzes current policies, both national and global, influencing the healthcare of immigrants in both the United States and abroad. Finally, a comparison of migrant healthcare in the United States versus Thailand shows how the current U.S. healthcare system can be improved to better accommodate migrants and refugees.

Research was conducted using peer-reviewed articles, popular sources, government documents, and interviews with professionals working with immigrant populations. Those interviewed include:

- Eduardo Reyes, Manager of the Spanish Catholic Center in Silver Spring, MD, a medical clinic providing services to primarily uninsured Latino immigrants.
- Dr. Christopher Dunford, a physician at the Spanish Catholic Center.

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INTRODUCTION

Since 1997, the estimated global number of migrants has increased by over 20 million (Dijstelbloem, 2017). One in seven of the world's population is a migrant ("Refugee and migrant health", 2019). This is due to a number of factors, including armed conflict and civil unrest, poverty, crime, persecution, and climate change (Hayes et. al., 2016). With such a high population of people with no set country of residence, it is hard to establish protective policies which extend globally. Currently, one of the only documents serving to protect refugees is the 1951 Refugee Convention, which guarantees liberty, security, right to family life, protection, and freedom of movement ("10 things to know about the health of refugees and migrants", n.d.). However, there are no documents specifically advocating for migrant and refugee health. At the 72nd World Health Assembly in May 2019, delegations from all World Health Organization member states discussed a report to promote the health of refugees and migrants in a global action plan for 2019-2023. This plan would promote both short-term and long-term public health goals, while mainstreaming the global agenda of refugee and migrant-sensitive health policies (Pant, Eder, Vračar, Mosca, & Orcutt, 2019). As of April 2021, nothing has been done to put this plan into action.

Approaches to migrant healthcare vary around the world, and are especially different between the United States and Thailand due to fundamental differences in healthcare systems. The U.S. combines both private and public insurance coverage, with many migrants either unable to afford or ineligible for either system. Thailand, on the other hand, has a universal health coverage system, with most migrants covered either through their work or an individually purchased health insurance card.

In the U.S. specifically, some of the problems leading to poor migrant healthcare are language barriers and stigmatization. The majority of the migrants crossing the U.S. border are coming from Central America, where indigenous languages are commonly spoken. Interpreters are few and far between, and these languages are unknown by them, leading to miscommunication and confusion for both doctor and patients. Even in migrants with access to insurance, healthcare usage is much lower than the U.S.-born population, in many cases due to fear. Those with undocumented status (and even some documented migrants) fear public agencies due to the risk of deportation if their immigration status is known. Because of this, providing healthcare to migrants cannot be done with a single intervention, but should rather be a multi-stage approach.

METHODOLOGY

Research was performed through both literature review and interview with individuals working in the field of migrant healthcare. Most information was gathered from scholarly articles, government publications, and releases from universal rights organizations such as the United Nations and the World Health Organization.

I developed a series of questions in order to gain more candid insight on the issues facing migrant and refugee healthcare today, specifically from those who have worked with them firsthand. The interview subject was selected based on convenience sampling of professionals with experience working with refugee populations. Both Eduardo Reyes and Dr. Christopher Dunford are employed by Catholic Charities at the Spanish Catholic Center in Silver Spring, MD, where I completed a summer public health internship. Catholic Charities is a nationwide social services agency running a variety of programs including immigration services, integrated healthcare, food and homelessness assistance, and foster care services. The Spanish Catholic Center offers medical services to immigrants from around the world and continues to operate at a loss in revenue each year in order to support the low-income immigrant community. Dr. Dunford provides primary care as a specialist in internal medicine, while Eduardo functions as the manager of the medical clinic.

Interviews were performed over email. The questions were emailed to each subject individually, and each was given ample time to respond.

Although this thesis involves interviews of human subjects, IRB approval is not required. Please see the following statement from the UofSC Office of Research Compliance regarding undergraduate research:

"USC defines undergraduate research as a scholarly effort, generally beyond the classroom, aimed at developing a student's skills in inquiry through opportunities to contribute to and/or pursue original intellectual or creative work. This is a research experience undertaken for the student's benefit. It is not research as defined in regulation and policy; therefore, IRB review is not required. This includes capstone projects, honors theses, and similar activities such as Magellan, Honors, and other undergraduate initiated grant projects.

Faculty advising undergraduates involved in a research experience are responsible for ensuring that the students understand and abide by ethical obligations in carrying out their projects. The IRB recommends that, at a minimum, students complete the training modules available through CITI. Additionally, instructors are responsible for reviewing student projects to ensure that the methods and procedures are ethical and appropriate. This includes monitoring student activities during the conduct of the project to ensure that the rights and welfare of participants are adequately protected."

BODY OF THESIS

Current Health Issues and Barriers to Care

The migratory process has a large impact on the effectiveness of healthcare policies for refugees. To examine the process, we can separate it into three phases: pre-departure, travel, and destination. The pre-departure phase includes all time before leaving the country of origin, the travel phase consists of any time migrants are between the country of origin and their destination, and the destination phase refers to when migrants begin to settle in their long-term location and establish careers and permanent places of residence. Each phase has risks for different health problems and has different limitations to healthcare delivery (Lee, 1966).

