



Euro Observer

**The Health Policy Bulletin
of the European Observatory on Health Systems and Policies**

Winter 2007

Volume 9, Number 4

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Migration and health in EU health systems

Philipa Mladovsky

Little is known about access to health care among the 35 to 40 million foreign-born people in Europe. Indeed, the European Commission has found that “While Member States identify immigrants among those particularly at risk of poverty and social exclusion, many countries still fail to provide in-depth analysis of the factors leading to this situation. Little attention is given to promoting access to resources, rights, goods and services, in particular to appropriate healthcare.”¹

Recognizing the dearth of attention paid to the welfare of migrants in Europe, the Portuguese Presidency of the European Union in 2007 has chosen migration as one its principle issues. In relation to health, it hopes to “develop a shared vision on health and migration based on common EU values and principles.”²

The lack of attention paid to migrant health policy to date is undesirable both from the perspective of European integration and human rights.^{3,4} However, it is also understandable, in light of the methodological difficulties associated with studying migrant health. Migrant health policy should be developed in response to the health problems affecting migrants and whether these differ from the health problems affecting the general population; and whether migrants have equity of access to health care. However, while the role of migration in the spread of

epidemics has long been of interest in public health, relatively little is known about the health of migrants once they settle in host countries and interact with the health care system. This is particularly true of Europe, since unlike North America and Australia, most European countries do not systematically collect health data by migrant status or ethnic group (UK, Sweden and the Netherlands being exceptions).

A systematic review of the literature on migrant health trends⁵ drew the broad conclusion that migrants do not necessarily display worse health than non-migrants but that they generally tend to exhibit disadvantaged risk factor profiles. Indeed, many studies have found a relative ‘mortality advantage’ in relation to the diseases of affluence among migrants, compared to non-migrants. For example, studies have found that some immigrant groups experience lower coronary heart disease mortality than the general population, controlling for income and socioeconomic group. However, it seems that this effect is lost over time and subsequent generations, as migrants acculturate to the less healthy lifestyles of host populations. Furthermore, for many other causes of mortality and morbidity, migrants are at a relative disadvantage. This is the case for many communicable diseases, accidents, injuries and violence. Some studies also suggest that migrant women experience specific health

** The articles in this issue are based on research undertaken for a project funded by the European Commission, DG Employment, Social Affairs and Equal Opportunities on Health Status and Living Conditions in the EU, Contract No. VC/2005/0781.*

The Observatory is a partnership between the WHO Regional Office for Europe, the Governments of Belgium, Finland, Greece, Norway, Spain, Slovenia and Sweden, the Veneto Region of Italy, the European Investment Bank, Open Society Institute, the London School of Economics and Political Science and the London School of Hygiene & Tropical Medicine.

problems, particularly relating to sexual and reproductive health.

Data on utilization of health care by migrants are relatively sparse, but several studies suggest migrants do experience unequal access to health care, particularly in terms of utilization of prevention programmes such as screening and vaccination. Barriers to health care may result in worse health outcomes, as is suggested, for example, in one study by the relatively higher rate of avoidable mortality among immigrants than among native Dutch.⁶ Evidence also suggests that barriers often lead to delaying care, resulting in the increased consumption of more expensive emergency treatments.

Why can access to health care be a problem for migrants? One issue is that requirements for permanent status vary across Europe and obtaining this status may take several years.⁷ Secondly, undocumented migrants in many countries are not granted equality of treatment.⁴ Besides the legal barriers, migrants also face other specific difficulties in accessing health care. In clinical encounters, language and literacy are by far the most obvious cultural obstacles to providing care, impacting on adherence to medicine. A common response by health systems is to provide translators. Where the state does not make such services available, NGOs may fill the gap. Alternatively, migrants may have to rely on members of their family or friends who are bilingual, although this raises issues of privacy. In addition to language, miscommunication and dissatisfaction stemming from cultural differences and expectations can also contribute to sub-optimal care. For some migrant women, lack of access to female doctors may be a problem. Furthermore, categories and concepts used by migrants to explain health problems may differ significantly from Western understandings, as the field of medical anthropology has long demonstrated. Significantly, a lack of knowledge about the health care system may be a serious obstacle to access, sometimes even despite tailored publications and orientation services, and mistrust of service providers may be an important issue for some, particularly

undocumented migrants fearing detection. Finally, in countries with complex registration systems for social health insurance, such as France, administration and bureaucracy are major barriers.

