



## Health policies for international migrants: A comparison between Mexico and Colombia



Ietza Bojorquez-Chapela <sup>a</sup>, Victor Flórez-García <sup>b</sup>, Alhelí Calderón-Villarreal <sup>a</sup>, Julián Alfredo Fernández-Niño <sup>b,\*</sup>

<sup>a</sup> El Colegio de La Frontera Norte, Km 18.5 Carretera Escénica Tijuana-Ensenada, Tijuana, Baja California CP 22560, Mexico

<sup>b</sup> Universidad del Norte, Km 5 Puerto Colombia, Barranquilla, Atlántico 081007, Colombia

### ARTICLE INFO

#### Article history:

Received 21 June 2019

Received in revised form 10 January 2020

Accepted 12 January 2020

Available online 10 February 2020

#### Keywords:

Health policy

Migration

Mexico

Colombia

### ABSTRACT

**Objective:** The aim of this study was to compare the health policies for international migrants in Mexico and Colombia. **Methods:** A descriptive comparative study of the documents issued by the national-level government of the most recent past administrations in each country (2012–2018 for Mexico, 2013–2018 for Colombia) was conducted. We identified the documents' objectives, strategies, and evaluation of results, and the representation of international migrants and migrant health in the policy.

**Results:** Both countries situate health care policies for international migrants in a human rights framework. In both, migrants are entitled to health care, but access is limited by migration status. The main contrasts are the focus on different migrant populations (Mexican migrants in the Mexico-US migration circuit in Mexico; Venezuelan immigrants and Colombians returning from Venezuela in Colombia), and the discursive framing of policies as a response to the crisis in Colombia. As a result, while concrete actions are detailed in the Colombian policies, most documents in Mexico are limited to general strategies. These differences can be explained by the context in which each set of policies was issued: a relatively stable Mexico-US migration flow in Mexico, and the reception of hundreds of thousands of migrants from Venezuela in a very short time in Colombia.

**Conclusions:** Tradition in matters of migration, and the current migration context, influence health policies for migrant populations.

© 2020 The Author(s). Published by Elsevier B.V. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

### 1. Introduction

Migration is a massive demographic phenomenon, with 244 million international migrants worldwide in 2015. While most international migrants live in high-income countries, close to a third of them arrive to middle-income ones. Migration is an opportunity, but it can also be a challenge for middle- and low-income countries with limited resources and institutional capacities. Lack of experience in the reception of immigrants can also make their integration into local society difficult [1,2].

Health is a human right, and signatories of the United Nations' International Covenant on Economic, Social and Cultural Rights commit to providing health care to migrants independent of their legal status. The guiding principles for health care of migrants and refugees include non-discrimination, equitable health access (to prevention and care), and inclusion of the migrants in national health and social protection systems [3–5].

The pledge to ensure that migrants enjoy “the highest attainable standard of health” was recently ratified in the Global Compact for Safe, Orderly and Regular Migration of Morocco [6]. Still, in most countries these principles are not fully implemented [7], and migrants face greater barriers to health services access when compared with the native population [5,7,8].

While public policy as expressed in documents is not the sole determinant of health care access, it is the first step towards it [9]. Health policies state objectives and guidelines, and make evident the position of governments regarding healthcare provision. Even while documents per se do not guarantee implementation, they influence actions. According to Vazquez, Terraza-Nunez, Vargas, Rodriguez, and Lizana [10], differences between countries in terms of their health policies for migrants can be explained by each nation's experience with migration, and by their approach to migration. Comparative studies between countries can improve our understanding of how public policy limits or facilitates migrants' access to health.

Mexico and Colombia are two Latin American, upper-middle income countries [11], where the main international migration-related phenomenon has traditionally been emigration. They occupy the first and second place in the sub-continent as senders of international migrants. The Mexico-US migration corridor is the most important corridor globally

\* Corresponding author at: Km 5 Puerto Colombia, División Ciencias de Salud, Oficina 20, Universidad del Norte, 081007, Colombia.

E-mail addresses: [ietzabch@cofex.mx](mailto:ietzabch@cofex.mx), (I. Bojorquez-Chapela), [vfloreza@uninorte.edu.co](mailto:vfloreza@uninorte.edu.co), (V. Flórez-García), [alhelicalderon@gmail.com](mailto:alhelicalderon@gmail.com), (A. Calderón-Villarreal), [aninoj@uninorte.edu.co](mailto:aninoj@uninorte.edu.co). (J.A. Fernández-Niño).

[12], and Mexico has the second place worldwide in number of international emigrants, with over 12 million people born in Mexico living in the United States (US). About one third (34.6%) of Colombian migrants also go to the US, and a significant percentage (23.1%) to Spain [13]. Meanwhile, both countries have historically had low levels of immigration. In 2015, out of Mexico's close to 120 million inhabitants, slightly over one million (0.8% of the total population) were foreign-born [14]. About nine hundred thousand of them had been born in the US [15], so it is likely that they were of Mexican origin [16]. Similarly, in Colombia, the net international migration rate has been historically negative [17].