Health in the pre-departure phase is influenced by multiple factors, including biological characteristics, environmental factors, and political and personal circumstances. The country of origin is where many chronic diseases such as diabetes or hypertension can begin to develop, and citizens may be exposed to physical and emotional trauma resulting in PTSD and depression and infectious diseases such as tuberculosis or intestinal parasites without access to adequate treatment. Because many immigrants come from low-income backgrounds, their country of origin may have stunted healthcare infrastructure to begin with, which would limit access to regular primary care screenings, mental health services, and even access to specialized physicians such as dermatologists or dentists (Welshman, 2006).

Travelling across borders opens migrants up to a variety of risk factors for poor health, including but not limited to close proximity to other migrants and fluctuations in weather. Risk for highly contagious diseases is high due to pathogen transport and differences in immune systems, while sexual and physical assault occurs at alarming rates among women and children (Epstein et.al., 2011). Weather-related injuries such as heatstroke and hypothermia are also

common, along with accidental injuries such as drowning or falls. Migrants can expect very little access to health care along migration routes, and care for life-threatening injuries is likely to be unaffordable to most. Because of this, minor colds and small cuts may develop into much bigger problems, such as pneumonia and infection (Sapkota et.al., 2006).

The destination phase of the migratory process is in most cases the longest phase, and therefore leaves room for many problems to arise. Upon arrival, most if not all migrants will not have an established primary care physician, and therefore are more likely to develop non-communicable, chronic diseases such as heart disease, hypertension, and reproductive health problems, which can lie dormant and go unchecked for years (Marmot & Syme, 1977). It may be difficult to obtain affordable insurance coverage, especially in a country without universal coverage such as the U.S. Undocumented migrants and refugees may also fear deportation if their migratory status is learned. Both of these factors may deter migrants from visiting the doctor altogether, causing further complications in existing illness. Migrant workers are at increased risk of illnesses due to close living conditions, poor sanitary conditions, and workplace safety violations. Because of fear of deportation in the U.S. in particular, there is very little specific data available about health problems after migration, especially in asylum seekers (Ahonen,et.al., 2007). Eduardo Reyes, manager of a privately funded clinic for migrants, states that even for migrants with access to primary care barriers to equitable care can include "being underinsured or uninsurable, Latino migrants' low health literacy, generational health issues, out-of-pocket health care costs, complexity of health issues, political vulnerability, and trauma."

In matters of mental health specifically, it is found that migrant groups experience rates of mental disorders which do not reflect the rates in the countries of origin, meaning that rates of certain mental health problems can be linked to specific migration trajectories. The table below

shows specific factors related to migration which negatively affect mental health (Kirmayer et al., 2010).

Premigration	Migration	Postmigration
Adult		
Economic, educational and occupational status in country of origin	Trajectory (route, duration)	Uncertainty about immigration or refugee status
Disruption of social support, roles and network	Exposure to harsh living conditions (e.g., refugee camps)	Unemployment or underemployment
Trauma (type, severity, perceived level of threat, number of episodes)	Exposure to violence	Loss of social status
Political involvement (commitment to a cause)	Disruption of family and community networks	Loss of family and community social supports
	Uncertainty about outcome of migration	Concern about family members left behind and possibility for reunification
		Difficulties in language learning, acculturation and adaptation (e.g., change in sex roles)
Child		
Age and developmental stage at migration	Separation from caregiver	Stresses related to family's adaptation
Disruption of education	Exposure to violence	Difficulties with education in new language
Separation from extended family and peer networks	Exposure to harsh living conditions (e.g., refugee camps)	Acculturation (e.g., ethnic and religious identity; sex role conflicts; intergenerational conflict within family)
	Poor nutrition	Discrimination and social exclusion (at school or with peers)
	Uncertainty about future	

One of the greatest limitations in effective healthcare delivery is the language barrier. Language barriers in healthcare lead to miscommunication between clinician and patient, facilitating dissatisfaction on both sides and decreasing healthcare delivery quality and overall patient safety. In the United States specifically, limited proficiency in English is linked to higher risk of adverse events in hospitals resulting in detectable physical harm, as well as missed appointments and difficulty scheduling. Interpreter services, however, may lead to increased costs and treatment length (Al Shamsi, et. al., 2020). The United States also receives an increasingly large number of migrants coming from indigenous communities with specialized

languages, creating a challenge in ensuring interpreters are proficient in any language they may hear. While accessible programs for people with limited English proficiency is a civil rights requirement under federal law, the U.S. is lagging behind on actually providing equitable care (Jawettz & Schuchart, 2019).

Comparison of U.S. and Thailand

Around the world, no two countries have the exact same healthcare system, and interactions with different migrant populations can make it even harder to compare them. The United States and Thailand approach migrant health care and general treatment in very different ways, as each country has a fundamentally different healthcare delivery system. Before we can examine the differences in how the United States and Thailand provide health care to migrants, however, lets first examine the fundamental differences in their healthcare systems for documented citizens. The United States healthcare system is complex, made up of a mix of private sector facilities and publicly funded aid programs. The majority of Americans receive health insurance directly through their employers, with much of the population below the poverty line receiving coverage through government-funded programs such as Medicaid and Medicare. Although the Affordable Care Act aimed to provide coverage for all Americans following its inception in 2010, 13.7% of US adults did not have health insurance in the last quarter of 2018 (Sofer, 2019).

