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Migration and health in the European Union

Policy developments under the
Portuguese and Spanish EU Presidencies

Developing a migrant sensitive health workforce

Access to health care for undocumented migrants

Legal framework and the right to health • Child migrants: health and wellbeing
Spain: Equity and migrant health policy • Approaches to migrant health in Portugal

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COMMENT

Migration and health: a dynamic challenge for Europe

Patterns of migration in Europe are evolving dynamically. This is not just as a result of the expansion of the EU and the growing phenomena of internal EU migration; it also has reflected the demand for both skilled and unskilled labour from outside the EU, economic migration and the arrival of displaced individuals from areas of conflict, persecution and/or natural disaster. Yet only a minority of countries in the EU provide the same access to health care services for all migrants as for the resident population. Regardless of their legal status, migrants can be at particular risk of poor physical and mental health; they may be isolated after arrival in their host country or be unaware of any entitlement to use publicly funded health care services. Even where available, services may not be suitable to the needs of many migrant groups.

Most of the articles in this issue of *Eurohealth* are based on background papers prepared for the International Organization for Migration (IOM) project 'Assisting Migrants and Communities (AMAC): Analysis of Social Determinants of Health and Health Inequalities' co-funded by the EU and the Portuguese Government. The papers were presented at the EU-level Consultation on *Migration Health – Better Health for All*, which took place on 24–25th September 2009 in Lisbon, organized by IOM within the AMAC project under the auspices of the Office of the Portuguese High Commissioner for Health and the Portuguese Ministry of Health.

In 2007, health and migration was a major theme of the Portuguese Presidency. It was also prominent under the recent Spanish Presidency, which notably hosted and gave political support to the WHO/International Organization for Migration Global Consultation on Migrant Health. As María-José Peiro and Roumyana Benedict describe in this issue of *Eurohealth*, both Presidencies have also contributed to several developments at national, European and global levels. While positive progress has been made, substantial challenges remain. Not least among these, as Paola Pace notes, are some of the legal obstacles to health care access, while María-Teresa Gijón-Sánchez and colleagues highlight the need to develop a more migrant sensitive workforce.

When we think about migrants we often think about working age young adults and may overlook other population groups. Michal Molcho and colleagues suggest that there is a gap in our understanding of the impacts of migration on some of these groups. They call for more focused studies on child immigrants, looking at different circumstances, as well as country of origin and of residence.

Patterns of migration are evolving dynamically, so too must the response of policy makers and practitioners.

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Migrant health policy

The Portuguese and Spanish EU Presidencies

María-José Peiro and Roumyana Benedict

Summary: Health is essential to migrants' wellbeing and contribution to society. The European Union, European governments and the international community are progressively recognising this link and attempting to address the negative socioeconomic determinants of health which disproportionately affect migrant populations. At the EU level, attention to migrants' health has been framed by two EU Presidencies, the Portuguese in 2007 and the Spanish in 2010. This article reviews the migrant health policy context, marked by the momentum provided by these two Presidencies, as well as by landmarks set by high-level events and key documents both at EU and global levels. It ends by presenting the emerging migrant health priorities in Europe.

Key words: migrants, social determinants, public health, European Union

Migration movements in Europe have increased in size and complexity. Approximately 7.6% of the total EU population is foreign born, and it is estimated that between 2.6 million and 6.4 million migrants* are in irregular status.¹ Migration into the EU is nowadays accepted as a phenomenon that is necessary (both for demographic and economic growth) and unavoidable. Migration implies challenges and opportunities. Health is one major challenge and an essential element for migrants' wellbeing and contribution to societies.

Conditions surrounding the migration process and settling into the reception country, particularly when under unfavourable circumstances, can increase vulnerability for ill health. Moreover, migrants are at risk of not receiving the same level of health care in the preventive, diagnostic and treatment services that host communities receive due to a combination of factors including legal and working status, social exclusion, language and cultural barriers and lack of knowledge on local systems. Lastly, current health care

systems may often not be responsive enough to the specific needs of these groups.

European countries face a threefold situation of: (i) constant migrant flows, (ii) health services and practices that are largely inaccessible or unused by migrant populations and often ill-suited to migrants' needs and (iii) higher vulnerability of migrants and their children to ill health due to negative socioeconomic circumstances. On the other hand, protection of migrants' health and their access to quality health care are recognised as: (i) a human right and a basic entitlement according to EU values; (ii) vital to migrants' integration and critical to reduce poverty and (iii) essential for social cohesion, good public health and the wellbeing of all.

Policy framework

Migrants' health and its implications for their integration, public health and health services in the EU are becoming more important as EU Member States increase in their numbers of foreign born populations. The health of migrants is seen by many experts and stakeholders as an

essential theme in the current EU and Member States' health agendas.

Few EU legal references exist in the field of health since it is a recent and limited EU competency. The Treaty establishing the European Community states that a high level of human health protection shall be ensured by the Community, with the proviso that Community action, by the principle of subsidiary, can only complement national policies, for instance in relation to cross border health threats, patient mobility and reducing health inequalities. The Council Conclusions on 'Health in All Policies' under the Finnish EU Presidency stressed the fact that the impact of health determinants is unequally distributed among population groups, resulting in health inequalities.² These Conclusions also recognised that immigration, integration and social policies could have a positive or negative impact on health determinants. Before the Finnish EU Presidency, the UK EU Presidency in 2005 also devoted attention to health inequalities, notably via a summit on 'Tackling Health Inequalities: Governing for Health'.

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* There is no universally accepted definition of migrant. The term migrant is usually understood to cover individuals moving to another country or region to better their material or social conditions and to improve the prospects for themselves or their families. Migration today involves migrants in regular and irregular situations, as well as asylum seekers, victims of trafficking, refugees, displaced persons, returnees and internal migrants. For ease of reference, they are all referred to as 'migrants' in this article.