The way migrant health is approached from a policy perspective to some extent depends on the type of immigration affecting the country. A country's approach to migrant health issues will also depend on its overall welfare regime, with different nations responding to similar political challenges in idiosyncratic ways.⁸

In this issue of *Euro Observer*, three countries' migrant health policies are described, revealing considerable differences. In Italy, policy regarding the health of migrants is relatively developed and at the central level, immigrant related health policy targets have been set since the 1990s. However, it is not clear how successful the government has been with implementation. The Netherlands stands out in Europe for its sustained and systematic attention to problems of migrant health, although a closer look at the current situation suggests there is a danger of these initiatives stagnating. In Spain, migrant health and health care issues have only recently started to feature in national and regional plans for the integration of immigrants.

In light of this variability, there appears to be a significant role for the EU to play in facilitating the development and transfer of evidence and information on immigrant health policy. Certainly, the Portuguese Presidency's focus is designed to create the momentum needed to realize this objective. A good starting point would be addressing the methodological problems associated with migrant health research. Specifically, there is a need for: increased funding to develop research techniques; increased collaboration at the European level between national research centres; and increased attention paid to the methodological barriers to including data on migrants in national and European health surveys.

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Migrant health policies in The Netherlands

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In 2000, the Council for Public Health and Health Care (RvZ) published two reports highlighting the health and health care accessibility problems of migrants and ethnic minorities.¹ In response, the Minister of Health established a Project Group to work out a strategy for 'interculturalizing' health care, leading to the approval of a four-year Action Plan for intercultural mental health. At the same time an 'intercultural mental health centre of expertise' (MIKADO) was established, with financing guaranteed until 2007.² Another important milestone was the publication by the central body for medical research (ZonMw) of a report summarizing 163 projects set up under the programme 'Culture and Health'³ while in 2004 two major conferences took place: one on the Action Plan for Intercultural Mental Health and another on 'Migrant Health in Europe'.⁴

While the Netherlands stands out in Europe for its sustained and systematic attention to problems of migrant health, there is currently a danger of these initiatives stagnating. The 'Culture and Health' programme and the Action Plan both ended in 2004, and the present government has distanced itself from creating additional interculturalization programmes, preferring a new approach where the onus is placed on migrants to adapt to Dutch society.² Citing evidence that existing programmes work well, that immigrants are able to find their way within the health care system (GPs are visited more often in comparison to the Dutch), and that in some cases immigrants' health is better in comparison with the Dutch (for example, higher life expectancy among some immigrant groups), since 2005 the government's premise has been that differences in health status will reduce over time and as immigrants become accustomed to living

in the Netherlands.⁵ More recently, however, the Secretary of State for Health concluded that at least with respect to older immigrants, new programmes may be needed to improve long-term care, as it can no longer be automatically assumed that children will take care of their aged parents.⁶

Currently, specific programmes include 'immigrant health promoters' who provide patients with information in their own language and mediate between care providers and immigrants. Their activities are coordinated by the Netherlands Institute for Health Promotion and Disease Prevention. A free interpreter service (in almost 100 languages) is also available for most health care providers such as GPs and doctors and nurses in hospitals.

More targeted government policies include The Community Health Service for Asylum seekers (in Dutch: MOA), which provides health care services for this group. Using government funds, the Central Agency for the Reception of Asylum Seekers (COA) contracts through a health care insurer to organize the provision of services including general practitioners, pharmacists, dentists, physiotherapists, obstetricians, hospitals, mental health care providers and home care services. Services such as health education, child health care, infectious disease control, and hygiene and safety inspections are also provided.