Thailand, on the other hand, transitioned from an income and career-based coverage program to a universal coverage program in 2002, and has since seen greatly improved health outcomes overall. Prior to 2002, the coverage patchwork was intended to cover the entire population but instead missed target groups due to income assessment difficulties. The universal

coverage system still groups the population by career, but limits the patchwork to three overarching groups: civil servants, private employees, and the rest of the general population. These groups are separated under the finance, labor, and public health ministries, respectively, and healthcare is financed predominantly by government taxation (Sumriddetchkajorn, et. al., 2019). Many migrants also receive healthcare coverage through annually-purchased health insurance cards, which are included as an incentive in the documentation process. The distribution of health care coverage among Thai nationals and Non-Thais can be better visualized in the table below (*In Thailand, Noncitizen Health Matters: Think Global Health*, 2020):

Where Do People in Thailand Get Their Health Care Coverage?
A variety of schemes provide health-care coverage to Thai nationals and people from other countries

SOURCE OF COVERAGE	THAI CITIZENS	NON-THAI CITIZENS
Civil Servant Benefits	~9% of Population	N/A
Social Security Scheme	~18% of Population	~30% of Non-Thais
Thai Universal Coverage	~72% of Population	N/A
Health Insurance Cards	N/A	~25% of the Non-Thais
Uninsured People	N/A	Up to 49% of Non-Thais

NOTE: The percentage of non-Thai citizens who are uninsured is difficult to estimate exactly because of the uncertainty in the denominator—the actual number of undocumented migrants in Thailand.

Both countries differ greatly in their entry and citizenship procedures as well. The United States has a notoriously difficult citizenship procedure with ten steps involved, beginning with determining eligibility. You must be a Permanent Resident for at least five years and will then

answer a series of questions to continue in the process. After completing a naturalization application, you may still be denied, and if you are approved will be required to interview and pass tests in civics and English (*10 Steps to Naturalization,* 2021). The application for Permanent Residency is another lengthy process with at least $1,000 of accompanying fees (*Green Cards and Permanent Residence in the U.S.*, n.d.). Becoming a Thai citizen is also a lengthy process requiring knowledge of the country, but the road to Permanent Residency is much more accessible in Thailand for one reason: a Thai Permanent Residence visa never expires and grants you the same freedoms of Thai citizens for the price of only around $240 USD (Admin, 2020). Restrictive entry policies such as temporary visa status and detention have been associated with worsened mental health, and restrictive welfare eligibility and documentation requirements weakened self-rated health, low mortality & low odds of general healthcare service use (Juárez et.al., 2019). Thailand greatly diminishes the likelihood of these issues with a non-expirable Permanent Residency.

Both countries receive migrants and refugees from all over the world, but for the sake of this paper we will focus on the majority migrant demographics in each country. For the United States this means Latin American immigrants, and for Thailand this means Burmese migrants.

Burmese migrants are pushed to settle in Myanmar for many reasons. Myanmar has a severely underdeveloped economy, having been ruled by a military regime from 1962-2010 and facing harsh economic sanctions imposed by the US, EU, Canada, and other Asian countries which limit trade and investment, as well as foreign travel. The government of Myanmar is also deeply unstable. After being previously ruled by the military, the moderate reformist Thein Sein was elected president in 2011 after previously serving as a key member of the ruling military junta. Aung San Suu Kyi came into power as state counselor in 2016, a position created for her

by the people due to previous indictments that barred her from the position of prime minister. Just recently in March of 2021, the government was once again overtaken by the military in a coup d'etat after deeming the 2020 election fraudulent (McGann, 2020). Myanmar is also a Buddhist majority country and Rohingya Muslims have faced state-sponsored persecution since the 1970s, including anti-Muslim riots in 2013 and a 2016 genocide that killed hundreds and resulted in the burning of thousands of homes (IOM Myanmar, 2018). Thailand has emerged as a welcome destination due to its relatively stable economy and employment opportunities for migrant workers. The middle-income country has an open two-way exchange of international investment, trade, and tourism, and boasts a very low national unemployment rate. Migrants are responsible for up to 6.6% of Thailand's GDP, working in sectors such as fishing, agriculture, hospitality, domestic work, and manufacturing, all at comparatively higher wages (*Thailand Migration Report 2019 [EN/TH] – Thailand,* 2019).

