Episode 16 Transcript

Covid-19 and Migrant Care Workers

Hosted By: Rebecca Richards

Guest: Professor Lisa Eckenweiler

This transcript may have been slightly edited for clarity.

Hello everyone and welcome to another episode of Just Emergencies. I'm Rebecca Richards and I'm joined today by Professor Lisa Eckenweiler to discuss Covid-19 and migrant health workers.

Lisa Eckenweiler is Professor in the Department of Philosophy and the Department of Health Administration and Policy, and former Director of Health Ethics at George Mason University. She is currently the faculty director for the Global Health Fellows Program, a joint program of the Department of Philosophy and Global Affairs and the Vice President of the International Association for Bioethics. Member of the Independent Resource Group for Global Health Justice. She has published widely on research ethics, including work on the concept of "vulnerability". Her research at present focuses on global health inequities, refugees, migrants and other vulnerable populations, and humanitarian health ethics.

In today's episode, Professor Eckenweiler will discuss how the Covid-19 pandemic has both had a disproportional impact on migrant health care workers, while the responses to the pandemic have also heavily relied on these groups and their labour. I hope you find my conversation with Professor Eckenweiler as interesting as I did.

[Intro Music]

This is 'Just Emergencies', the podcast where we show that global health emergencies are anything but just. In each episode we explore an issue,

question, or event that makes us think about global health emergencies, humanitarian crises, and how to best respond to them.

Without further ado, let’s get into the episode!

Rebecca: Hi Lisa, thank you so much for joining me today on the 'Just Emergencies' podcast. How are you?

Prof. Eckenweiler: Doing really well, Rebecca. Thank you for having me. It's really a treat to be here.

Rebecca: You're one of our project collaborators, so we've worked quite closely together over the past couple of years. You're interested in the roles, positions, and vulnerabilities that migrant health care workers have and face in our health systems. So broadly speaking, how has the Covid-19 pandemic affected migrant health workers?

Prof. Eckenweiler: Thanks for that question. It's hard to give a concise answer to that, but I'll do my best to hit some highlights.

I think the first thing to say is that healthcare workers who are born in other countries and educated there - and we can be talking about doctors, nurses, nurse assistants, radiologists, dentists - so these people have for a long time, laboured under inequities in what we can call 'destination countries' - the countries they migrate to. But as the pandemic has unfurled, they've found themselves on the frontline of crisis response - to their peril.

So, for example, there's now abundant evidence that shows that the BAME - Black, Asian, Minority Ethnic - doctors working in the UK's NHS, have become ill and died in disproportionate numbers. Now it's interesting to point out here that a lot of these health workers, as migrants, were just prior to the pandemic in the midst of being 'herded out' - and I use that term intentionally - of the

country under Brexit. But, in order to mobilise them in the country's fight against the virus, the government hastily extended their visas.

We can also look to the substantial portions of migrants working in long-term care in the context of the pandemic. This is as a sector notorious for poor working conditions, even in high-income countries, and has been for some time. [Long-term care workers], in addition to doctors and nurses, have also stood in harm's way as the pandemic has gripped nursing homes. So here I'm talking more about people who are nurse's aids. These care workers - who are mostly women and some of them residents or even citizens in destination countries, though they've been born and educated abroad as health workers - have also long withstood injustices as migrants. But in the context of the pandemic, they've been in a particularly vulnerable situation.

There's one group I think that's especially interesting to give some attention to. And those are people who are seeking residence in a high-income country, as migrants. So, for example, there's some interesting evidence about the experiences of Haitians who are asylum seekers in Quebec. What happened to them in the pandemic as they have been awaiting decisions on their applications for admission, is that they only have access to temporary and part-time work, because of immigration law. And that's work that they need urgently, for the sake of survival for themselves and their families, and which they also hope is going to strengthen their case for asylum. So many of these women have had multiple jobs working in long-term care, which is one of the few available options for them - they get referred to staffing agencies that have connections to long term care institutions. So, they have multiple jobs, which means they travel from care setting to care setting. And what that's meant is that it's heightened their vulnerability to exposure and infection. And as they move from work site to work site, if they're sick themselves, they pass on that infection to vulnerable residents of long-term care settings.