With respect to illegal immigrants an infamous piece of legislation (Koppelingswet) was enacted in 1998, making it impossible for them to apply for health insurance. Health services such as hospitals may opt to treat only patients whose life is in danger or when public health is endangered. However, medical care providers (such as GPs) are entitled

to reimbursement for non-emergency care from a special fund (but this may change in the future).

National collection of data

Unlike most EU countries, national surveys in the Netherlands include data about immigrant health and access to health care for official purposes. Among Dutch researchers it is generally agreed that all epidemiological studies should make use of the same immigrant status indicators, i.e. country of birth, and maternal and paternal country(ies) of birth. All persons with at least one parent born outside the Netherlands are referred to as 'allochtonen'.

Box: Nongovernmental programmes

NIGZ (Netherlands Institute for Health Promotion and Disease Prevention) develops programmes in support of healthy behaviour and healthy environments and at times is contracted by the Ministry of Health, Welfare and Sports. The Institute has developed educational materials for immigrant patients, provides professionals with basic knowledge about immigrant health, and coordinates the activities of immigrant health promoters.

Pharos offers knowledge, insight and skills for improving the quality of health care provided to refugees and asylum seekers.

FORUM strives to promote understanding between people of different origins. Amongst others it advises professionals and develops methods and materials for professionals on health care issues.

Mikado is the Dutch national centre of expertise on interculturalization for the care sector. It pools existing knowledge, experience and expertise on migration issues, intercultural (health) care and transcultural psychiatry. No longer funded by the government, since November 2007 it is contracted by individual care organizations who want to draw on its knowledge and experience.

The Pacemaker in Global Health Foundation is an expert centre for ethnic difference and health. It aims to stimulate the achievement of health among an ethnically diverse population and to improve accessibility and quality of care.

Websites:

www.pharos.nl/Over/P-over.html

www.forum.nl/pdf/folder2002-eng.pdf

www.pacemaker.nl/english.html

www.mikadonet.nl/pagina.php?id=english

Two main government surveys gather data on migrant health. The general POLS (Permanent Research Life Situation) Survey is carried out every year and includes topics such as health, safety, leisure time, and living and working conditions. Health indicators covered are morbidity, self-assessed health, psychological health, risky lifestyles, Body Mass Index, medical consumption, limitations in daily activity, chronic diseases, and unhealthy behaviours. Questions about health care utilization are also included and migrant status is differentiated as described above.

The Local and National Health Monitor consists of three different monitors focussing on child and youth health, public health and health of the elderly. The health data registry gathers uniform data on determinants of health which are used by local government community health and home care services for quality assessment purposes. The data is disaggregated by migrant status.

Another survey that differentiates migrant status is the Second Dutch National Survey of General Practice, carried out by an influential non-governmental organization, NIVEL (Netherlands Institute for Health Services Research). The last survey was held in 2000–2002 and collected data on health and health care utilization from 104 participating GPs.

Reporting of data

Two large reports published by the National Institute of Public Health and the Environment (RIVM) - *The Future Exploration of Public Health* and the *Dutch Health Care Performance Report* - are used by the Ministry of Health, Welfare and Sport to evaluate Dutch health care policy. Both reports have a specific summary on research outcomes with respect to immigrants and in addition to the standard indicators of ethnicity, data on asylum seekers, refugees, and illegal immigrants are also included.

The latest *Future Exploration Public Health Report* (published in 2006) provides information on the health of the population, prevention and health care

Table 1: Utilization (not adjusted) of health care by people aged 18 years and over as a % of population by ethnic group, 2001–2002

	Dutch	Turks	Moroccans	Surinamese	Antilleans
General practitioner (past 2 months)	41.8	52.2	46.9	53.3	48.4
Medical specialist (past year)	16.4	13.9	12.6	20.2	11.4
Physiotherapist (past year)	16.4	13.9	12.6	20.2	11.4
Hospital admission (past year)	7.3	7.6	6.8	6.4	9.2
Home care (past year)	6.3	3.9	2.3	4.8	6.7
Prescribed medicines (past 2 weeks)	47.2	38.4	35.9	52.4	41.1
Over-the-counter medicines (past 2 weeks)	37.8	31.3	31.1	37.4	38.9