More recently, the Portuguese and Spanish EU Presidencies of 2007 and 2010 respectively have spurred interest in the health of migrants. They have fostered policy consideration and action on migrant health and health inequalities, crystallising momentum and attention to the topic and laying the groundwork for future policy and programmatic initiatives at EU and Member State level.

2007 Portuguese EU Presidency: Migrant health, better health for all

Health and migration was a major theme of the Portuguese Presidency (July–December) and the central topic of its health programme, with the declared goals of addressing the lack of exchange platforms between Member States and fostering strategic approaches around the health implications of the 21st century migratory context.

A conference ‘Health and Migration in the EU: Better health for all in an inclusive society’ (Lisbon, September 2007) was a landmark event of the Presidency. It discussed the health implications of migration and the realisation of its economic and social potentials. The Conference reports published in preparation and as a follow up³ were the culmination of a process of policy dialogue led by Portugal, with the support of the European Commission (EC), which had at its centre the relevance of addressing migrants’ health, health determinants and access to health services.

An ad-hoc Advisory Group on Health and Migration, hosted by the EC DG Health and Consumers (DG Sanco), was created to support the dialogue process led by the Presidency with Member States and other stakeholders, including the European Centre for Disease Prevention and Control (ECDC), the Council of Europe, the World Health Organization (WHO) and the International Organization for Migration (IOM), and to build a consensus on the approach towards migrant health. The identification of good practices at various levels (from prevention and health promotion to diagnosis, care and referral to social services) was a cornerstone of this group’s dialogue allowing for the direct contribution by Member States, as well as the discussion with governmental and non-governmental parties at country level.

In Portugal, in addition to the Ministry of Health, the process had the support and involvement of the High Commissioner for Health and the High Commissioner for Immigration and Intercultural Dialogue.

Portugal also hosted the first EU National AIDS Coordinators Meeting ‘Translating principles into action’ during the Presidency, with IOM providing a background report on migration and HIV in seven EU Member States.

The conclusions of the ‘Health and Migration in the EU’ Presidency Conference, presented by Portugal, were adopted at the Employment, Social Policy, Health and Consumer Affairs (EPSCO) Council in December 2007. Council Conclusions highlighted the importance of cross-sectoral action and invited European institutions and Member States to take action on the subject and integrate migrant health issues into health, employment, social and other national policies.⁴

At EU level, Council Conclusions called for the inclusion of aspects “aimed at improving knowledge of migrant health and developing health promotion, prevention and migrants’ access to care” in the implementation of the new Health Strategy ‘Together for Health: A Strategic Approach for the EU 2008–2013’. They also called for the Seventh Research Framework Programme and other EU programmes to support interventions regarding migrants’ health.

Additionally, given that the Council Conclusions recognised tuberculosis, HIV and other infectious diseases as a priority, ECDC was commissioned by the EC to prepare a series of technical reports on migration and infectious diseases by 2010 (one of these reports, tendered by IOM, focuses on comparability of HIV data on migrant populations).

The Portuguese Presidency remains a very successful example of how an interested government can effectively lead and build momentum on an issue. The Presidency achieved real policy progress, as evidenced in the 2007 Council Conclusions. Most importantly, it provided political impetus for the further development and consolidation of migrant health initiatives in Europe.

2007 to 2010: Fertile years for policy dialogue

More generally, 2007–2010 was a period of remarkable activity in the field of migration health, in Europe and internationally, with high-level benchmarking conferences on migrant health and related topics including health inequalities and fighting poverty. Different texts and actions identified migrants as a particularly

vulnerable or disadvantaged group that could benefit from heightened protection and better targeted interventions. All this activity amounted to a concerted call for increased and better coordinated efforts to improve migrant health and address health inequalities and the social determinants of health in an effective manner.

At the global level, the WHO European Office for Investment for Health and Development held a Technical Consultation on Poverty and Health in November and December 2007, which promoted the health of migrants as a disadvantaged group living in poverty.⁵ The Portuguese-led EU Council Conclusions were echoed at WHO, where efforts culminated in the discussion and approval of a Resolution on the Health of Migrants at the 61st World Health Assembly in May 2008.⁶ This urged WHO Member States to protect migrant health and promote its inclusion in health strategies.

In addition, the WHO European Region Ministerial Conference on Health Systems resulted in the Tallinn Charter in June 2008, to which WHO Member States as well as international organisations such as IOM were committed. Principles of relevance to migrant health included recognition of the right to health, the need to address health inequalities faced by vulnerable groups and the concept of ‘health in all policies’.⁷

On a related note, the WHO Commission on Social Determinants of Health, set up in 2005, issued in 2008 the *Closing the Gap in a Generation* report,⁸ which then contributed to the Resolution on Reducing Health Inequities through Action on the Social Determinants of Health at the 62nd World Health Assembly in May 2009.⁹ This urged WHO Member States to tackle health inequities disproportionately affecting vulnerable and mobile groups within and across countries. In the following two years migrant health remained prominent within the health inequalities agenda.

The WHO Resolution on the Health of Migrants mandated a review of progress within two years. On this occasion, WHO co-convened with IOM a Global Consultation on Migrant Health, held on 3–5 March 2010, gathering representatives of all five continents, as well as concerned UN agencies. It was charged with taking stock of achievements since the Resolution was adopted, as well as reaching consensus on priority areas and best strategies to

address health issues associated with migration. The Consultation developed an operational framework for leadership and action on migrant health with four axes, based on the action points of the Resolution: monitoring migrant health, policy and legal frameworks, migrant sensitive health systems and partnerships and multi-country frameworks.¹⁰

At the European level, in November 2007, the Eighth Conference of Ministers of Health of the Council of Europe adopted the Bratislava Declaration on Health, Human Rights and Migration (<http://tinyurl.com/33zmjst>). Further to this, the Council of Europe entrusted its European Health Committee to develop a work programme on the health challenges of “vulnerable groups including migrants, refugees, asylum seekers, Roma and Travellers”. In September 2008, the Committee on Mobility, Migration and Access to Health Care was established to draft non-binding but goal-setting recommendations on improving access to health care for people on the move in Europe. These are expected to be adopted following end of the Committee’s mandate in June 2010. In February 2010, the Council of Europe also passed a Resolution on Detention of Asylum Seekers and Irregular Migrants including consideration to health aspects.¹¹