Latin American immigrants are also pushed to the U.S. for a variety of reasons. In the past twenty years, migratory groups have slowly adapted from majority Mexican migrants to majority migrants coming from the Northern Triangle countries of Guatemala, Honduras, and El Salvador. These countries all share patterns of political volatility, high crime rates, widespread gang violence and intimidation, extreme poverty, and climate change. The majority of Guatemalans and Hondurans live below the poverty line, and most lack government protections and insurance due to the popularity of work in the informal sector and lack of adequate education. Shifting weather patterns have resulted in devastating hurricanes throughout the region, endangering the large agriculture industry and causing subsequent food insecurity (Council on Foreign Relations, 2021). Not only have origin countries shifted from Mexico to the Northern Triangle in recent years, but previously individual adult migrants have shifted to

mainly families and unaccompanied children. This can be attributed mainly to increased gang violence, as a study by Doctors Without Borders revealed that almost 40 percent of Northern Triangle migrants mentioned direct attacks or threats to themselves or families, extortion and gang recruitment as the main reason for fleeing, and 43.5 percent reporting the death of a relative due to violence in the past two years (Doctors Without Borders, 2017). The U.S. pulls Latin American migrants with its virtual opposite social, political and economic circumstances, but also due to desire for family reunification. One in five Salvadorans has already migrated to the U.S., along with one in 15 Hondurans and Guatemalans (Rosenblum, 2016). Families and children can feel some comfort in leaving their home country with the knowledge that a relative is waiting in the U.S.

The path to Thailand from Myanmar is eased through the interdependence in the Greater Mekong Subregion (GMS). The GMS is composed of six countries (Cambodia, China, Laos, Myanmar, Thailand, and Vietnam) which all share the Mekong River. The GMS was formed as an economic cooperative with nine priority areas including transport, telecommunications, energy, tourism, human resources development, environment, agriculture, trade, and investment. While political instability in some countries such as Myanmar has slowed progress, more stable countries such as Thailand have been able to reap the many economic benefits of this partnership, and the GMS still exists today since its inception in 1992 (Shimizu, 2007). The interdependence of these countries has relayed into the migration network between Myanmar and Thailand. Myanmar represents the largest migration source country in the GMS, with 4.25 million Burmese nationals living abroad. 70% of all migrants in the GMS move to Thailand with up to 3,000,000 of these being Burmese, and nine refugee camps exist along the Thailand-

Myanmar border, housing around 105,000 refugees (*Roles of Countries of Origin > Mekong Migration Network,* 2021).

The path to the United States from Central America is not as straightforward and much more dangerous. Many migrants travel along The Migrant Trail, between a 2,000- and 3,000-mile journey from Honduras, El Salvador, and Guatemala through Mexico to border cities in Texas, New Mexico, Arizona, and California. After crossing through violent stretches of land in Mexico, susceptible to gang violence, drug and sex trafficking, many migrants reach the U.S. border only to be ordered to turn around and return home. Especially with increasingly loud anti-immigrant and anti-Latino sentiment showcased in America, the borders have become a hostile environment for migrants. Migrants must make this journey by foot, train, and/or bus. Many opt to cross borders along a network of freight trains which runs from the Mexico/Guatemala border all the way to the U.S. known as "La Bestia" or "el Tren de Muerte", meaning "The Beast" or "the Death Train." Over 500,000 migrants ride the trains each year, riding from weeks to months and many times never reaching their destination, whether due to arrest, injury, or death (Sayre, 2014).

Immigrants in America are forced to live in fear due to their immigration status. Health care and social services are often overlooked because immigrants fear that an interaction with a public agency will reveal their immigration status and therefore result in deportation. Studies show that factors such as socioeconomic background, immigration status, limited English proficiency, access to publicly funded health care, location, and marginalization lead to inadequate health care for migrants, including lower healthcare use, lower rates of insurance, and lower quality of care (Derose et al., 2007). Specifically, in a 2012 study performed in North Carolina, prenatal care utilization was examined in Latina mothers before and after a law

allowing local law enforcement to enforce federal immigration laws was passed. Latina mothers were found to seek prenatal care later and had inadequate care when compared to non-Latinas, accompanied with profound mistrust of health services and avoidance of health services altogether (Rhodes, et.al., 2015). Symptoms of toxic stress are also common, especially among children. This type of trauma can have harmful effects on long-term physical and mental health, presenting in children as a barrier to normal physical and mental development (*Immigration, Health Care and Health*, 2019).

Burmese children in Thailand also experience strain on mental health, particularly among displaced children. However, interventions have been put into place to combat these health delays. Family skills training iss administered to Burmese children and primary caregivers, and within one month child attention problems and externalizing problems are significantly reduced, along with a significant increase in prosocial behavior (Annan, et.al., 2017). In the decade since expanding Thailand's Universal Health Coverage to non-Thai migrants, overall life expectancy has risen from 71.8 to 74.2 years, infant deaths have continued to decline, out-of-pocket spending has greatly reduced, household savings increased even among previously uninsured, and overall satisfaction in the policy has remained consistently high (Sumriddetchkajorn et. al., 2019).

Public Perception of Immigrants

Around the world people tend to reject what they do not understand, whether that be concepts, things, or in this case people. For many natural born citizens who have not lived in diverse communities, it is easier to reject immigrants as fellow members of society than to work to understand their cultural differences. In recent years, as anti-immigration rhetoric spreads

through the media, this sentiment has become more widespread. According to recent polling data, the majority vote in every region other than Europe has gone from increasing/maintaining the level of immigration to decreasing immigration. It is a common belief that immigrants put too much pressure on social services, and immigrants are generally more accepted if they are of a similar race, ethnicity, or cultural background of the destination country (Leach, 2020).