Source: Dutch Health Care Performance Report, 2006, p. 102). Bold = significantly different from the Dutch population.

services, combining the outcomes of several surveys. Its main conclusions regarding immigrants are that in general they have worse health compared to the Dutch, but differences can also be found between different ethnic groups. Asylum seekers, refugees and illegal immigrants similarly report worse health. The report concludes that knowledge about immigrants' health and access to health care is still scarce. While it is hypothesized that there are important differences between first and second generation immigrants, no data is available.

The *Dutch Health Care Performance Report*, also published in 2006, provides information on access to, quality, and cost of Dutch health care using approximately 125 indicators. In terms of access, Table 1 shows that a higher proportion of immigrants makes use of GP services than the Dutch population but the reverse is true for medical specialist visits.

The conclusions regarding immigrants are that, in general, the Dutch health care system is accessible although under-utilization of care persists in some sub-groups and for some health care services.

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Migrant health policies in Italy

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Italian policy on migrant health is relatively developed, although how successful central and local government have been with implementation is not clear, in part due to the increasingly decentralized nature of the system. While responsibility for achieving overall objectives rests with central government, the regions are responsible for administration of services and provision of '*Livelli Essenziali di Assistenza – LEA*' (Essential Levels of Care), a basket of services to be delivered uniformly across the country. At the central level, public health care policy is set by the National Healthcare Plan¹ and migrant-related health policy targets have been set since the 1990s. In particular, the National Health Plan for 1998–2000 contained general objectives to guarantee migrants uniform access to medical and health assistance and to extend to migrants the vaccinations that are guaranteed for the Italian population. Moreover, a special programme for the health of migrants, *Salute degli immigrati*, was established.

The 2001–2003 plan sets general aspirational targets for different groups of vulnerable people, including migrants:

- to guarantee uniform access to medical and health assistance;
- to increase vaccination levels among migrant children to equal those of the Italian population;
- to improve the administrative health information system on migrants registered with the National Health Service (*Servizio Sanitario Nazionale*, SSN) and the registration rates of foreigners with a regular permit of stay;
- regions should indicate and plan how to guarantee essential and continued care to irregular migrants;
- each local health authority should promote information campaigns for migrants and educational programmes for health care personnel;

- a target of a 10% reduction in voluntary abortion rates among migrant women was set for the three year period of the plan.

More recently, the 2003–2005 National Health Plan introduced a solidarity pact to introduce more equity in the availability of health care services for the different categories of vulnerable groups, including migrants.

Narrowing the structural and quality gaps between the health care services provided in different Italian regions is still a priority in national health planning for the years 2006 to 2008. The underlying principles of the 2006–2008 Plan reiterate the central objective to “promote the equity of the system, understood not as the capacity to give everyone everything but to provide what is necessary, overcoming social and regional inequalities.” Guaranteeing the uniform provision of LEAs has a central role. For migrants the main policy targets are more focused than previously and include the following:

- to increase prevention programmes among adolescents and young adults;
- to promote incidence and prevalence studies for HIV infections, evaluating access barriers to prevention and care for sexually transmitted diseases;
- to reduce the growth rate of voluntary abortion;
- to promote education programmes in cooperation with volunteer and non-profit organizations;
- to establish interventions for banning female genital mutilation practices;
- to prevent work injuries which predominantly affect migrant workers;

Currently, at the regional level, health plans are not uniform. Most regions, particularly in the south of the country, have old and/or inadequate laws on immigration. At the local level, provincial, local and municipal administrations have introduced new programmes for migrant health and social care, although these initiatives are often not integrated or coordinated. In many cases these policies are led in conjunction with non-governmental organizations.

Generally, targets for policy are not used at the central level, although at regional level, progress indicators are often used for target purposes; eg in Umbria indicators on vaccine coverage are used to monitor child immunization policies.