At the EU level, EC DG Sanco had begun paying explicit attention to issues of health and migration, which resulted in a number of European-level actions being funded. An Expert Group on Social Determinants and Health Inequalities had also been formed to study and tackle health disparities, while a EC Communication on Reducing Health Inequalities followed in 2009.¹²

Additional key texts with relevance to migration and health were issued. The Framework Action Plan to Fight Tuberculosis in the EU called for the development of mechanisms to share data on asylum seekers and detained migrants and strategies for effective health promotion about tuberculosis. A joint EC, ECDC, WHO European Region meeting in 2009 on tuberculosis reinforced inter-institutional cooperation in this field. October 2009 saw the launch of the Strategy and Second Action Plan (2009–2013) on combating HIV/AIDS in the EU and its neighbourhood.

Finally, the EU Communication on Global Health highlighted the relevance of migration and migrant health, and underlined the right to health and the aspiration

to universal coverage in one of its Staff Working Documents.¹³

The AMAC Project and the EU-Level Consultation on Migration Health

Building on this good momentum for migrant health, the IOM-managed multi-partner ‘Assisting Migrants and Communities (AMAC): Analysis of Social Determinants of Health and Health Inequalities’ project provided a networking platform for the discussion and advancement of migrant health issues in Europe. The project, supported by the EC Health Programme and the Office of the Portuguese High Commissioner for Health, thus ensured continuation of the Portuguese Presidency focus on migration and health, fostering multi-lateral governmental dialogue and collaboration bridging through to the health priorities of the Spanish EU Presidency.

The project held three thematic workshops and ran an EU-Level Consultation on ‘Migration Health – Better Health for All’, (Lisbon, September 2009) with five main themes: social determinants of health; legal and policy frameworks; research; capacity building for health professionals; and maternal, child and adolescent health. Preparatory background papers were prepared for the consultation (see www.migrant-health-europe.org). Coinciding with the second anniversary of the Portuguese Presidency conference, the Consultation also provided an effective link to the health inequalities focus in the Spanish EU Presidency Health Programme, which was announced at the Consultation. The event facilitated the development of conclusions and recommendations for translation to effective migration health policy, programmes and research.¹⁴

2010 Spanish EU Presidency: Moving forward equity in health

As noted, migration and health fell under the overarching theme of health inequalities under the Spanish Presidency (January–June). This priority built on Spain’s good record of work in the area since the early 1990s, including the development of National Action Plans, yearly work plans since 1996 on health equity for migrant and Roma groups among others, and more recently the creation of a National Experts Group on Health Inequalities (2008).

The Ministry of Health and Social Policy hosted an Expert Conference ‘Moving

forward Equity and Health’ and an Informal EU Ministerial Council under the same title in April 2010 where it presented a Situation Analysis Report on health inequalities in the EU. The report highlights European and national initiatives on the reduction of health inequalities, reviews current systems for monitoring social determinants of health and points at opportunities for future actions. Chapter VI focusing on socially excluded groups, which IOM co-authored, concludes that little is known on the health resources and needs of the groups most vulnerable to health inequalities and proposes a list of indicators for monitoring social exclusion and structural health inequality with regard to migrant, ethnic minority and disadvantaged groups.

As a direct output of the above meetings, the Spanish put forward ‘Conclusions on ‘Equity and Health in All Policies: Solidarity in Health’ which were adopted at the EPSCO Council of June 2010.¹⁵ Council Conclusions express concern at the wide and persistent differences in health statuses between and within EU Member States across the entire social gradient, with particularly poor average levels of health being experienced by vulnerable and socially excluded groups including migrant and ethnic minorities such as Roma. Council Conclusions invite the EU Member States and institutions to enhance public health capacities and promote equity in health across the different policy sectors and to aim at universal access to health care, including health promotion and disease prevention services

Further in the Presidency, a session on migrant health and social determinants of health was held at an event on ‘Vulnerability and HIV in Europe’. A conference on the ‘Basic needs of foreign minors in Europe’ also addressed health and social inequalities. Also of interest, an EU Ministerial Conference discussed the foundations of EU integration policy as one of the fundamental pillars of EU immigration policy. Another highlight of the Spanish Presidency was the hosting and political support provided to the WHO/IOM Global Consultation on Migrant Health, held in Madrid. The Consultation outcomes were presented jointly by the Portuguese and Spanish governments at a lunch event, supported by WHO and IOM, at the 63rd World Health Assembly in May 2010.

By effectively using the prism of health inequalities, the Spanish Presidency gave

Box 1: Areas for action identified in the EU-level Consultation on Migration and Health

Fostering collective will and leadership for the health of all to be regarded as a common good

Improving both access to quality health care and health literacy

Developing policies that recognise and address inequalities faced by migrants and set up multi-sectoral coordination mechanisms to address the social determinants of health

Setting up structures to support research and comparable data collection to better underline the health specificities of migrant and other populations;

Developing migrant-friendly quality health systems

Increased focus on specific migrant groups: mothers, children, youth, undocumented migrants, older people and those with mental health needs;

Supporting initiatives to promote migrant health through EC funding and regularly evaluating the effectiveness of such actions

an important political drive to the migrant health agenda, further consolidating the achievements of the Portuguese Presidency and positively directing EU Member States' interest in future years. It has not only maintained awareness on the topic, while widening its scope, but has effectively promoted dialogue and commitment by Member States to fight health inequalities and monitor social determinants of health in Europe.