When it comes to Latino immigrant socialization in the United States, one of the main stereotypes immigrants must overcome is their perceived "illegality", whether that be their documentation or criminal status. A false association exists in the media between undocumented migration and violent crime, especially following the surge of support in opinions voiced by President Trump. In a 2017 study which tasked white Americans with looking at hypothetical immigrant profiles to determine if they were undocumented/illegal, it was found that coming from Mexico or Central America disproportionately marked an immigrant as illegal (Flores & Schachter, 2019). In comparison, hypothetical Asian immigrants were almost never identified as undocumented, and in reality, make up almost 15% of the undocumented immigrant population.

This sentiment is somewhat mirrored in the Thai perception of Burmese migrants. Thai people show a prejudice against non-registered migrant workers due in large part to "fear of the unknown," and over half of Thai residents perceive migrant workers as a threat to their safety and property. Although this fear does exist, the majority of Thai people believe that both refugees and migrants are entitled to the necessities of life and humanitarian aid. Specifically, in the case of healthcare, the majority of Thai people believe that Burmese migrants are entitled to the same standard of healthcare, especially if financed by non-governmental organizations such as the UN and private healthcare facilities or if self-financed such as through the Health Insurance Card scheme (Sunpuwan & Niyomsilpa, 2014). In a 2019 poll, 62 percent of

Americans agreed that a national health insurance program available for undocumented immigrants was a bad idea. In a 2017 poll, 28 percent of Americans agreed that immigration puts too many burdens on government services and in turn weakens and detracts from the United States, even under current laws that restrict access to benefits. In reality, undocumented immigrants consume only about 0.13 percent of government healthcare expenditures, and documented immigrants pay 12.6 percent of all private health insurance premiums while accounting for only 9.1 percent of expenditures (Goldman et al., 2006). Immigrants use disproportionately fewer medical services and contribute less to healthcare costs yet are believed to be a major strain and this belief is widespread among Republican Americans. In almost all poling on migration issues, Republicans and Democrats vote oppositely of each other, with Democrats leaning toward allowing use of social services and easing the citizenship process (*Immigration/Border Security,* 2021).

In the wake of COVID-19, travel restrictions have been passed and labor migration and asylum assistance have slowed in many destination countries in order to contain the virus. In countries that have not completely closed their borders health screenings at the border have been performed in order to mitigate spread, but many migrants coming from low-income countries have no personal protective equipment and may be exposed to the virus when required to quarantine in cramped detention or refugee camps. Migrants have been stigmatized and excluded for decades before the COVID-19 pandemic as disease characters when in reality they may be healthier than the receiving communities. Because of this, migrants may actually hide potential COVID-19 symptoms in order to gain entrance and not perpetuate any more stereotypes (IOM UN Migration, 2020). Burmese migrant workers have been targeted as scapegoats for virus outbreaks in Thailand, with the Thai Health Minister making a public unsubstantiated claim that

migrant workers were responsible for transmitting COVID-19 to a Thai vendor believed to be a super spreader. Some Thai citizens believed Burmese migrants were genetically more susceptible to the virus, when in reality their close living conditions and strenuous fields of work put them at high risk (The Irrawaddy, 2020).

Existing Policies

Most countries have very little existing legislature surrounding the health and healthcare of migrants, and the policies that they do have center around the process of migration itself. The conversation about immigration in the United States is mostly consumed in debate over the process to documentation, and in recent years has been targeted toward Latino immigrants crossing the Mexico/U.S. border. Migration to Thailand consists mostly of migrant workers, and control of legal crossing at their borders is made more difficult by the fact that they are surrounded on all sides by countries with large rates of migration (Myanmar, Laos, Cambodia, and Malaysia). In any country, the challenges of legal migration across borders remain the same: high costs and long wait times, a lack of effective and safe law enforcement, and a history of bureaucratic red tape.

The CDC provides guidance on refugee and migrant health to physicians working in the U.S. and overseas who may see migrant patients during the resettlement process. Domestically, state public health departments and providers should adjust initial medical screening procedures if patients are refugees, including tests for intestinal parasites, malaria, sexual health issues and tuberculosis, as well as nutrition and mental health screenings. Overseas, it is recommended to administer presumptive treatments for malaria and intestinal parasites, as well as necessary vaccinations. In both the domestic and overseas guidelines, the CDC stresses the importance of

allowing adequate time for screening and creating a comfortable, trusting environment to ensure that a thorough, culturally appropriate history is recorded (Centers for Disease Control and Prevention, 2021). Surprisingly, prior to 2019 there was no policy in place mandating health screenings of children in U.S. Customs and Border Protection (CBP) custody. Migrants were expected to notify border patrol agents about a specific need for medical care. Only after the December 2018 deaths of two Guatemalan children in U.S. Border Patrol custody did DHS announce a policy change calling for prompt health screenings of all children in CBP custody (Jawettz & Schuchart, 2019).