Italian legislation states that all migrants in the national territory needing urgent (for life or permanent health-threatening conditions) or essential care (e.g., vaccinations, infectious diseases prophylaxis and treatment, maternity care) have the right to access public health care services such as inpatient and emergency care.

As with all Italian citizens, regular migrants have access to services provided by the SSN, either by compulsory or voluntary enrolment,* whatever their economic condition. Irregular (illegal or clandestine) migrants may go to special SSN centres for medical assistance, provided that they are identified and certified as a ‘Temporarily Present Foreigner’ (*Straniero Temporaneamente Presente*, STP). According to the law, foreigners without official identity cards, need only certify their name, date of birth and nationality to receive a STP number and fiscal code, and generally access to health care services should not be reported to government authorities. Holders of STP status have a right to basic medical assistance, to urgent and non-urgent hospitalization and out-patient treatment.

Moreover, a new reference centre to promote the health of migrant populations and to tackle diseases due to poverty (*Centro di riferimento nazionale*

* Compulsory enrolment is for foreigners holding a valid ‘Permit to Stay’ or those who have applied for renewal of their Permit; for example, individuals seeking political asylum, or those waiting to be adopted, to be granted custody, or citizenship. Optional enrolment is for other regular migrant categories such as students and foreign professionals in firms.

per la promozione della salute delle popolazioni migranti e il contrasto alle malattie della povertà)² has been established by the Ministry of Health at the 'Istituto San Gallicano' in Rome.

Government collection and reporting of data

As in most European countries, the measurement of migrant health status and utilization of health care by the government is limited, although some data are available. ISTAT (Italian Institute of Statistics) health and lifestyles periodic surveys, *Indagine Istat Multiscopo Condizioni di salute e ricorso ai servizi sanitari*, do not report on migrant health. However, there have been one-off, ISTAT-conducted surveys that do allow for analysis of health data by migrant status. These surveys include data on:

- Voluntary abortion rates by age and country of citizenship. These are available in a report by the Italian Ministry of Health for the years 2000, 2002 and 2003;³
- Birth and fertility rates (at regional/municipal level) of the resident population by country of citizenship.⁴

The *Istituto Superiore di Sanita* (the scientific institute of the Ministry of Health) also collects some health data disaggregated by migrant status. For example, two surveys on maternity and ante-natal care utilization by migrants were conducted in 1995–96 and 2000–01.⁵

The Ministry of Health also has reported in recent years on the health of/access to health care by migrants in its annual report on the health conditions of the country. However, information is not systematically reported. The reported data are mostly taken from the literature and from the one-off surveys conducted either by ISTAT or the *Istituto Superiore di Sanita*.⁶

A report by the Rome-based Agency for Regional Health Services (*Agenzia Per i Servizi Sanitari Regionali*, ASSR)^{*7},

which provides information both at the national and regional level for 2004, contains an analysis of DRG data for both public and accredited private hospitals in all the Italian regions. Indicators of inpatient rates and hospital expenditures are disaggregated by migrant status. Moreover, the report contains:

- a survey on the role of non-profit volunteer organizations working in migrant health;
- a survey of the regional health plans and policies for migrants;
- a survey on the presence of migrants working in the nursing sector;

In addition, a report was published in 2005 on migrant health and health care services utilization by migrants in the province of Bologna.⁸

Nongovernmental collection and reporting of data

The *Dossier Statistico Immigrazione* (Statistical Dossier on Immigration),⁹ published every year by *Caritas* (see Box), is one of the main sources of information on immigration in Italy. It collects all the available data on immigration, placing it in its national, regional and local context, discussing its various aspects and problems. The report also contains an analysis of the statistical data by major experts in the field. *Caritas* reports contain statistics on migrant access to *Caritas* ambulatory care centre, together with the prevalence rates of the main groups of diseases affecting patients treated by these centres.

There also have been a number of mostly epidemiological studies conducted by universities, central/regional/local health authorities, and non-profit organizations, surveying health care access of specific categories of migrants at national level or in specific geographical areas.