Despite the high level of policy attention since 2007, funding by EC and Member States for migrant health initiatives has declined. The Spanish Presidency's focus on health inequalities and the natural overlaps of the topic with broader agendas such as addressing social determinants of health, patient-oriented health care and improving quality of care for all – which require health systems to be responsive to the diversity of the populations they serve – will hopefully help redress this situation and encourage translation of the agreed goals and priorities into concrete programmes and actions. Moreover, 2010 is the European Year for Combating Poverty and Social Exclusion and further initiatives may direct attention to the situation of migrants in the coming months.

Recommendations and conclusions

Despite the migrant health agenda gaining significant momentum, difficulties remain in translating its vision into coherent and sustained policies and programmes. The work and policy dialogue undertaken by the Portuguese and Spanish Presidencies, in collaboration with international organisations such as WHO and IOM, indicate that there is a clear margin for improvement for EU Member States. Health policies and

programmes can better service diverse migrant origin communities and achieve better health for all populations living in Europe. The EU Level Consultation on Migration Health put forward a number of areas where progress in policy and practice should be achieved by EU Member States, also following the priorities highlighted by the Presidencies (Box 1).

The health gap between and among populations currently residing in the EU is widening; Member States need to bolster efforts to address this. Well-managed migrant health promotes the well-being of all, addressing both the needs of individual migrants and of host communities. Narrowing the health gap and making good health a reality for everyone is essential if we are to create a Europe of social justice as well as prosperity.

We face an extraordinary opportunity to create better chances for good health and better health care systems for all people in Europe. A critical mass of interested stakeholders and partnerships, evidence from research and projects, as well as a commitment from European policymakers at all levels, is necessary to make a difference. The actions of the Portuguese and Spanish Presidencies should be used and effectively combined in future years with those of Member State governments, stakeholders at different levels, as well as the EU institutions' to achieve real and sustainable progress.

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What can be done in EU Member States to better protect the health of migrants?

Paola Pace

Summary: The right of everyone to the highest attainable standard of physical and mental health (right to health) is a human right recognised in numerous instruments at the international, regional and national levels and supported by a range of accountability mechanisms. Those who migrate are human beings and therefore rights holders, as well as active agents of economic, cultural, social and political development. Notwithstanding the attention that the health both of those who migrate and affected communities, so called migration health, has gained in Europe in recent years, as well as the flourishing of good policies, legislation and practices grounded in the rule of law, migrants in Europe today face a variety of legal and practical obstacles to accessing their rights, including their right to health. This article provides an overview of the substance of the right to health and the current legal framework. Examples from all stages of the migration lifecycle, from pre-departure to eventual return and reintegration, are used to illustrate the particular challenges to the realisation of the right to health for migrants in Europe. Recommendations are also provided.

Keywords: Human rights, migrants, health, law, Europe

Migration to and within Europe is varied and complex. It may be multi-directional and is often temporary. Those who migrate constitute a diverse group of individuals. While those involved in migration are often thought to be non-nationals within the territory of a host State, this is not necessarily the case, as it does not take account of the phenomenon of return migration, internal migration and internal displacement. Moreover, a large percentage of European migration is, in fact, intra-European migration. In 2008 nearly 31 million non-nationals were living in the EU. This included 11.3 million individuals from other EU nations, 6.0 million other Europeans, as well as 4.7, 3.7 and 3.2 million from Africa, Asia and the Americas respectively. Non-EU nationals accounted for 6.2% of the total EU27 population.¹

Attempting to understand migrants through the spectrum of nationality alone

not only mischaracterises migrant patterns but also overlooks a fundamental element of migration, namely its dynamic character. Several migration-related economic and social factors, including aspects of migrant behaviour and many health-related influences associated with migration, can persist long after nationality or permanent residence is acquired.² Similarly, some biological and genetic determinants of health may extend over generations regardless of nationality.³

Notwithstanding the importance of monitoring the health implications and consequences of migration beyond nationality, in a world characterised by States and borders, nationality remains a central concept that may be used as a starting point to consider migration and the legal framework. While EU citizens working or residing in other EU Member States have to overcome numerous challenges in order to realise their right to health, in principle health care provision is clearly available to them under EU law. This paper does not address the situation of EU citizens but examines the challenges concerned with the realisation of the right to health of non-

EU or third country nationals. Third-country nationals include migrants in a regular or irregular situation with the intention of staying in the EU Member State on a short or long-term basis, students, victims of human trafficking, asylum-seekers, refugees, displaced persons and returnees. For ease of reference, all these diverse categories of individuals will be referred to as migrants.

The heart of the right to health

The right to health is the right to health care and to the underlying preconditions for health (also known as determinants of health). According to the Committee of Economic, Social and Cultural Rights, the latter include “access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information.”⁴

It also states that the right to health contains freedoms, such as the right to be free from non-consensual medical treatment and to be free from forced sterilisation and discrimination, as well as entitlements,

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such as the right to a system of health protection. Another important aspect is the participation of the population, including migrants, in all health-related decision-making at the community, national and international levels.

Current legal framework: instruments and accountability mechanisms

A variety of instruments enshrine the human rights of migrants, including their right to health. Treaties, (which may also be called Conventions, Covenants, Protocols or Agreements) are binding instruments of an international, regional, or sub-regional scope. States are bound to accept the legal obligations arising out of the treaties to which they agree to be parties. Under the European Treaties, the EU institutions may make regulations, issue directives and take decisions.⁵ Non-binding international and regional instruments include declarations, resolutions and recommendations as well as opinions. These documents provide guidelines and authoritative interpretations, and they create moral obligations.

The norms embodied in non-binding instruments may be incorporated into binding instruments or become customary international law (i.e. legally binding upon all States). Additionally, non-binding legal instruments can lead to the adoption of binding ones. Compliance with binding and non-binding instruments is monitored and enforced through a range of accountability mechanisms.⁶

International level

Health as a human right was first articulated at the international level in the Constitution of the World Health Organization (WHO) of 1946 and then in Article 25 of the Universal Declaration of Human Rights of 1948. It has since been included in several treaties legally binding on EU Member States, for example, the International Covenant on Economic, Social and Cultural Rights of 1966 (Article 12), and belonging to various branches of international law, in particular, but not exclusively to human rights law.⁷

Moreover, some European countries, like Portugal and Norway, were among the WHO Member States that requested WHO to assess the health aspects in migration environments and to explore options to improve the health of migrants.⁸ They were among those who successfully promoted the adoption in May 2008 of resolution WHA 61.17 on migrant health⁹ by the Sixty-first World Health Assembly.