More recently, however, there have been changes in both countries. In Mexico, transit migration has become an important issue, with more and more people from Central America and other world regions crossing the country on their way to the US [12]. As the anti-immigration policies of the US harden, migrants in transit might be more likely to spend longer periods in Mexico, or even decide to stay in the country [16]. Migrants in transit and asylum seekers became more visible since the end of 2018, when "caravans" (large groups of people travelling together) gained significant media attention [18]. In Colombia, the number of migrants coming from Venezuela began to increase after 2016, following the economic and political crisis in the latter country. The rise became sharper in August 2017, and by July 2018 slightly over one million Venezuelans were living in Colombia [19], about half of them irregular migrants.

Mexico and Colombia thus share similarities, as countries with a tradition of South–North emigration that more recently experienced increases in South–South immigration and migrants in transit. The change was more abrupt in Colombia, where the number of migrants coming from Venezuela increased sharply in a relatively short period, while in Mexico migrants in transit have been a constant for years, with numbers ebbing and flowing in the 2012–2017 period [20]. The number of migrants entering Colombia in the past years is higher in relative terms, coming to about 2% of the population. The intensive media coverage and occasional xenophobic reactions show the significance of these situations, that in the near future might result in changes in migration policies, and consequently in health policies for migrants.

The objective of this study was to compare the health care policies for international migrants of Mexico and Colombia, as described in documents issued by the national-level governments of each country. For the purposes of this work, we considered policies for international migrants to be those related to documented and undocumented immigrants, migrants in transit, refugees and asylum seekers, and return migrants (voluntary and deportees). As detailed above, we selected the two cases for being part of the same world region (Latin America), and also similar in terms of economic and human development, migration tradition, and recent migration changes. They also provide a contrast with the more frequently researched high-income countries in Western Europe, Oceania, and North America. In exploring these two cases, we aim to increase knowledge of the characteristics of the governmental response that should, in principle, guarantee the right to health for all persons independent of their migration status.

## 2. Materials and methods

We conducted a descriptive comparative study of public policy documents stating principles, norms, and guidelines for the health care of international migrants in Mexico and Colombia (including immigrants, migrants in transit, refugees and asylum seekers, voluntary return migrants, and deportees). Since the aim of the study was exploratory, we did not define a hypothesis, but our guiding assumption was that health policies would be related to the tradition of migration of each country [10].

We reviewed documents issued during the most recent administrations (2012–2018 for Mexico, and 2013–2018 for Colombia), including legislation and non-legal documents from national-level governmental agencies, that presented the public policy addressing the health care of migrants. We followed five strategies of document search. First, we employed the Google search engine with the terms: (health) AND (migrants | migration | immigrants | immigration | refugees) AND (plan | law | norm | strategy |

actions | policies) AND (Colombia | Colombian) filetype:pdf, and the equivalent for Mexico, and reviewed up to the third page of results. Second, we reviewed the web pages of the national health ministries of both countries. Third, we searched Medline for references to public policy documents in scientific articles published in 2008–2018, with the terms: health AND (policy | policies) AND (migrants | migration | immigrants | immigration | refugees) AND (Colombia\*), and the equivalent for Mexico. Fourth, we conducted a search in Google Scholar, limited to 2008–2018, with the terms: health (migrants | migration | immigrants | immigration | refugees) AND "public policy" AND (Colombia | Colombian), and the equivalent for Mexico. The first and second searches were performed in Spanish, the third search in English, and the fourth search in Spanish and English. In addition, we employed our knowledge of the subject to identify documents not retrieved by the previous strategies. We included in the analysis documents that fulfilled the following inclusion criteria: 1) issued by a national-level government agency; 2) issued by the 2012–2018 administration in Mexico, or by the 2013–2018 administrations in Colombia; 3) addressing health care for immigrants, migrants in transit, return migrants, refugees, or asylum seekers. One researcher conducted the search for each country, and the resulting document list was reviewed, discussed, and complemented by all authors, in order to check that the documents fulfilled inclusion criteria and were relevant to the migrant groups addressed in this study.

After reviewing documents and excluding those that did not fulfill inclusion criteria, we registered the following characteristics of those selected: agency issuing the document, type of document, types of migrants considered, health issues addressed, and evaluation plans. Our analytic framework for the analysis was based on the dimensions suggested by Vazquez, Terraza-Nunez, Vargas, Rodriguez, and Lizana [10]: objectives, strategies (specific health issues, access to health services, and improving health care), and evaluation. We developed a codebook reflecting those dimensions, and two researchers (one for each country) coded the documents. During this first round of coding, emerging codes were identified and added to the codebook following an inductive process. We discussed the pertinence, definitions, and exemplars of all codes, and modified them when needed, before performing a second round of coding. Finally, we synthesized the content of the documents in themes. Coding was done with AtlasTi 8.3.1. To increase validity, the results and conclusions were triangulated through discussion between all authors.

## 3. Results

Following the search strategy described above, we retrieved 24 documents for Mexico, and 13 for Colombia. We discarded nine documents for Mexico (six for not mentioning healthcare, one that was a proposal for a program, and two that did not mention public policy), and three for Colombia (one for being a project of law not yet approved, one that was a technical document that did not consider health issues, and one issued by an international agency).