Because Thailand extends their universal healthcare policy to migrants, migrants in the country are entitled to all elements of healthcare that Thai citizens have access to. Migrant workers are covered through the Social Security scheme which is financed through contributions from payroll, while many low-skilled and undocumented migrants in the informal sector are covered by low cost Health Insurance Cards, at only 365 Baht or 11 USD for children and 1,600 Baht or 49 USD for adults annually (*In Thailand, Noncitizen Health Matters: Think Global Health*, 2020).

It is incredibly difficult to regulate each countries' migration laws under one overarching policy, as the mechanisms underlying migration in each country are incredibly different depending on political structure, healthcare systems, and the mix of cultures within them. There are, however, three documents that we can use as a framework for possible global policy. One of these is the Universal Declaration of Human Rights, which explicitly states that healthcare is a human right. In Article 25, it is outlined that:

"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary

social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

While the Universal Declaration of Human Rights was unanimously accepted in 1948 and has since paved the way for many laws, treaties, and policies protecting human rights, the declaration itself is not legally binding and simply embodies ideals without any concrete legal framework (*Universal Declaration of Human Rights: 60th anniversary special edition, 1948-2008*, 2007).

The WHO Global Action Plan provides member states and partners with possible policy options which when implemented allow partners to reach targets stated in the action plan. In May of 2019, the health of refugees and migrants were designated a global priority by recognition in the WHO Global Action Plan to Promote the Health of Refugees and Migrants. This document aims to promotes public health goals while mainstreaming global agenda of migrant-sensitive health policies. It reiterates that refugees and migrants are entitled to the same universal human rights as other people, and states that "[n]ationality should never be a basis for determining access to health care; legal status (often) determines the level of access, as appropriate within national insurance schemes and health systems, without revoking the principle of universal health coverage as set in international agreements" (World Health Assembly, 72., 2019). However, the Global Action Plan relies solely on accountability and not global governance, and any policy action developed based on the plan is not likely to be taken (and no action has been taken since the announcement of the plan). As is common in most countries around the world, policy rhetoric and reality are entirely opposite, with migrant detention centers in the U.S. overpopulated with migrants living in appalling conditions and similar conditions existing in refugee camps globally.

The third globally accepted document providing guidance for migrant and refugee health policy is the United Nations 2030 Agenda for Sustainable Development. The Sustainable Development Goals are a replacement for the previous Millennium Development Goals, a series of eight goals developed in 2000 to tackle the issues of poverty, health, and education (*Background of the Sustainable Development Goals,* n.d.). The goals listed in the Agenda are intended as a universal call to action and range from protecting people to protecting the planet as a whole. In regard to refugees and migrants specifically, Section 23 states that vulnerable populations including refugees and internally displaced persons and migrants must be empowered and require strengthened support, while Section 29 reads as follows:

"We recognize the positive contribution of migrants for inclusive growth and sustainable development. We also recognize that international migration is a multi-dimensional reality of major relevance for the development of countries of origin, transit and destination, which requires coherent and comprehensive responses. We will cooperate internationally to ensure safe, orderly and regular migration involving full respect for human rights and the humane treatment of migrants regardless of migration status, of refugees and of displaced persons. Such cooperation should also strengthen the resilience of communities hosting refugees, particularly in developing countries. We underline the right of migrants to return to their country of citizenship, and recall that States must ensure that their returning nationals are duly received."

Migrants are also included as part of Goal 8.8 in seeking to protect labor rights for all workers, specifically migrants and especially migrant women (UN General Assembly, 2015). As with the other two documents, the Agenda has no link to any global health laws and simply serves as an idea guide for countries to develop their own policy. The Universal Health Coverage system in Thailand plays a big role in protecting migrant populations, while the Greater Mekong

Subregion network helps to protect migration and labor rights. Regardless of legal status or nationality, migrants are granted access to equitable healthcare, accomplishing the goals stated in each of these three global declarations. The United States, however, lags behind in almost every accord, with restrictions to care based on legal status, unequal labor and work safety protections, and lack of access to equitable care.

Improving Migrant Health in the U.S.

In order for the United States to adopt an accessible migrant healthcare program such as Thailand, it would require a total reform to the existing U.S. healthcare system. These two countries are completely different: healthcare in the U.S. is a combination of private health insurance and public aid such as Medicare and Medicaid, while Thailand has adopted a system of universal health coverage. However, the United States can adapt some of Thailand's policies to fit the joint public/private coverage system.

While established in the United States, we have a responsibility to provide equitable care to migrants. Under the Affordable Care Act (ACA), lawfully present immigrants are entitled to limited federal coverage, subject to the individual mandate and tax penalties, but children and pregnant women may still be required to wait at least five years for access to affordable coverage due to states' rights to choose whether or not to provide Medicaid benefits. DACA grantees are ineligible for Medicaid and ACA benefits, and undocumented immigrants are ineligible for any federal coverage including the purchase of private health insurance. Should undocumented immigrants require health services, they can receive emergency care at hospitals around the country and nonemergency care at community health centers but must pay fees out of pocket (*Immigrants and the Affordable Care Act (ACA)*, 2017). By extending lawfully present

immigrant coverage rights to undocumented immigrants and DACA recipients as well, immigrants would be much less inclined to avoid going to the doctor for seemingly minor issues, thus mitigating the risk of serious preventable illnesses. In order for the current presidential administration to match public opinion while still aiding migrants, even simply extending Medicaid or qualified health plan enrollment to migrants could make a big difference in health outcomes and frequency of health services use.