In March 2010, a global consultation on migrant health was organised by the International Organization for Migration (IOM), WHO and the Spanish Ministry of Health and Social Policy. The consultation took stock of the actions taken since the adoption of WHA61.17 by Member States of the WHO and other stakeholders in the following areas: monitoring migrants' health, policy and legal frameworks affecting migrants' health; migrant-sensitive health systems and partnerships, networks and multi country frameworks. The consultation reached consensus on priority areas and strategies to improve the health of migrants and communities in today's increasingly diverse societies. It also initiated an operational framework to promote migrant health on the international health agenda and to work with IOM and WHO Member States and stakeholders in their efforts to address the health of migrants and health issues associated with migration.

A variety of accountability mechanisms exist at the international level. The decisions of two international courts, the International Criminal Court and the International Court of Justice, have the potential to impact health policy at the domestic level. In addition, the United Nations treaty monitoring bodies supervise the implementation of the core international human rights treaties, primarily by reviewing reports submitted by States Parties and issuing 'concluding observations' expressing concerns and recommendations. The treaty monitoring bodies' concluding observations on States' reports have also considered non-nationals' access to health services. They have argued for the application of relevant treaty provisions to irregular migrants in European countries. They also issue general comments and recommendations, which have emphasised that States Parties are under the legal obligation to respect the right of non-citizens to health by, *inter alia*, refraining from denying or limiting their access to preventive, curative and palliative health services.^{4,10} In addition, several treaty monitoring bodies have the authority to consider individual communications if such a mechanism is provided for in the governing treaty and is being applied.

Additionally, the UN Human Rights Council (which replaced the Commission on Human Rights in March 2006) has endorsed and extended the mandate of a number of special procedures. 'Special procedures' is a term describing an individual

or a working group mandated to monitor, examine and report on a particular human rights issue, a specific human right or the human rights situation in a particular country or territory. Particularly relevant to the right to health are the mandate of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, which was created in 2002, and the mandate of the Special Rapporteur on the human rights of migrants, which was established in 1999. Both Special Rapporteurs report to the UN General Assembly and to the Human Rights Council. The 2006 mission to Sweden and the subsequent report of the Special Rapporteur on the right to the highest attainable standard of physical and mental health, for example, have reinforced existing civil society action to ensure access to health care by irregular migrants.¹¹ Law 2008:344 has formally recognised the entitlement of children of rejected asylum seekers or children rejected asylum seekers to access health care on the same conditions as Swedish nationals.¹²

However limitations prevent them to access health care in practice. This said, it has to be recognised that the whole process has reinforced networks, attracted the attention of the media, and created a debate among politicians. To some extent this attention has contributed to a heightened awareness among the general public. In this context, several regional initiatives have been put in place to extend health care coverage for migrants in an irregular situation in Sweden.¹³

The Special Rapporteurs frequently receive information alleging human rights abuses falling within their mandates. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has taken up complaints on the denial of health services to migrant workers. In addition, the report of the Special Rapporteur on the human rights of migrants submitted to the Human Rights Council in June 2010 has a thematic session focusing on migrants' rights to health and to adequate housing.

Regional level

Many EU Law and Council of Europe instruments enrich the right to health. The European Social Charter of 1961 (and Revised Charter of 1996), Article 11, recognises the right to protection of health. The Council of Europe Convention on Human Rights and Biomedicine of 1997, Article 3, aims to ensure equitable access to

health care of appropriate quality in accordance with a person's medical needs and imposes an obligation on States to use their best endeavours to realise this objective. The European Convention on Social and Medical Assistance of 1953, Article 1 and the European Social Charter (and Revised Charter), Article 13, explicitly require that nationals of one contracting party lawfully present in the territory of another be afforded medical assistance on terms equal to those of nationals of the second party. The now legally binding Charter of Fundamental Rights of the European Union of 2000 recognises under Article 35 that "everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities".¹⁴

During the Eighth Conference of European Health Ministers in 2007, health ministers of the 47 Council of Europe Member States signed the Bratislava Declaration on health, human rights and migration. This declaration states that "someone's health should not be a ground for any exception to the principles and standards embodied in international migration law".

At the regional level, the European Committee of Social Rights, the European Court of Human Rights, the European Court of Justice and the Parliamentary Assembly of the Council of Europe act as accountability mechanisms. The European Committee of Social Rights monitors the application of the European Social Charter (and Revised Charter). A 2004 decision of this Committee under the Additional Protocol to the European Social Charter Providing for a System of Collective Complaints found that restrictions on the access of the children of irregular migrants to health care were contrary to the Charter despite the wording in the Appendix that limits the personal scope of the instrument to lawfully resident nationals of other contracting parties.¹⁵

The European Court of Human Rights is responsible for the implementation of the European Convention on Human Rights (ECHR). The cases brought before the Court can have a health dimension that applies to migrants. For instance, it appears from the Court's case law that, in certain circumstances, the denial or failure to provide health care for irregular migrants

could result in a violation of the right to be free from inhumane and degrading treatment (Article 3, ECHR), to the right to life (Article 2, ECHR), or respect for private and family life (Article 8, ECHR).^{16,17} A policy that keeps migrants in situations of destitution (and thus threatens their health) would also be contrary to Article 3 of the ECHR.¹⁸

Finally, "the [Parliamentary] Assembly considers that the right to health associated with access to health care is one of the basic universal human rights and should be equally applied to all people, including migrants, refugees and displaced persons."¹⁹ The Assembly "call[s] on the member states to take as their main criterion for judging the success of health system reforms the effective access to health care for all, without discrimination, as a basic human right and, as a consequence, the improvement of the general standard of health and welfare of the entire population".²⁰

National level

The right to health has been recognised in the national constitutions of Belgium, Hungary, Italy, the Netherlands, Portugal and Spain. In countries whose constitution or legislation do not specifically recognise the right to health, elementary health care issues may be derived from more general human rights provisions. For instance, Germany's human dignity provision may be read in conjunction with its 'social state' or solidarity principle.²¹ Some national legislation has clearly specified entitlements to health care for migrants, as in the case of Italy (Articles 34 and 35 of legislative Decree no. 286, 1998) and Spain (Article 1(2) of General Health Law 14, 1986). Less clear definitions of entitlements in other EU countries have resulted in a wide range of different services depending on the interpretation of individual health care providers.