Table 1 shows the 25 documents included in the analysis (15 from Mexico and 10 from Colombia), by year of publication. Nine documents from Mexico defined aspects of the country's migration policy, and were issued either by the Congress or by government agencies not directly related to health [21–29]. Six documents were issued by the Ministry of Health [30–35], but only one of them [31] specifically addressed migrants' health. In contrast, most documents from Colombia were issued by the Ministry of Health and Social Protection, some of them in response to the influx of migrants from Venezuela [36–42]. As we will show below, this difference was accompanied by contrasts in terms of the conception of migration and of migrants health, and in the actions proposed by each country. The migration and health policy of Mexico appeared in documents issued by two different sectors, without much connection between them, while in Colombia the subject was addressed only by the health sector.

In the following sections we present the results of the analysis, according to the dimensions proposed by Vazquez, Terraza-Nunez, Vargas, Rodriguez, and Lizana [10]: objectives, strategies for specific health

**Table 1**  
Documents included in the analysis.

Title <sup>a</sup>	Year of publication	Agency issuing document
<i>Mexico</i>		
Agreement by which the guidelines for protection of migrants by the National Institute of Migration are emitted [22]	2012	Ministry of Interior
National Development Plan 2013–2018 [24]	2013	Federal Government
Sectorial Program for Health 2013–2018 [30]	2013	Ministry of Health
Migration Law [26]	2014	Lower Chamber
Refugees, Complementary Protection and Political Asylum Law [21]	2014	Ministry of Interior
Special Program for Migration 2014–2018 [22]	2014	Ministry of Interior
Specific Action Program: Health Promotion and Social Determinants 2013–2018 [32]	2014	Ministry of Health
“Migrants Receive Popular Insurance” (MX_24) [33]	2014	Ministry of Health
Annual Work Plan 2015 of the General Directorate of International Affairs [31]	2015	Ministry of Health
National Commission for Social Protection in Health. Manual for Affiliation and Operation [34]	2016	National Commission for Social Protection in Health
Protocol to Guarantee the Respect of Principles and the Protection of Rights of Children and Adolescents in Migration Administrative Procedures [23]	2016	Ministry of Interior
Model for the Attention of Unaccompanied Migrant Children [27]	2016	System for the Development of Family
Model for the Attention of Unaccompanied Migrant Adolescents [29]	2016	System for the Development of Family
Specific Organization Manual of the General Coordination of the Mexican Commission for Refugee Assistance [28]	2017	Mexican Commission for Refugee Assistance
National Commission for Social Protection in Health. Guides for Affiliation and Operation [35]	2018	National Commission for Social Protection in Health
<i>Colombia</i>		
Institutional Human Rights Policy [51]	2013	Ministry of Foreign Affairs/Migration
Decree 1768 of 2015 [40]	2015	Ministry of Health and Social Protection
Decree 1495 of 2016 [36]	2016	Ministry of Health and Social Protection
Decree 780 of 2016 [38]	2016	Ministry of Health and Social Protection
Circular 025 of 2017 [39]	2017	Ministry of Health and Social Protection
Decree 866 of 2017 [41]	2017	Ministry of Health and Social Protection
Resolution 3015 of 2017 [42]	2017	Ministry of Health and Social Protection
Decree 1288 of 2018 [43]	2018	Presidency of the Republic
Decree 542 of 2018 [52]	2018	Presidency of the Republic
Response Plan of the Health Sector to the Migration Phenomenon [37]	2018	Ministry of Health and Social Protection

<sup>a</sup> Translated by the authors, the original title in Spanish appears in the list of references at the end of the article.

problems, strategies to improve health care access, strategies to improve health services, and evaluation. We also analyze the representation of migration and migrants health in the documents, and the framework in which they situate healthcare for migrants. For each dimension, we highlight (when present) the differences between countries and the divergences of policies within each country.

### 3.1. Objectives

As mentioned above, most of the documents from Mexico aim to define the country's migration policy, and therefore the description of health-related objectives is brief or non-existent. Two documents issued by the Ministry of Health [30,32] define objectives for the whole population, with migrants mentioned among the “vulnerable populations” that should be prioritized. In both of them, the emphasis is on Mexican international migrants, and there are few mentions of foreign-born persons in Mexican territory. Likewise, the Annual Work Plan 2015 of the Ministry of Health's General Directorate of International Affairs [31] states that its main objective is to grant access to health services for Mexican international migrants.

In the case of Colombia, most documents address foreign-born persons in the country (especially Venezuelans) and return migrants, and mention one of the following objectives: promoting affiliation to the public health system [37,43]; specifying routes for access to health care for the affiliated and non-affiliated [37,39]; public health management [37,39]; and health care financing.

Thus, while documents from Colombia list specific, health-related objectives for the health care of immigrants (especially Venezuelans), the Mexican documents mention specific objectives only for Mexican international migrants.

### 3.2. Strategies: health issues

In the documents from Mexico, mention is made of prevention of HIV/AIDS [22], control of communicable diseases (including sanitary

regulations applicable at the time of entrance) [26], healthcare for pregnant migrants and victims of sexual violence [22,29], and mental health (including prevention and treatment of drug use) [22]. Documents that refer to specific groups emphasize the health issues that are considered relevant for each of them. Thus, documents about unaccompanied minors [23,27,29] mention contraception, sexual violence, and vaccination, while those referring to migrants detained in the Ministry of Interior's migratory stations say that the stations should provide physical and mental health services and adequate food [21–23,25–29].