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Box: Nongovernmental programmes

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The International Institute of Medical Anthropological and Social Sciences (IIMASS) (<http://www.iismas.it>) is a non-profit organization in the fields of medical research and anthropological and social sciences. In collaboration with the non-profit association *Camminare Insieme* (Walking Together) in Turin, it promotes prevention, diagnosis and treatment of the diseases that affect vulnerable social groups in Italy, including immigrants.

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* The ASSR report follows a previous report by the Ministry of Health on the inpatient rates of immigrants in Italy in 1998. See Fortino A, et al. *Rapporto nazionale sui ricoveri ospedalieri degli stranieri in Italia dati sdo 1998* available in Italian at: <http://www.ministerosalute.it/programmazione/resources/documenti/13ricoveristranieri.pdf>

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Migrant health policies in Spain

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In Spain, migrant health and health care issues feature in national and regional plans for the integration of immigrants. The government recently approved the Citizenship and Integration Strategic Plan 2007–2010,¹ targeting the whole (indigenous and immigrant) population, which aims to promote social cohesion through policies based on equality of opportunity and equality of rights and duties. Within the Plan the budget for health objectives is only 3.58% of the total €2 billion. The Plan defines 12 priority areas (welcome, education, employment, housing, social services, health care, childhood and adolescence, women, equal treatment, participation, public awareness, and co-development), but special emphasis is put on education, welcome and integration policies, and employment. The Plan is based on three principles: equality, citizenship and intercultural awareness.

Among the 10 main objectives those that relate to health are to adapt public policies, especially those in education, employment, social services, health and housing, to better meet the needs of the immigrant population. The specific goals within the health area are to guarantee rights to health protection, better identify socio-health needs and to provide special training for health professionals.

Most of the Autonomous Regions have developed regional immigration plans. Health and health care of the immigrant population is included among the priority areas of action in all of the plans. Given that the existence of health inequalities and of barriers to access is assumed (even though in most cases sound scientific evidence is lacking), the plans incorporate the goals of reducing health inequalities and ensuring equal access to health care among the immigrant population. These goals are aspirational. For example, the Basque Country's Immigration Plan for 2003–2005* contains the objective that health care provided to the immigrant population will be similar to that of all Basque residents. The main objectives of the Plan regarding health and health care include:

- interventions to promote immigrants' knowledge about access to and organization of the Basque health system;
- providing health professionals with specific knowledge related to the provision of health services to the immigrant population, especially women;
- developing health prevention and promotion programmes targeting the immigrant population;
- promoting collaboration among

various public and private (not-for-profit) institutions and associations to guarantee comprehensive intercultural communication; and

- adapting access to and provision of health care services to the characteristics of immigrants.

Government collection and reporting of data

Information on the health status and health services utilization of the immigrant population in Spain is quite scarce and the existing data are relatively recent and not very comprehensive. In 2003 the National Health Survey incorporated, for the first time, a question about the citizenship of the respondent and household members. The Survey is carried out by the National Statistical Institute in collaboration with the Ministry of Health and Consumption. However, the sample of foreign citizens is not representative of the immigrant population and does not include irregular immigrants.**

In addition to the national survey, some of the latest waves of the regional health surveys include a question on citizenship. Regional Health Surveys are carried out by the Departments of Health of the Autonomous Communities, sometimes in collaboration with the Regional Statistical Office. The Catalan Health Survey 2006 (ESCA 2006) gives us the most in-depth analysis of the situation of foreign residents among the regional surveys. For example, one question asks interviewees if they felt that they had been discriminated against by the health care system. In addition to a question on citizenship, the survey also asks about place of birth and year of arrival in Spain.

Some regional and local authorities have elaborated, or are currently drafting studies that analyze the health status and access to health care of the immigrant population in the Autonomous Region, the municipality or the city of residence (in the case of Madrid or Barcelona). One example is the *Estudio de salud de la ciudad de Madrid 2005: Análisis de resultados relativos a la población inmigrante* (Study of the Health of the population of Madrid 2005: An analysis of the results

* The Second Basque Country Immigration Plan 2007–2009 (http://pdf.biblioteca.hegoa.efaber.net/ebook2/13198/Plan_Vasco_Inmigracion_2007-09-1.pdf) maintained immigrants' health and access to health care among the priority areas of action.

