Tidsskriftet Tidsskrift for Den norske legeforening

Immigrants and COVID-19 infections

EDITORIAL

ARILD AAMBØ

E-mail: arild.aambo@fhi.no
Arild Aambø, MD, former specialist in general practice and senior adviser at the Norwegian Institute for Public Health since 2018. He has worked on immigrant health issues in various contexts since the 1980s. The author has completed the ICMJE form and reports no conflicts of interest.

Are differences in the infection rate between immigrants and the population as a whole yet another example of a general pattern?

Health equity is a Norwegian policy objective. It is therefore alarming when some population groups systematically appear as more ill or vulnerable than others. This is the case for immigrants, among others.

Immigrants are no sicker than other people. On the contrary, several studies show that newly arrived migrants are healthier than both the population they migrated from and the population in the country they come to (1). After several years in the host country, however, their health declines to the level of the native population or worse (2). Many factors contribute to this. In recent decades, more attention has been given to allostatic load, i.e. the overall chronic stress caused by migration, such as language problems, cultural expectations and the burden of perceived discrimination.

> ***«In recent decades, more attention has been given to the overall chronic stress caused by migration»***

Regarding COVID-19, reports from the Norwegian Institute of Public Health show that the infection rate and disease burden among immigrants are high, and for some groups it is extremely high. Immigrants are overrepresented with respect to confirmed infections and number of hospitalisations (3, 4). Age, gender, municipality of residence and occupation cannot adequately explain

these differences. Socioeconomic factors, such as low level of education, low income and loose labour market attachment impact on infection rates and morbidity, probably also with regard to COVID-19 (5).

To date, we know little about the extent to which such factors affect COVID-19 infection rates. It is therefore appropriate that this journal has now published a study that seeks to shed light on precisely these associations, taking its point of departure in the variation in the rate of infection between the different Oslo districts (6). Immigrant ratio, socioeconomic status and household density in the districts were all associated with higher infection rates when the factors were analysed individually, but only the immigrant ratio in the individual districts was statistically significant in adjusted analyses.

Søegaard and Kan suggest that cultural/ethnic background in itself may be a factor in the spread of infection (6). However, a new study from the Norwegian Institute of Public Health shows that immigrants in general have a more positive attitude towards and a higher self-reported compliance with social distancing and hygiene guidelines than the general population (7). However, the study by the Norwegian Institute of Public Health is hardly representative of all segments of the immigrant population since the data were obtained from an online survey requiring both a BankID login and relatively good Norwegian language skills. Language barriers, the need for adapted information and health competence can therefore still be important factors.

In Norway, some immigrant groups have an especially high incidence of diseases that are associated with a severe course of COVID-19, such as obesity, diabetes and cardiovascular disease (8). Still, the cause of the high infection rate among immigrants is largely uncertain. Søegaard and Kan have used aggregate averages in their analyses, and as the authors themselves suggest, the conclusions that can be drawn from these figures are limited (6). The Norwegian Institute of Public Health has so far not had access to individual data on relevant socioeconomic differences. If more effective methodology is used, it might be possible to show that such associations exist and that taken together they constitute a substantial risk factor, even though each one by itself is insignificant. Such research requires considerable human and economic resources. However, if this is shown to be the case, it would be in keeping with research on allostatic load.

It can also be beneficial to turn our attention to other factors. A study from England showed that although only 21 % of healthcare and social workers in the public health service were of Asian descent or had a dark complexion, these groups accounted for 63 % of the deaths from COVID-19 (9). A potential factor highlighted by the authors to explain their findings is that immigrants age more quickly due to physical, chemical and psychosocial stress, including perceived discrimination, which may result in allostatic overload.

> ***«Despite the uncertainty around the causal mechanisms – or perhaps because of it – it is important that healthcare workers, administrators and policymakers are aware of the health differences found in the actual study»***

Despite the uncertainty around the causal mechanisms – or perhaps because of it – it is important that healthcare workers, administrators and policymakers are aware of the health differences found in the actual study and that we do not assign blame but rather try to understand what is at stake in each case. Moreover, there is a clear need to examine how structural factors can have a discriminatory effect and contribute to health inequities.

LITERATURE

1. Syse A, Strand BH, Naess Ø et al. Differences in all-cause mortality: a comparison between immigrants and the host population in Norway 1990–20. Demogr Res 2016; 34: 615–56. [CrossRef]

2. Diaz E, Kumar BN, Gimeno-Feliu LA et al. Multimorbidity among registered immigrants in Norway: the role of reason for migration and length of stay. Trop Med Int Health 2015; 20: 1805–14. [PubMed][CrossRef]

3. Indseth T, Godøy A, Kjøllesdal M et al. Covid-19 etter fødeland fra mars 2020 til februar 2021. Oslo: Folkehelseinstituttet, 2021. https://www.fhi.no/publ/2021/covid-19-etter-fodeland-fra-mars-2020-til-februar-2021/ Accessed 19.3.2021.

4. Indseth T, Grøsland M, Arnesen T et al. COVID-19 among immigrants in Norway, notified infections, related hospitalizations and associated mortality: A register-based study. Scand J Public Health 2021; 49: 48–56. [PubMed] [CrossRef]

5. Abubakar I, Aldridge RW, Devakumar D et al. The UCL-Lancet Commission on Migration and Health: the health of a world on the move. Lancet 2018; 392: 2606–54. [PubMed][CrossRef]

6. Søegaard EGH, Kan Z. Koronasmitte i Oslos bydeler. Tidsskr Nor Legeforen 2021; 141. doi: 10.4045/tidsskr.20.1022. [CrossRef]

7. Nilsen TS, Johansen R, Aarø LE et al. Holdninger til vaksine, og etterlevelse av råd om sosial distansering og hygiene blant innvandrere i forbindelse med koronapandemien. Oslo: Folkehelseinstituttet, 2021. https://www.fhi.no/publ/2021/holdninger-tilvaksine-og-etterlevelse-av-rad-om-sosial-distansering-og-hyg/ Accessed 19.3.2021.

8. Kjøllesdal M. red. Helse blant innvandrere i Norge. Levekårsundersøkelse blant innvandrere 2016. Oslo: Folkehelseinstituttet, 2019. https://www.fhi.no/publ/2019/helse-blant-innvandrere-i-norge-levekarsundersokelse-blant-innvandrere-2016/ Accessed 19.3.2021.

9. Razai MS, Kankam HKN, Majeed A et al. Mitigating ethnic disparities in covid-19 and beyond. BMJ 2021; 372: m4921. [PubMed][CrossRef]

Publisert: 25 March 2021. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.21.0218