On the other hand, documents from Colombia mention communicable diseases, public health surveillance, vector transmitted diseases, violence (especially gender-based), mental health, and chronic conditions that might be complicated by migration (diabetes, hypertension, and asthma) [37,39]. Also mentioned are vaccination and contraception, and health promotion strategies such as the strengthening of sexual and reproductive rights, and the promotion of community networks [37,39].

The health issues mentioned in the documents are thus similar, with the exception of chronic conditions, which are only addressed in documents in Colombia.

### 3.3. Strategies: access to health services

Mexico and Colombia have fragmented health systems, with a combination of public and private schemes and providers covering different population groups, according to employment and other characteristics (including ability to pay) [44,45]. Both systems are limited in terms of infrastructure, personnel, and availability of medicines, and in practice are unable to provide effective access to health care for the population as a whole [46–48]. In this section, we describe what the reviewed documents say about health services access for migrants: who is entitled to care, the possibility of and mechanisms for affiliation to a health coverage scheme, which agencies are deemed responsible for granting access to health care, and how agencies and other actors are expected to coordinate in order to grant access.

Documents from both Mexico and Colombia indicate that foreign-born people should have access to health care, irrespective of their migration status [26], and that emergency care is to be provided at no cost [26,39,41]. However, in both countries, full and permanent coverage is limited by migration status, as we describe below.

People living in Mexico without employment-related health insurance, and who are in the lower income levels, are mainly covered through the System of Social Protection in Health (better known as “*Seguro Popular*”). As most international migrants in Mexico (including some return migrants) are not in formal employment, *Seguro Popular* would be their path to care. According to the reviewed documents, there were two ways for foreign-born international migrants to affiliate to *Seguro Popular* during the period covered by this study: using their temporary or permanent resident visa as an identification to register for the same three-year (renewable) period as the rest of the Mexican population; or registering without an identification document for a 90-day (non-renewable) affiliation. The first option, restricted to regular migrants, still left out those with “regional visitor” or “regional worker” cards, used by Central American migrant workers in Southern Mexico. Even more, while this option was mentioned in the manual for *Seguro Popular* affiliation of 2016 [34], it disappeared in the equivalent manual for 2018 [35], so at the time of writing this article, even regular migrants couldn't be covered by *Seguro Popular*. The second option, registering without a document, was open to irregular migrants, and in the 2016 manual for *Seguro Popular* affiliation [34], this option is explicitly described as a way through which migrants in transit to the US can affiliate. The measure was also publicly promoted as “*Seguro Popular* for migrants” [33]. Still, this is a limited-time option, and there are no provisions in the revised documents for full coverage, in equal conditions to the local population, for immigrants not in formal employment. On the other hand, while the Special Migration Program [22] mentions an initiative to boost the portability of social security and to promote access to social security for immigrants, no concrete actions for pursuing these objectives are defined. As for the financing of health care, documents from Mexico do not address the issue, although payment to providers through *Seguro Popular* is implicit for those affiliated to that scheme.

In the Colombian health system, health coverage is mainly based on affiliation to either a contributory or a subsidized scheme (depending on employment status and the capacity to pay). The Colombian documents specify that all departments, districts, and municipalities should promote the affiliation of returned Colombian migrants formerly living in Venezuela, and of Venezuelans with an alien's identity card (*cédula de extranjería*) or valid special permit of permanence (PEP), to one of these schemes. Affiliation for these two groups of migrants begins with a questionnaire applied by the Ministry of Health at the department or district level in order to assess eligibility and register beneficiaries in the System for the Identification of Social Assistance Beneficiaries (SISBEN) [36,37,39,40,43]. For Venezuelan immigrants, the affiliation is valid for as long as their migration status remains regular (two years in the case of PEP holders, renewable); irregular migrants cannot affiliate to a coverage scheme. An exception is made for indigenous people in the border areas, who can affiliate irrespective of their migrant status if they are named in a list issued by the indigenous authority [37]. In contrast to the Mexican documents, documents from Colombia detail the financing mechanisms both for the emergency care of “nationals of bordering countries” [38,41], and for treatment of chronic diseases [36–38,40,41], including a description of who is responsible for payments [38].

As for which dependency is tasked with securing health care access for migrants, the Mexican documents establish that the National Institute of Migration and other dependencies in charge of migration are responsible for subscribing agreements with health dependencies at the state level, so that the later will provide health care to immigrants [25], and should arrange for the health care needs of refugees and asylum seekers to be covered [28]. The National Institute of Migration and other dependencies in charge of migrants, refugees, asylum seekers, and unaccompanied children and adolescents, are responsible for guaranteeing that they receive the necessary health care in migratory stations and shelters, mobile medical units

in border areas and other areas through which they transit, through in-site first-aid and mechanisms to refer to health services. These dependencies are also responsible for negotiating inter-agency coordination to guarantee that the health needs of migrants are met [21–23,25,26,28,30]. One interesting initiative in this respect is the Beta Groups of Mexico's Interior Ministry (Secretaría de Gobernación), which assist migrants who have accidents, are stranded in dangerous places, or have other problems in the Mexican Northern and Southern borders. As part of their activities, Beta groups provide first aid care and reference to medical facilities [22,25]. At the same time, according to the documents reviewed, the direct responsibility for providing health care falls on the Ministry of Health [26], which, as described above, has few policies in place to address the health needs of foreign-origin international migrants.