** Moreover, nationals of most south- and central-American countries can adopt Spanish citizenship after two years legal residence, (one year for immigrants, irrespective of nationality, married to Spanish citizens). In these cases, and given that no question about second citizenship is asked, it is possible that some 'immigrants' are interviewed as Spanish citizens.



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Box: Nongovernmental programmes

There are many NGOs working with the immigrant population in Spain. However, most of them work on projects focusing on immigrants on their arrival. The few projects aimed specifically at health and access to health care are based mainly on providing information about the functioning of the health care system and on translation and interpretation services.²

Medicos Sin Fronteras – MSF (Doctors without borders): participates in projects to provide health care, shelter and food to undocumented immigrants on their arrival in Spain. Moreover, in November 2004, the NGO begun a programme titled 'Ensuring better access to public health care for undocumented immigrants residing in Health Area 11 of the Autonomous Community of Madrid'.

Comité de Defensa de los Refugiados, Asilados e Inmigrantes en España – COMPADRE (Committee for the Defence of Refugees and Immigrants in Spain – COMRADE): provides support to different immigrant groups in order to guarantee equal rights and duties to all people irrespective of their nationality, sex, race, etc. Among the NGO's projects are: providing support and information about social services; translation and interpretation services; legal advice; job-search guidance; Spanish language classes; psycho-social health service; and physiological treatment of victims of violence and torture.

on the immigrant population*). Some of the main findings of this study are:

- immigrants consider that they have better health and quality of life compared to the perceptions of the indigenous population (84.8% of immigrants and 75.8% of the Spanish population say they have good, very good or regular health). However, the self assessed health status of the young immigrant population (aged 16–24) is lower than that of their Spanish counterparts;
- immigrants suffer less chronic conditions than the rest of the population (34% vs. 56%), but the prevalence of mental disorders among immigrants is higher than among the rest of the residents of Madrid (22% with more than two points according

to the GHQ-12 test** among immigrants vs. 19% among those from Madrid).

- immigrants use less medical and mental care than other Madrid residents, basically due to lack of time;
- 9.8% of those who visited a doctor (21.3%) felt they were discriminated against and in 90% of cases, it was because they are foreigners;
- the number of live births per 1000 women is almost four times higher among foreign-born women;
- immigrants consume less tobacco than people from Madrid, but do have similar alcohol consumption patterns;
- children and adolescents with immigrant backgrounds are exposed to higher psychosocial risks, i.e. lower levels of parental education; more one-parent families; children spend more of their spare time alone; watch more hours of television; do worse at school; and feel less happy.

Another example of research in this area is a book published in October 2006 by the Catalan Department of Health (Generalitat de Catalunya), *Health Economics Studies*.³ One chapter is dedicated to analyzing the impact of the increase in the immigrant population on the use of emergency care.

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2. *Practical Guide to the 346 NGOs on the Internet* elaborated by Consumer.es EROSKI (<http://ong.consumer.es/conclusiones>).
3. English summary at <http://www.gencat/salut/estudiseconomiasalut>

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* The report is not available, but the main findings can be downloaded from: http://www.muni-madrid.es/UnidadesDescentralizadas/ServALaCiudadania/InmiCoopVolun/Inmigracion/Publicaciones/EstudioInmigracionYSalud/Inmigrantes_y_Salud.pdf

** The 12-item General Health Questionnaire (GHQ-12) is a commonly used measure of psychological well-being. It is based on individuals' perceived general levels of happiness, depression, anxiety and sleep disturbance over the past 4 weeks rated on a four-point scale.

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Euro Observer is published quarterly by the European Observatory on Health Systems and Policies, with major funding provided by a grant from Merck & Co., Inc., Whitehouse Station, New Jersey, USA.

The views expressed in *Euro Observer* are those of the authors alone and not necessarily those of the European Observatory on Health Systems and Policies or its participating organizations.

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