Addressing migration and health inequity in Europe

Narrative change for inclusionary health and migration policies

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Several papers in this Series on "Addressing migration and health inequity in Europe" reflect discrepancies between Universal Health Coverage (UHC) ambitions and the actual exclusion of many migrants from national health systems. Amidst increasingly hostile discourses towards migrants, we argue that endeavours for UHC should not only address "implementation gaps", but challenge the narratives fuelling these discourses.

Evidence shows that the costs of restricting migrants' access to healthcare outweigh the benefits. In Germany, restrictions on asylum-seekers' healthcare were shown to compromise health equity, efficiency, and other health system outcomes, including up to 40% higher expenditures.[1,2] The 2015 NHS charging regulations in the UK have aggravated health inequities and adverse public health outcomes, thus potentially increasing costs.[3] In Spain, the 2012 Royal Decree-Law restricted undocumented migrants' access to healthcare, with adverse public health and economic effects.[4] Still, exclusionary narratives advocate for restricting migrants' health entitlements as a means to safeguard resources, invoking welfare nationalism and portraying migrants as 'free-riders' and presumed burdens on health systems.

Given the existing evidence to the contrary, one may wonder why exclusionary narratives persist and thrive in health policy-debates. What makes them so compelling? And what lessons can we draw? The success of exclusionary narratives has been explained with Othering as a simple, powerful, and emotional narrative that demarcates and depreciates out-groups, thereby enhancing the perceived value of the in-group. In migration contexts, Othering sums up to "they come to get what is ours".[5] This narrative resonates with fears of competition for housing, labour and welfare resources, and with a neoliberal performance ideology devaluing those (genuinely or supposedly) reliant on the welfare state.[6] Essentially, exclusionary narratives provide simple, albeit delusional answers to complex questions—such as healthcare inequalities—while leveraging negative emotions like uncertainty and resentment and engrained beliefs about identity, belonging, and deservingness. Against this backdrop, they help mobilise support for broader authoritarian agendas, including policies "that worsen the conditions for those who support them, yet manage to retain their support by blaming others".[7] In obscuring the real causes of social inequities and those who benefit from them, exclusionary narratives legitimise political and economic elites in times of crises and deflect their responsibilities.[8] Indeed, governments were shown to decouple evidence-based practice from rhetorical commitment to illiberal, radical-nationalist narratives when they are under pressure to deliver outcomes; while they tend toward technocratic narratives when under less pressure.[9]

What if we used these insights to promote healthy societies and inclusive health policies? This would mean acknowledging the role of narratives in policymaking and, consequently, that mitigating the gap between the status quo and UHC will require more than technical solutions alone. It would mean developing a better understanding of when, how, and why decision-makers embrace, reject, or ignore narratives. Primarily, it would require the health community to develop narratives that are captivating and powerful enough to garner broad public support for equity, diversity, and inclusion, and thus side-line exclusionary frames.

What would such narratives look like? Narrative change comprises a more comprehensive and complex

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approach than trying to counter exclusionary frames (which may achieve the opposite[10]). It advises prioritising shared values over problems; creating solutions rather than reducing something bad; and bringing real people, their decisions and actions, into the frame rather than vague concepts like "widening gaps".[11] Narratives should anchor in people's lived experiences to engage them in jointly realising a positive vision. Too often, public health addresses migrant health by talking about problems and needs, invoking subordinating metaphors of vulnerability and charity, and unwittingly singling migrants out from "the general public". Instead, we need narratives that unite and empower us, whether settled or on the move, to jointly build a desirable future for ourselves, our families, and societies. Finally, good narratives are an asset, but not enough for change. Credible politics, institutions, and leaders are essential, not only in rhetoric but in action.

Public health and medicine should lead such narratives to maintain the moral groundwork and public credibility, but they often lack the tools. Communication science has the tools but is poorly represented in the migrant health community. Civil society and migrant organizations are ahead of academia in understanding and leveraging narrative change; however, the academic community often operates separately, foregoing their expertise. Building alliances between migrant health and communication science, as well as between academia and civil society and migrant organizations, will be instrumental in jointly changing narratives and policies toward greater inclusion, equity, and social justice.

Contributors

NG conceptualised and wrote this Commentary, with substantial input from KB. AG, IP, ICD, BG, ILDA, and KB each contributed as co-authors by providing input to several iterations of the manuscript. All authors have reviewed and confirmed its final version.

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