But why make this change? One of the main reasons the Thai government has pushed so strongly to protect migrant health is because they realize that migrants are one of the greatest drivers of their economy and therefore should be protected. Migrant workers contribute to 6.6% of the nation's total GDP, while constituting only 4.5% of the total employment share. Burmese migrants also improve the overall economy in the Greater Mekong Subregion, with remittances sent to bordering countries totaling almost $10 billion dollars annually. In many areas of the country, hospitals can earn revenue from migrant insurance as migrants are typically younger than native Thais and therefore diversify the risk pool by using health services less frequently. Offering the annual Health Insurance Card to migrants also incentivizes the path to citizenship, establishing permanent workers in the country (*In Thailand, Noncitizen Health Matters: Think Global Health*, 2020).

While public sentiment in the United States describes migrants as a drain on resources which should be reserved for U.S.-born citizens, the Immigrant Industrial Complex actually supplies a continuous flow of immigrant workers in and out of major corporations, resulting in major profits. The labor force participation rate in migrants is almost 4% higher than that of native-born adults, and immigrants without a college degree make up a third of the workforce in fields such as farming, fishing, agriculture, tourism, maintenance, and home health. While many

Americans believe that immigrants are taking jobs from the U.S.-born, in reality they are filling gaps in low-skilled fields that natives are unwilling to take (Sherman et al., 2019). The work we see migrants doing in the U.S. is very similar to migrant work in Thailand, yet they lack the same protections. American businesses can currently hire immigrant laborers for cheap, employ them short-term, then report and replace them before their salary increases to an acceptable amount (Stribley, 2017). If American industries actually valued their workers, rather than using them for profit, workplace safety and productivity would increase and work-related anxiety in immigrants would greatly reduce. If the United States implemented workplace safety laws specifically for low-income and undocumented immigrants, such as a minimum employment time, a higher minimum wage, or required insurance taken from payroll, migrant workers would be able to circulate earnings back into the United States economy while increasing their own health. Individual corporations implementing policies to limit or prevent reporting of suspected undocumented employees to ICE would also reduce fear of working for government sponsored companies, leading to increased workplace safety for migrants as well.

Patient understanding of a physician and vice versa can be the difference between life and death, which is why diminishing language barriers is so important. The first line of health screening that most migrants will go through is at the border in the custody of U.S. Customs and Border Protection. Not only will migrants be screened for health issues, but may also be questioned on vulnerability to trafficking and fear of persecution. The U.S. CBP lags behind in interpretation services for people most at risk. Implementing officers at the border who can accurately identify language needs (specifically indigenous languages) rather than defaulting to Spanish can make a huge difference in the effectiveness of initial screenings. Medical professionals should also take a proactive approach to health screenings, as many immigrants

and especially children may have little ability to identify their own medical needs. All CBP officers should undergo a training to ensure that they can identify and clearly determine if an immigrant is competent in Spanish or requires a different language. In hospitals and community health centers, the cost of interpreter services can be very high and may drive prices up and deter migrants from services all together. In health centers without adequate funding, employees should receive training on how to use online translation tools such as Google Translate and MediBabble to communicate more effectively with patients. Both of these tools have shown success as medical translators, with patients and physicians reporting fast and easy collection of information. Increasing the number of medical phrases programmed into these softwares will also increase effectiveness (Al Shamsi, et. al., 2020).

Increased migrant health coverage and policies in the U.S. do not necessarily correlate to improved health outcomes, however. Latino migrants, especially those who are undocumented, have an internalized fear and distrust in public medical professionals. Migrants believe that public sector professionals may expose their immigration status. Currently, the ICE tip form is designated specifically for violations of criminal law, yet tips of suspicion over legal status have been accepted and can result in deportation without a hearing in as little as 24 hours after detention. Eliminating programs such as the ICE tip line for use in non-emergencies could reduce the stigmatization of Latinos in the U.S. Limiting use of the phrase “illegal immigrant” should be considered, especially in the vocabulary of politicians. While living in the United States as an undocumented immigrant is in fact a criminal offense, the immigrant themselves is not illegal, and this phrasing further perpetuates a stereotype that immigrants are criminals who bring violence and crime with them to the United States.

CONCLUSION

Although many countries around the world have developed policies and programs for the improvement of population health, many of these are "big picture" programs without specific interventions for specialized groups (in this case, migrants and refugees). Given the need for such specialized intervention programs currently, this analysis of current policies and problems may offer health professionals a resource to aid in implementing an effective migrant health program. By modifying Thailand's Universal Health Coverage approach to fit the United States' current healthcare system, physicians can begin on a path to providing affordable, available, self-sustaining, and diverse equitable care for migrants. Using a cost-effective approach of implementing free translation services and trainings to health employees, along with eliminating policies which criminalize immigrants, both the health care system as a whole and immigrants' perception of healthcare can improve.