Judicial, quasi-judicial and political accountability mechanisms exist at the national level. There are administrative mechanisms, such as the human rights impact assessment, which measures the impact of policies and programmes on human rights. Social mechanisms at the national level include the monitoring work of civil society. The media and the health workforce also have an important role to play. For example, the practice of Italian health professionals to provide greater access to health services for irregular migrants despite the existence of a law to

the contrary led to the transformation of this very legislation.⁷

Challenges facing migrants and recommended directions

Despite the principles agreed to by governments, migrants are frequently unable to exercise their right to health throughout the migration process. The negative impact of this is exacerbated by the fact that migration itself is a health determinant: the migration experience can pose particular challenges to physical, mental and social well-being.

Pre-departure

Providing migrants with pre-departure or post-arrival information regarding their rights, including their right to health, is essential. Pre-departure or upon-arrival medical screening could be a useful means of facilitating integration of the migrants into the host community. Medical screening could identify the health needs of migrants, introduce them to the health care system, address threats to public health, and minimise long-term costs. In order to be effective, however, the screening would need to include assessment of non-infectious conditions, chronic illness, mental health and mental trauma. However, the effectiveness of medical screening has been questioned. It cannot detect diseases during their incubation period. Moreover, it can provide a false sense of security, leading to decreased public health surveillance and a narrow focus on the health problems of the migrating persons. It also raises issues of ethics and discrimination and may result in stigmatisation of migrating persons in both communities of origin and destination.^{7,22} These considerations do not undermine the utility of medical screenings that, if done with the appropriate safeguards and particularly if supported by adequate pre- and post- arrival health services and community based interventions, can contribute to addressing the health needs of migrants and of host communities alike.²³

Entry

When States exercise their sovereign powers to deny admission to migrants, the principle of non-discrimination requires that they not treat migrants differently based solely on their health status unless there is an objective and reasonable basis for doing so. Nonetheless, migrants frequently face discrimination based upon their health status. Such discrimination may occur at the border, as when States cat-

egorically deny entry to persons living with HIV,²⁴ or during migrants' subsequent attempts to acquire permanent residence or nationality. For instance, several countries, including Australia, Canada and Switzerland, have denied permanent residence or nationalisation to migrants with disabilities despite the migrants' length of stay in the country or their ability to support themselves without placing a strain on national resources. A case-by-case analysis is paramount in order to prevent discrimination and ensure conformity with international human rights law.

Stay/Residence

Host countries have a duty to ensure effective protection of the rights of those in their territory or within their jurisdiction, such as the right to health. During their stay in the destination country migrants may continue to face barriers in accessing health facilities, goods or services. Both health providers and migrants are frequently unaware of legislative measures concerning access to health care for migrants, particularly irregular migrants. For instance, a survey by the HUMA network found that asylum-seekers and irregular migrants in Malta often paid for medications they should have received for free, because doctors, pharmacists and asylum-seekers and irregular migrants themselves were not aware of this entitlement.²⁵ In addition, health providers are often hampered by inappropriate implementation measures or insufficient funding for implementation of new legal provisions. Costly and time-consuming reimbursement procedures create further administrative barriers.²⁶

Migrants themselves are often unable to take steps to access health care. Illiteracy, language barriers and lack of time preclude migrants attempting to complete application processes from obtaining regular access to health care. Many migrants are unable to afford user charges and other costs of accessing publicly funded health care. Finally, the fear of being denounced to the police or immigration authorities keeps many irregular migrants from seeking health care or even causes them to flee hospitals before any necessary surgery. Although only a few countries require public employees to report irregular migrants, uninformed migrants in other countries are deterred by the false belief that they may be denounced to the authorities if they seek treatment.

Many migrants also lack access to the

underlying determinants of health. Migrants, particularly those in irregular situations, often have difficulty locating adequate housing. This is exacerbated by the general lack of social housing in Europe.²⁷ Migrants face additional challenges in their work environments, which often fall into the 3-D category: dirty, dangerous and difficult. Unsafe conditions and a lack of training, among other factors, can lead to increased risks of injury.^{28,29} Victims of trafficking and smuggling may be exposed to additional violence and trauma.^{30,31} Depending on their status, many migrants are separated from their families, some for extended periods of time. Prolonged separation from loved ones is associated with mental and psycho-social illness, as well as with risk-taking behaviour that results in an adverse health outcome.³²

Detention

Detention of migrants can negatively impact their physical and mental well-being. Detained migrants often lack access to health care or the underlying determinants of health. Even in countries that allow access to medical services, detrimental health effects often arise from poor living conditions inside the detention centres, including overcrowding, lack of hygiene and failure to separate those with infectious and contagious diseases.^{25,33}

As the United Nations Special Rapporteur on the human rights of migrants recommends, infractions of immigration laws and regulations should not be considered criminal offences under national legislation; and governments should consider the possibility of progressively abolishing all forms of administrative detention.^{34,35} Alternative measures to detention should also be explored.