For its part, the documents from Colombia state the Ministry of Health and Social Protection's responsibility in providing health care to migrants, in coordination with public and private providers, and with the *Entidades Promotoras de Salud* (entities that purchase services from health care providers) [39]. In contrast with Mexico, where migration dependencies are expected to negotiate agreements with the Health Ministry, in Colombia, the Ministry of Health and Social Protection expects the state and local level administrations to promote affiliation to the health coverage scheme for regular migrants [37,39,43].

Regarding coordination, the Mexican documents mention the importance of ensuring collaboration between governmental agencies [22,25,26,28], and between levels of government [22]. At the same time, while the Special Program for Migration details how its objectives relate to those of the Sectorial Program for Health, and one of its lines of action is to “harmonize the federal and local legislations in matters of health... with the migration normative framework” [22], there is a disconnect between migration policies and health policies, reflected in the scarcity of mentions to foreign-born migrants in Mexico in the documents issued by the Ministry of Health. In contrast, the documents issued in Colombia describe precise directions for intersectoral actions [37]. Beyond intra-governmental coordination, documents from Colombia also mention collaboration between the government and international organisms such as the United Nations High Commissioner for Refugees, the International Organization for Migration, the United Nations Children's Fund, the Colombian Red Cross, and the Pan American Health Organization. In Mexico, there is no mention of international organisms, but collaboration between government and civil society organizations is mentioned [22].

As the above shows, both countries contemplate the possibility of regular immigrants accessing healthcare through affiliation to the existing coverage scheme, while access for irregular immigrants is limited. The limitations of access to healthcare for irregular migrants that are apparent in these documents likely constitute a barrier to access and continuity of care.

#### 3.4. Strategies: improving quality of healthcare

Strategies to improve the quality of healthcare for migrants are scarcely mentioned in the reviewed documents. Two main areas are addressed: training and interculturalism.

As for the former, the Mexican documents mention that, in order to improve the attention that migrants receive, public servants including (but not limited to) health workers should receive training in areas such as human rights, gender, vulnerability, and interculturality [22]. In Colombia, training is mainly directed to health workers, and the areas mentioned are mental health, sexual and reproductive rights, care for pregnant women, children and adolescents, communicable disease prevention, and chronic diseases [37].

Regarding interculturalism, Mexico's National Development Plan [24] states that health promotion should be conducted “with differential criteria” in the case of migrants, and mentions “linguistic and intercultural attention”. The Program for Health Promotion and Social Determinants [32] similarly mentions the need to consider the cultural differences of the indigenous migrant population. In Colombia's Response Plan for migration from Venezuela [37], attention to cultural difference is mentioned, and

the plan suggests that community based strategies that allow for the continuation of culture and “the customs of places of origin, as well as the political and civic participation of migrants and their communities, and their capacity to advocate for their rights” should be implemented. It is interesting to notice that documents in both countries seem to assume that migrants are culturally different from the receiving community, even when most of them come from neighboring Latin American countries or from the same sub-region of the continent.

Thus, while some aspects that might have an impact on healthcare quality are mentioned in documents from both countries, none of them have a comprehensive plan for improvement.

### 3.5. Strategies: evaluation

None of the reviewed documents present a plan for evaluation of health care for foreign-born migrants, and we were unable to locate any evaluations of it. Some of the Mexican documents mention indicators for evaluation, but only for non-health related policies, and for access to health care services for Mexican return migrants [22,31]. There are no such indicators in the documents from Colombia, and only one of them [37] mentions general aspects that should be evaluated, without defining the method or indicators for the evaluation. Evaluation of health policies for migrants, therefore, seems a relatively neglected area in both countries.

### 3.6. Representation of migrants and health care

According to Bacchi [49], the representation of an issue in public policies has real life consequences, as representation defines the scope of possible actions. Similarly, Knoepfel, Larrue, Varone, and Hill [50] suggest that problems do not exist in themselves, but are constructed as part of the development of public policy. We explored how issues of migrant health and health care were represented in the documents, and how the policies were justified.

In documents from both countries, international migrants are represented as a vulnerable group, with vulnerability related to the situations they experience during transit, their working conditions, the fracture of their social networks, and their socioeconomic status [21,27,32,33,36]. Migration is understood to be the consequence of social and economic difficulties, violence, human rights violations, disasters, and war [27,37]. Health care provision and the protection of migrants are situated in a human rights framework [21,25,26,31,33,37,51]. One document from Mexico states that the human rights of migrants should be guaranteed “... just as we fight for the rights... of Mexican migrants abroad” [25]. This notion of “treating others as you want to be treated” does not appear in documents from Colombia, but there are mentions in them to the reciprocity owed to Venezuelans (who in past decades received Colombians displaced by conflict) [38]. Similarly, in Mexico there is an appeal to the common history of “fraternal peoples” [33] of the Mesoamerican region, in order to justify health care for immigrants.