Here we can look at the relationship between immigration policies, health policies, and also labour policy. And you mix that together with a reluctance

to raise concerns that many migrants have. Concerns about things like adequate staffing, adequate protective equipment... because they're afraid of everything from discrimination to job loss, having their asylum claims rejected, and deportation. All of these things come together to heighten their risk of exposure, illness, and death. It has implications not just for the migrant care workers, but also for the people they care for, their family members, and the communities around them.

One last example of migrant care workers in the pandemic that's worth noting here, comes from the experience of high-income countries that recruited migrants who were living in other countries when the pandemic began. For example, you had Chinese and Albanian health workers being recruited for work in Italy; immigration restrictions waived in order to bring them into the country. You also have situations where there were migrants living in a country whose credentials had not been recognised. So, for example, Algerian doctors living in France.

When we take all of these examples, what we see is that in combatting Covid-19, some high-income countries - what I'll call destination countries – were already reliant on migrant care workers - like the BAME workers in the UK. Those countries that were already reliant on them were eager to retain them when the crisis hit and also to grant status recognition to others who had been waiting, and to welcome new migrants into the country who were living on other side of borders under rapid immigration and licensing policy reforms.

Rebecca: Throughout the project, we're obviously very interested in this idea of justice during global health emergencies. What kinds of concerns do the experiences and situations of migrant health care workers raise for us, or force us to think about?

Prof. Eckenweiler: That, I think, is really the heart of the matter here: to think about this as concerns of justice. The way long-term care has come to be organised under globalisation - the way that it operates - is in a way that

erodes autonomy. Not just a concern of justice, but of autonomy and equality for these workers and that it really threatens their capability to be healthy. And when I say capability to be healthy, I understand that as synonymous with this concept of 'health justice'. There I'm drawing on the work of one of our colleagues Sridhar Vankatapuram. He says we ought to think about health justice in terms of capability to be healthy. So I think that's really the first thing: health justice is undermined for these workers.

We want to think about the relationship between the injustice that these care workers suffer and the implications for the people they care for. If we think about the elderly or other sorts of vulnerable populations, a lot of time, migrant care workers are caring for these vulnerable populations and their vulnerabilities and, as in the case of the Haitian asylum seekers, creating vulnerabilities for the people they're caring for. If we're thinking about the migrant care workers' capability to be healthy being threatened, or health justice being threatened for them, it in turn affects health justice for the people they care for.

More generally, in terms of global justice, the concern here is for the capability to be healthy for people living in source countries. So those people suffer burdens of disease that are very often greater than that suffered by people in high-income countries. They're also dealing with ageing populations - so ageing as a global phenomenon. Those countries have urgent, pressing needs for health workers. But if those health workers are migrating, they're not able to address [the health needs]. I think the biggest concern here are that the inequities that people suffer in low-income countries will be exacerbated.

Some people would think about these issues in terms of distributive justice. So, for example, the lack of personal protective equipment (or PPE) for these care workers that I described in hospital settings or long-term care settings, as a problem of inadequate allocation of resources. That's fair. I think we can also think about the unfair distribution of health workers around the world as a problem of distributive justice.

But I think the better way to frame this is in terms of structural injustice. And the way that I understand that follows the work of Iris Marion Young. And she defines structural injustice in the following way - this is a quote from her work *Responsibility for Justice*: 'Structural injustice exists when social processes put large categories of persons under a systematic threat of domination or deprivation of the means to develop and exercise their capacities. At the same time, these same processes enable others to dominate or have a wider range of opportunities for developing or exercising their capacities.'

I think if we [look at] the experiences of migrant care workers generally, but certainly in the context of a pandemic, we can understand their plight and the plight of people in low-income countries in terms of structural injustice. Global structural injustice. That's what I mean when I talk about the combination of health policy, how we distribute health workers around the world, labour policies, who gets paid for what kind of work, what occupation health and safety policies are, and immigration policies. Those things, just for starters, come together in complicated ways to generate injustices against these groups of people.

You add to that things like racist stereotypes, social norms that suggest that women are better care workers, that women from particular countries are better care workers because they're more obedient. Whatever those stereotypes or unquestioned assumptions are, they function in a way - when they came together with immigration policy, labour policy, and health policy - that generates these kinds of injustices. And the worry is [not only] the injustice that people experience in their lives but also over time, the implication that it expands opportunity for people who are already privileged and constrains opportunity for people over time who are already vulnerable. So that's the worry with structural injustice.