Article 5(1)(f) ECHR is an exception to the liberty principle and does actually allow for the detention of foreigners in certain circumstances. In Resolution 1509 (2006) of the Parliamentary Assembly on human rights of irregular migrants, the Parliamentary Assembly considers that, in terms of civil and political rights, the ECHR provides a minimum safeguard and notes that the Convention requires that its contracting parties take measures for the effective prevention of human rights violations against vulnerable persons such as irregular migrants. It highlights the following minimum rights: "(...) detention of irregular migrants should be used only as a last resort and not for an excessive period of time. Where necessary, irregular

migrants should be held in special detention facilities and not with convicted prisoners. Children should only be detained as a measure of last resort and then for the shortest appropriate period of time. Detention or holding of other vulnerable people (pregnant women, mothers with young children, older people, those with disabilities) should be avoided wherever possible. Suitable accommodation should be available to lodge families together but otherwise men and women should be housed separately. Detainees should have the right to contact anyone of their choice (lawyers, family members, NGOs, UNHCR, etc.), have access to adequate medical care and access to an interpreter and free legal aid where appropriate". Additionally, the Parliamentary Assembly considers that, in terms of economic and social rights, the following minimum rights should, *inter alia*, apply: (...) "emergency healthcare should be available to irregular migrants and States should seek to provide more holistic health care, taking into account, in particular, the specific needs of vulnerable groups such as children, disabled persons, pregnant women and the elderly;" (...) "all children, but also other vulnerable groups such as the elderly, single mothers and more generally single girls and women, should be given particular protection and attention".

When migrants are detained, international standards should apply to help ensure that they are held in centres specifically designed for that purpose and in conditions which do not violate their human rights, including their right to health. Sufficient provision of health goods and services, adequate living conditions, including hygiene conditions, as well as adequate safety and security are essential for guaranteeing the right to health of all detainees.

Return and reintegration

Studies suggest that migrants returning to visit their countries of origin may be at increased risk of acquiring travel-related diseases. In particular, children born in the destination country may lack local or herd immunity.³⁶ The migrants' return could also imply the introduction of health conditions acquired during the migration process into the community of origin.

The feasibility of assisted voluntary return and reintegration of persons living with HIV or other health conditions may depend upon the availability of specific conditions in the country of origin. A recent IOM report on the situation faced

by a group of migrants living with HIV in the Netherlands listed the following conditions as constituting the minimum for sustainable return and reintegration: necessary medical treatment is available and accessible; the returnee can acquire an income sufficient to cover both regular expenses and all costs related to medical treatment; and the returnee can find a supportive social network enabling him/her to cope with possible stigma from society as a whole.³⁷

With respect to involuntary or forced return, a person's health status can limit the sovereign power to expel non-nationals. The European Court of Human Rights held that individuals with life-threatening medical conditions or terminal illness who cannot continue treatment in their countries of origin may not be returned, as this would hasten death in distressing circumstances, a form of inhumane treatment contrary to Article 3 ECHR. (*D. v. U.K.* May 1997, application no. 146/1996/767/964; *B.B. v. France*, September 1998, application no. 30930/96). However, more recent jurisprudence of the Court appears to suggest that this principle applies only exceptionally. Therefore, a case-by-case consideration of factors such as the availability and economic accessibility of treatment in the country of origin, as well as the presence of family members or other support networks, must be taken into account in order to determine the legality of expulsion.

Further measures

There are numerous myths regarding the protection of social rights for migrants (and particularly irregular migrants) that need to be dispelled. First, generous social rights for migrants are not a 'pull factor'. Empirical evidence indicates that most migrants do not compare the benefits provided by welfare systems when choosing their destination countries.²⁶ Second, far from being a drain on national systems, migrants are indirect tax payers whose impact can be considerable in those countries where public health systems receive a significant portion of their funding from this kind of revenue.²⁶ A smaller but nonetheless significant impact occurs in countries with social health insurance.

Thus, fair national legislative measures based on a firm foundation of international and regional legal norms, together with their effective implementation, will not have a negative effect in countries of destination, or act as a pull factor. It is feasible

for European health care systems to assume the responsibility for migrants within their territories. Migrants are human beings and thus right holders as well as active agents of development.

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Migration:

A social determinant of migrants' health

Anita A. Davies, Anna Basten and Chiara Frattini

Summary: Migrants are affected by social inequalities and are exposed to several experiences during the migration process which put their physical, mental and social well-being at risk. Migrants' health is also to a large extent determined by the availability, accessibility, acceptability and quality of services in the host community or country. This article discusses how the migration process and legal status are determinants of migrants' health. It raises the issue that good public health practice should promote access to health and social services for all migrants, irrespective of their legal status, for the common good of all of society.

Keywords: migration, social determinants, health, inequality

The migration process and health outcomes

What is migrant health?

Migration is a process of moving, either across an international border, or within a state. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and cause.¹ Migration health addresses the state of physical, mental and social well-being of migrants and mobile populations. The structural inequalities experienced by many migrants have a significant impact on overall health and well-being. Migration health thus goes beyond the traditional management of diseases among mobile

populations and is intrinsically linked with the broader social determinants of health and unequal distribution of such determinants.

Conditions during the migration process create or increase vulnerabilities to ill health. Different migrant groups face different health challenges and have different levels of access to health and social services. This compounds social and economic inequalities. Lower socioeconomic position and irregular migration status increase these challenges. Even migrants with legal documents and in a more comfortable socio-economic position may experience particular challenges and limits

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to accessing services due to language and cultural differences as well as institutional and structural obstacles.

The migration process and the health of migrants

The mode of travel and legal status of the migrant are two factors that determine a migrant's health status at various stages of the migration cycle.

Migrants are exposed to various experiences that influence their health during all stages of the migration process. The physical and socio-economic environment at the migrants' place of origin (the pre-migration phase) determine many of the pre-conditions with which people migrate. The migratory journey itself (the movement phase) can affect the health of migrants in a negative way, especially when migrants travel in a clandestine manner using inappropriate means of transportation.