Moreover, the type of migration that is addressed more frequently varies by country, giving a different image of who “the migrants” are represented to be. In Mexico, “migrant health” mostly refers to Mexicans abroad (mainly in the US), or return Mexican migrants. Internal Mexican migrants are the second most frequently mentioned population, and there are few references to foreign-born migrants in Mexico [24,30–32]. Among foreign-born international migrants, refugees and asylum seekers are more frequently addressed [21,22], and two of the reviewed documents were specifically issued for this population [21,28]. Meanwhile, the documents from Colombia are mainly concerned with Venezuelans who entered the country recently, and Colombians who lived in Venezuela and returned in the same period, with a response plan issued especially for these two populations [37]. Colombians abroad are rarely mentioned, and neither are refugees or asylum seekers.

The documents from both countries emphasize some groups as vulnerable: women, children and adolescents, people with disabilities, persons with diverse sexual orientations, older adults, and pregnant and lactating

women in Colombia [36–38,51]; and unaccompanied minors, people with disabilities, victims of torture, sexual abuse, gender violence or human trafficking, older adults, and those with chronic illness in Mexico [21,22,25,27,30].

Just as with the types of migrants, the types of foreign-born persons that the reviewed documents emphasize vary by country. When the Mexican documents mention foreigners, they mostly refer to Central Americans in transit through Mexico, painting a picture of a non-permanent migration flow. This representation agrees with the lack of provisions for health care of immigrants who become long term or permanent residents. In the documents from Colombia, most of them focused on the recent migration of Venezuelans, and it seems to be assumed that immigrants will remain in the country. The degree to which the strategies for affiliation to the national health care schemes is detailed in the Colombian documents appear to support to this view, while the Mexican strategy of 90-day affiliation is targeted at people in movement, who will stay for just a short period.

Another contrast in the representation of the problem between the two countries is the narrative of crisis apparent in the Colombian documents. One of them was issued in 2015 in response to the expulsion of Colombians from Venezuela [40], and six in response to the arrival of Venezuelans and returned Colombians since 2017 [37,39,41–43,52]. Consequently, they paint an extraordinary situation that requires rapid adjustments from the health system. As part of this representation, migration is described as a challenge for the health system, and the Response Plan [37] underscores this aspect by presenting data of the increase in health care activities in the border and other areas. None of the Mexican documents employ a similar narrative.

## 4. Discussion

Health policies for international migrants, refugees, and asylum seekers in Mexico and Colombia share a human rights framework, and in both countries, immigrants are considered entitled to health care (with limitations by migration status).

On the other hand, according to our analysis the main difference between policies in the two countries is the migration process they focus on, which define the main challenges that the policies aim to address: access to healthcare for international Mexican migrants in Mexico, and for Venezuelan immigrants in Colombia. These differences can be explained by the characteristics of migration in each country during the period when the documents were issued. Most of the Mexican documents express the migration and health policies defined at the beginning of the 2012–2018 administration, a time when the most notable change was an increase in return migration, while the number and characteristics of migrants in transit, immigrants, and asylum seekers remained relatively stable [20]. As sending countries, both Mexico and Colombia have developed emigration policies to engage with and support their diasporas [53,54], and the Mexican documents reflect this. Meanwhile, during the period covered in this study, Colombia experienced the arrival of more than a million Venezuelans in a very short time. This contingency explains the references to crisis, as well as the mentions of coordination with the international agencies that Colombia had requested financial support from. In this way, the Colombian health sector response was aligned with the country's immigration policies of incentivizing regularization for Venezuelans [55], and also represents a view of the situation as a humanitarian emergency.

These differences in how the problem was seen and experienced are reflected in their policies [49,50]. In Mexico, the strategies and actions mainly address a transitory period, probably because it was assumed that Mexican return migrants would soon integrate into the Mexican health care coverage system, and that foreign-born migrants were just passing by. In contrast, the Colombian policies seem to be designed for a population that intends to stay in the country [19], and aim to promote their rapid and permanent affiliation to health coverage schemes.

Thus, our results coincide with the proposal of Vazquez, Terraza-Nunez, Vargas, Rodriguez and Lizana [10], who suggest that health policies for

migrants reflect the migration tradition of each country. The main migration tradition in Mexico is Mexico-US migration, and therefore health policies for migrants are focused on the protection of Mexicans abroad or return migrants, with little attention to foreign-born immigrants, refugees, and asylum seekers. In this sense, a recent development that will be interesting to follow is that of the “migrant caravans” coming from Central America. While this situation is outside the temporary framework of this study, not subject to review here, it could be the beginning of a different migration panorama [16], requiring a new policy response. Likewise, in Colombia, the main migration tradition had been emigration, but the country is currently in the midst of an important immigration flow. Choosing two cases with similar migration traditions, going through different migration circumstances, allowed us to observe how a specific situation can influence the development of public policy.