In this case: people in low-income countries that serve as source countries, and people in high-income countries/destination countries gathering all of the benefits and privileges that come from that.

Rebecca: Throughout conversation and discourse through this pandemic, another word that's popped up a lot - in addition to justice and equality - is this idea of 'solidarity'. Can you tell us a little bit about what solidarity entails and what it means going forward and in terms of supporting migrant healthcare workers?

Prof. Eckenweiler: That's a great question. It's terrific to see that that concept, or ideal, is getting more attention and I think, traction. I really think it's the one - for public health and global health generally - for us to really focus the most on and embrace … in the context of the pandemic that's going to get us through – if we can manage to really embrace it.

Just a quick definition: solidarity is usually understood as involving assisting and supporting other people. And critically, often at some cost, risk, or burden to ourselves. Think about mask wearing, in this context, as an example: nobody would really choose to wear a mask, unless it's super cold outside. But we do this, we accept this inconvenience, not just for the sake of ourselves, but for the sake of protecting the health of other people. So this is a good, concrete, everyday example at this point.

So that's the definition: assisting and supporting other people, often at some burden or cost to ourselves. Because we recognise something that we share: because we're all vulnerable to sickness and that we're all frail, in need of care, and need relationships of dependence with other people. I think that's really the ultimate basis for solidarity.

I and some other ethicists have more recently started thinking about solidarity as being a link to justice. We have this vulnerability that's shared, and very often, we've contributed to the vulnerability of others through our

contribution to structural injustice. And that generates a responsibility. Even if you don't want to link solidarity and justice, solidarity and solidaristic action call for action that don't necessarily say 'you have obligations for justice'. It could just be 'I recognise you as a vulnerable, fellow human. So in recognising that, I move to support you'.

This is another thing I really like about solidarity, that people have defined it not just as an ethical ideal, but as a *practice;* it's an ideal that must be acted upon. Fuyuki Kurasawa, for example: I love his work on solidarity because it talks about the fact that there has to be labour involved in solidarity. You can't just talk about it. It's not just legislative and policy reform, but it's volunteering, protesting, and advocating.

In this context, I would say, solidarity calls for really concrete things like ensuring that people have adequate PPE; making sure they have adequate education on all of the health threats that face them; working conditions that don't threaten people's health; supporting the right to raise concerns about things that threaten their health. And then much more deeply, what we're talking about here is some economic reform like living wages and fair benefits for all care workers. People in long-term care, many of them are on public assistance or have more than one job and lack the kinds of benefits that other workers enjoy, because they're regarded as 'unskilled'. Aanybody who spends five seconds in a long-term care facility would be pretty hard pressed to describe the work that goes on there as ‘unskilled’. But that means that they very often don't have access to things like retirement benefits, health insurance, continuing education… so long-term care workers suffer some of the worst plight.

But even, you know, people working in hospital settings, clinics, and certainly people in home settings, are really some of the most vulnerable workers in the health care sector. So really thinking about benefits for them that enable them to not live in precarity would be the best thing we could do to show solidarity.

The last point I would make - and this is a longer argument -, I think that in terms of global solidarity, not just with migrant care workers but populations in source countries, we really need to think about the way we invest in, education, train, and then deploy these people around the world. I think there's really a need to move beyond organising access to healthcare and the distribution of healthcare workers along state lines. I think this generates all kinds of problems and we need to think about some kind of model of global governance for this.

Rebecca: So you've left us with no small call to action there: to reform the global governance for global health. Thank you so much Lisa for joining us today. That was very very interesting and certainly gave us a lot to think about.

Prof. Eckenweiler: Thank you so much for the chance to talk about it.

[Outro music]

That's it for today – we hope you enjoyed the today's episode.

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If you have any questions, comments, or ideas for topics you'd like to hear about in future episodes, please emails us at ghe@ed.ac.uk. We're also on twitter as @GanguliMitra and @reb_richards.

Be sure to check out and explore our website "Justice in Global Health Emergencies and Humanitarian Crises" for more great content, just go to https://www.ghe.law.ed.ac.uk/.

Thanks for listening and see you again for the next episode.

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