In a perfect world, all of these possible interventions could be implemented at the drop of a hat, with funding being transferred from other government-funded sectors and mass approval from U.S.-born citizens. However, as Dr. Christopher Dunford states, "undocumented immigrants are VERY low down on the list of the persons that governments around the world are willing to fund programs for." Because of how divided the U.S. is, this turns into a partisan issue with the majority of pushback expected to come from the Republican party. The main reason for this is the encouragement of anti-immigrant sentiment throughout the party. With so much concern over legal migration and the stress undocumented immigrants will put on government programs, and a Democrat-run house challenging a Republican-run senate, any actual progress in migrant health on the national front is not likely. There is, however, hope for community-led, privately funded health organizations. These smaller scale organizations can truly ensure that

migrant voices are heard, and as Eduardo Reyes says "ensuring that the target population's, migrant population, voice is heard and that the population's perceptions are taken into consideration when developing health care efforts that target them" is the most effective way to ensure quality care. Many of these small health centers are underfunded and could be helped immensely by community support through fundraisers or partnerships/sponsorships from larger corporations. In the short-term, this is a realistic, viable option for care.

When we look at overall health outcomes in the United States, not specifically migrant health outcomes, the U.S. still lags far behind other countries with comparable levels of development. With overall healthcare spending rising each year and health outcomes remaining unchanged, an overall reform to the entire U.S. healthcare system is becoming increasingly necessary. However, due to fears of "socialism," a perceived strain on resources, and a general "every man for themselves" mindset, this will not happen in the foreseeable future.

This thesis is of personal significance because of its application to my future career, but also due to my personal experience. I am a public health major, and I will be attending graduate school to obtain my master's in public health with a concentration in global health, specifically focused on humanitarian health and health disparities. I know that this research will continue to be invaluable to me in improving my global health knowledge. I have worked with immigrant populations before, specifically in the state of Maryland as an ESOL tutor and an assistant at a free clinic for immigrants. While I have been given a glimpse at how small, specialized organizations provide access to healthcare for immigrants, understanding how health care coverage works as a whole in different countries will allow me to advocate for better coverage in countries which have not yet developed an effective migrant health care system.

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APPENDIX A

Full Interview with Dr. Christopher Dunford

Q: What is the most common health issue you see in Latino immigrants who have been in the U.S. for at least two months?

A: The biggest health problem that we see in Latino immigrants is diabetes. They have a very strong genetic predisposition for it and they typically have a very high carbohydrate diet (flour tortillas, rice, beans, yucca, etc).

Q: What is the most neglected health issue you see in Latino immigrants, whether by the patient or provider?

A: The second problem is the cost of healthcare. Undocumented immigrants can't get Medicaid so they are responsible for paying for their office visits, lab/X-ray tests, and medications.

Q: Would you say working at the Spanish Catholic Center or your work in typical primary care centers has been more difficult, and why?

A: Practicing at Catholic Charities is SO difficult. You have to think about EVERYTHING:

-do I need to run this blood test and how often?

-what is the best/cheapest medication AND will the patient take it?

-will they come back for their follow-up appointment?

When I was in private practice, it was SO much easier. My patients had health insurance with prescription cards that helped pay for their medications. I didn't have to think about ordering lab tests/X-rays, referring to specialists, etc.

Q: In your opinion, what is the most effective way(s) to ensure Latino immigrants receive quality, equitable health care?

A: How to rectify this situation is difficult. At CC, we have converted our DC health clinic into a volunteer-run, free clinic. However, this is still costing us over $600,000/year to run and it is only open 2.5 days/week right now. Therefore, we don't have much capacity for seeing patients. Undocumented immigrants are VERY low down on the list of the persons that governments around the world are willing to fund programs for.

Full Interview with Eduardo Reyes

Q: What are the most common barriers the clinic faces in delivering timely, effective care to Latino migrants?

A:

- Latino migrants' lack of health insurance coverage-being underinsured or uninsurable
- Latino migrants' low health literacy
- Generational health issues
- Out-of-pocket health care costs
- Complexity of health issues
- Political vulnerability
- Trauma

Q: In what ways does this clinic function differently from other primary care clinics in order to accommodate migrants?

A: The clinic serves as a health care safety net. Unlike most primary care facilities, Catholic Charities Medical Clinic provides health care to patients at a very low cost. The agency recruits volunteers to meet its patients' (mostly migrants) health needs and has a specialty care network

that provides pro bono specialty care to its patients. Some of the specialty services include surgical procedures and radiology services.

Q: Does public perception of migrants impact the day-to-day functions of the clinic in any way?

A: Perhaps not directly, but public perception can, and has before, impacted the patients' perception on their right to access health care in the USA. Negative public perception can create intimidation.

Q: In your opinion, what is the most effective way(s) to ensure Latino immigrants receive quality, equitable health care?

A: Ensuring that the target population's, migrant population, voice is heard and that the population's perceptions are taken into consideration when developing health care efforts that target them. It is important to empower migrant patients so that their health disparities are reduced and that effective interventions are implemented.