In our analysis, we identified two inconsistencies in the health policy as stated by the documents. First, the stated human rights framework in both countries contrasts with the limitations to access that the documents evidence. Second, while migrant health policies require a defined legal framework and financing mechanisms [3,4], neither Mexico nor Colombia have an explicit policy of migration and health. While Colombia issued indications and norms in response to an emergent situation, there was still no long-term policy, and the guidelines were limited to Venezuelan immigrants and returned Colombians. In Mexico, a gap was apparent between documents issued by migration-related agencies, stating that immigrants, migrants in transit, and refugees are entitled to health care, and the lack of provisions to implement that entitlement in documents issued by the Health Ministry. The development of a coherent policy on migration and health in these two countries would require a more ample view of the changing migration flows in the region, considering immigrants, migrants in transit, and asylum seekers, without limiting access to health care to some of these flows or to regular migrants. Without this, most foreign-born people will have access only via emergency services, likely increasing the costs of care and limiting their right to health [7].

One limitation of our study is that it does not constitute a comprehensive policy analysis, which should go beyond the norms, guidelines, and recommendations, to also assess the social and politic processes of policy definition and their historical changes [56,57]. It is also important to consider that our results do not refer to the actual enacting of policies. The implementation gap is a major issue in health policy, with migrants frequently facing barriers over and above those apparent in norms or laws [58], and further research is required in this area. Our decision to limit the analysis to the documents that describe and regulate public policy, however, responded to the exploratory nature of this work, and to the interest of getting a snapshot of a situation that is still currently changing [57]. Another possible limitation of our work is the omission of documents that were not retrieved by our searching criteria.

## 5. Conclusions

To conclude, our study shows that migratory tradition, current migration context, migration policies, and the representation of the problem [10,49,50], as well as politics and international relations [59], influence policies for the health care of migrants. As migration is a changing phenomenon, the gap between its characteristics and policies should be repaired [16]. As shown by this study, Mexico and Colombia still have much to do in this regard.

## Declaration of competing interest

The authors declare no conflicts of interest.

## Acknowledgement

As part of the project “Mexico-Guatemala trans-border region”, ACV received financial support from FORDECYT (no. FORDECYT/085E/201 7/

09/21-05) that contributed to the analysis reported in this article. The funding source had no involvement in study design, the collection, analysis or interpretation of data, the writing of the report, or the decision to submit the article for publication.

## References

1. Fernandez-Niño JA, Bojorquez-Chapela I. Migration of Venezuelans to Colombia. *Lancet* 2018;392:1013–4.
2. International Organization for Migration (IOM). La migración sur-sur: Asociarse de manera estratégica en pos del desarrollo. IOM; 2014.
3. World Health Organization. Draft framework of priorities and guiding principles to promote the health of refugees and migrants. WHO; 2017.
4. International Organization for Migration (IOM), World Health Organization (WHO). Colombo Statement; 2017.
5. International Organization for Migration (IOM), World Health Organization (WHO), United Nations. International migration, health and human rights. Geneva: IOM; 2013.
6. Global compact for safe, orderly and regular migration. Morocco: United Nations; 2018.
7. Abubakar I, Aldridge RW, Devakumar D, Orcutt M, Burns R, Barreto ML, et al. The UCL-Lancet Commission on Migration and Health: the health of a world on the move. *Lancet* 2018;392:2606–54.
8. Onarheim KH, Melberg A, Meier BM, Miljeteig I. Towards universal health coverage: including undocumented migrants. *BMJ Glob Health* 2018;3:e001031.
9. Aday LA, Andersen R. A framework for the study of access to medical care. *Health Serv Res* 1974;9:208–20.
10. Vazquez ML, Terraza-Nunez R, Vargas I, Rodriguez D, Lizana T. Health policies for migrant populations in three European countries: England; Italy and Spain. *Health Policy* 2011;101:70–8.
11. The World Bank. Country and lending groups. The World Bank Group; 2019.
12. Organización Internacional para las Migraciones (OIM). Informe sobre las migraciones en el mundo 2018. Ginebra: OIM; 2018.
13. Cancillería General de Colombia. Fortalecimiento de políticas públicas para la atención y vinculación de colombianos en el exterior; 2013.
14. Instituto Nacional de Estadística y Geografía (INEGI). Encuesta intercensal. Principales resultados. Mexico: INEGI; 2015.
15. Organización Internacional para las Migraciones (OIM). Informe sobre las migraciones en el mundo 2013: El bienestar de los migrantes y el desarrollo. Ginebra: OIM; 2013.
16. Giorguli-Saucedo SE, García-Guerrero VM, Masferrer C. A migration system in the making: demographic dynamics and migration policies in North America and the Northern Triangle of Central-America. Mexico: Center for Demographic, Urban and Environmental Studies/El Colegio de México; 2016.
17. World Bank Group. Net migration: Colombia; 2019.
18. El Colegio de la Frontera Norte. La caravana de migrantes centroamericanos en Tijuana 2018. Diagnóstico y propuestas de acción. Tijuana, Mexico: El Colegio de la Frontera Norte; 2018.
19. Registro Administrativo de Migrantes Venezolanos en Colombia (RAMV). Informe final. RAMV; 2018.
20. Consejo Nacional de Población, El Colegio de la Frontera Norte. Prontuario sobre movilidad y migración internaional en la frontera sur de México. Ciudad de México y Tijuana, México: SEGOB, El Colef; 2018.
21. Ley Sobre Refugiados, Protección Complementaria y Asilo Político. Diario Oficial de la Federación. México; 2014.
22. Programa Especial de Migración 2014-2018. Diario Oficial de la Federación. México; 2014.
23. Protocolo de actuación para asegurar el respeto a los principios y la protección de los derechos de niñas, niños y adolescentes en procedimientos administrativos migratorios. México: Diario Oficial de la Federación; 2016.
24. Plan Nacional de Desarrollo 2013–2018. México: Diario Oficial de la Federación; 2013.
25. Acuerdo por el que se emiten los lineamientos en materia de protección a migrantes del Instituto Nacional de Migración. Mexico: Diario Oficial de la Federación; 2012.
26. Ley de Migración. Diario Oficial de la Federación. México, 2014.
27. DIF/ITA. Modelo de Atención de Niñas y Niños Migrantes No Acompañados. México; 2016.
28. SEGOB/COMAR. Manual de Organización Específico de la Coordinación General de la Comisión Mexicana de Ayuda a Refugiados. México; 2017.
29. DIF. Modelo de Atención de Adolescentes Migrantes No Acompañados. México; 2016.
30. Programa Sectorial de Salud 2013–2018. México: Diario Oficial de la Federación; 2013.
31. Dirección General de Relaciones Exteriores. Plan Anual de Trabajo. Ministry of Health; 2015.
32. Secretaría de Salud. Programa de Acción Específico: Promoción de la Salud y Determinantes Sociales 2013–2018. México; 2015.
33. Comisión Nacional de Protección Social en Salud. Otorgan Seguro Popular a migrantes. Mexico; 2014.
34. Comisión Nacional de Protección Social en Salud. Manual de Afiliación y Operación; 2016.
35. Comisión Nacional de Protección Social en Salud. Guía de Afiliación y Operación. México; 2018.
36. Ministerio de Salud y Protección Social. Decreto 1495 de 2016; 2016.
37. Ministerio de Salud y Protección Social. Plan de Respuesta del Sector Salud al Fenómeno Migratorio; 2018.
38. Ministerio de Salud y Protección Social. Decreto 780 de 2016; 2016.
39. Ministerio de Salud y Protección Social. Circular 025 de 2017; 2017.
40. Ministry of Health and Social Protection. Decreto 1768 de 2015. In: Ministry of Health and Social Protection, editor. Protection MoHaS; 2015.

41. Ministerio de Salud y Protección Social. Decreto 866 de 2017; 2017.
42. Ministerio de Salud y Protección Social. Resolución 3015 de 2017; 2017.
43. Presidencia de la República. Decreto 1288 de 2018; 2018.
44. Guerrero R, Gallego AI, Becerril-Montekio V, Vásquez J. Sistema de salud de Colombia. *Salud Publica Mex* 2011;53:S144–55.
45. Gómez Dantés O, Sesma S, Becerril VM, Knaul FM, Arreola H, Frenk J. Sistema de salud de México. *Salud Publica Mex* 2011;53:S220–32.
46. Consejo Nacional de Evaluación de la Política de Desarrollo Social (CONEVAL). Indicadores de acceso y uso efectivo de los servicios de salud de afiliados al Seguro Popular. Mexico, D.F.: CONEVAL; 2014
47. Organisation for Economic Co-operation and Development (OECD). *OECD reviews of health systems: Colombia 2016*. Paris: OECD Publishing; 2015.
48. Gutierrez JP, Garcia-Saiso S, Dolci GF, Hernandez Avila M. Effective access to health care in Mexico. *BMC Health Serv Res* 2014;14:186.
49. Bacchi C. Introducing the 'What's the Problem Represented to be?' Approach. In: Bletsas A, Beasley C, editors. *Engaging with Carol Bacchi strategic interventions and exchanges*. Adelaide: University of Adelaide Press; 2012. p. 21–4.
50. Knoepfel P, Larrue C, Varone F, Hill M. *Public policy analysis*. Bristol, UK: The Policy Press; 2007.
51. Migración Colombia. *Política Institucional de Derechos Humanos*. Colombia; 2013.
52. Presidencia de la República. Decreto 542 de 2018; 2018.
53. Délano A. From limited to active engagement: Mexico's emigration policies from a foreign policy perspective (2000–2006). *Int Migr Rev* 2009;43:764–814.
54. González-Rábago Y. Engagement policies in favour of transnationalism: the expansion of transnational citizenship within Colombian emigrants. *REMHU* 2015;23:291–310.
55. Ministerio de Relaciones Exteriores. Resolución 5797 de 2017; 2017.
56. Bernier NF, Clavier C. Public health policy research: making the case for a political science approach. *Health Promot Int* 2011;26:109–16.
57. Walt G, Shiffman J, Schneider H, Murray SF, Brugha R, Gilson L. 'Doing' health policy analysis: methodological and conceptual reflections and challenges. *Health Policy Plan* 2008;23:308–17.
58. Suphanchaimat R, Pudpong N, Prakongsai P, Putthasri W, Hanefeld J, Mills A. The devil is in the detail—understanding divergence between intention and implementation of health policy for undocumented migrants in Thailand. *Int J Environ Res Public Health* 2019;16:1016.
59. Basok T, Rojas Wiesner ML. Precarious legality: regularizing Central American migrants in Mexico. *Ethn Racial Stud* 2018;41:1274–93.