Migrants who have legal travel documents have much better access to safe travel and access to health care during their migration journey. On the contrary, those who migrate without legal documents tend to undergo long and dangerous journeys. Travel conditions often include long days hidden in a truck or cramped in a small space on a boat or under moving trains.² Irregular migrants who fall ill during the transit journey or at the final destination often do not have access to health services. This will have detrimental effects on their physical and mental health, both in the short and the long term, if diseases remain undetected and/or untreated at any stage of their journey.

Social factors influencing migrants' health in destination countries

Migrants are often affected by poverty and social exclusion in destination countries. As such, they often do not have the autonomy, empowerment and freedom to lead their lives based on their social and cultural norms. Lacking control over various factors influencing health, migrants' opportunities to make healthy choices in life may already be limited.

The Commission on Social Determinants of Health illustrated the complexity of inequalities related to various factors including gender, age and ethnic identity.³ To the extent that migrants often find themselves in the lower social strata they are also especially affected by poor housing conditions. In addition, migrants are vulnerable to discrimination, stigmatisation

and xenophobia. These factors interact with social inequalities and can both result in, and be a result of, social exclusion which has also been recognised as a social determinant of health.

Migrants often work in environments that expose them to risk factors for both communicable and non-communicable diseases. Unskilled migrant workers tend to have a higher risk of work-related injuries and long-term occupational related illnesses. Separation from their families and from familiar social norms, as well as feelings of loneliness, poverty and exploitative working conditions including sexual abuse, all increase the risk of infection with sexually transmitted diseases. At the same time, these same factors may cause mental illnesses such as depression and anxiety disorders.

Many female migrants also face the risk of sexual abuse and exploitation. This has a negative impact on their mental health state. Female domestic workers and trafficked persons are particularly vulnerable to sexual exploitation and abuse due to their 'invisibility' and suffer from physical and mental health problems as a result. Moreover, migrants who have experienced sexual abuse are frequently confronted with major obstacles related to their right to reproductive health (sexually transmitted diseases, including infection with HIV, unwanted pregnancies, unsafe abortions).

Challenges to accessing health and social services

The availability, accessibility, acceptability and quality of services depends on multiple influences, including legal status as well as social, cultural, structural, linguistic, gender, financial and geographical factors. Different beliefs and knowledge about health and ill health deter migrants from using national health services. Mental ill-health may sometimes be misunderstood due to differences in culture and in the understanding of the aetiology of disease, as well as fear of stigma if mental health services are used.

Moreover, health literacy in the sense of awareness of entitlements to care and availability of services may pose a barrier to the use of services. This is true for all migrants regardless of their socioeconomic or legal status. The very nature of mobility makes it difficult to identify available health care service providers. Seasonal and temporary workers who have legal status may prefer to delay health care until they return to

their places of origin as they cannot afford to miss a day's work.

Mobility itself makes follow-up treatment and long-term care difficult. As a result of travelling and lacking access to care, migrants may be unable to complete a course of treatment, which in the case of tuberculosis may lead them to develop multidrug-resistant tuberculosis. Similar risks exist in respect of HIV and malaria.

In addition, many migrants face various communication problems when seeking care. This can be caused by cultural and language differences which prevent migrants from understanding the bureaucracies of health systems and from expressing their needs. This is further exacerbated by a second level of communication barrier, due to different perceptions and understandings of illness, disease and responses to them. As a result, some migrants prefer to seek help from informal health care providers in their social networks.

Cultural and ethnic reproductive and sexual health practices and norms of behaviour among certain migrant groups, such as female genital mutilation and the use of contraception, may challenge or conflict with those in the host community. Cultural norms may prevent women from accepting care from male practitioners, or vice versa. Recognition and management of reproductive and sexual health issues requires cultural competence in health care providers.

Migrants should be provided with information on the health services that are available for their use. Often migrants are neither included in the development of migrant services nor asked for feedback on these services. Thus, many services are not used because they are not culturally acceptable to migrants. Studies in Switzerland and Italy have shown that the migrants' lack of awareness of health care and preventive services has been a main reason why these services are underutilised by migrants. They identified a need for culturally and linguistically appropriate education on contraception, family planning and cancer screening.⁴

Acculturation and migrants' health

Depending on the cultures of countries of origin and destination, acculturation can have positive and negative effects on health. Rural to urban migration, as well as migration to different countries and cultural contexts, may lead to changes in life

style, notably adopting more Western dietary habits and activity patterns. This may lead to an increased risk of obesity, diabetes and cardiovascular disease. In addition to dietary changes and low levels of exercise, financial constraints, employment problems and the lack of a network of social support also significantly affect migrants' health.

Acculturation has both positive and negative effects on migrants' mental health. While acculturation to a different cultural setting can support healthy development and a healthy mental state, there is also the risk of an ethnic identity crisis, especially in young adolescents who lack a network of social support.

Realising Migrants' Health

Migrants and the human right to health: the institutional framework

An adequate approach to addressing migrants' health and well-being needs to be set in a human rights framework. Migrants, as all human beings, are entitled to basic human rights, including the right to health.

A framework for considering migrants' right to health from a human rights perspective exists; however, it needs to be turned into a reality for migrants. The right to health is recognised in the International Covenant on Economic, Social and Cultural Rights. According to the interpretation given by the Committee on Economic, Social and Cultural Rights, the right to health not only encompasses the right to health care, but also the right to the underlying determinants of health.⁵

The International Convention on the Protection of the Rights of All Migrant Workers and members of their Families explicitly identifies the right to health for migrants in regular and irregular status.⁶ The World Health Assembly Resolution 61.17, endorsed by the Sixty-First World Health Assembly in May 2008 urged Member States and WHO to promote the inclusion of migrants' health in health strategies. The European Social Charter and the European Convention for the Promotion of Human Rights and Fundamental Freedoms and its protocols equally recognise the right to health.

Migrants face specific difficulties in relation to the right to health. In some states there is no specific legislation on access to health care for undocumented migrants.⁷ In several countries, irregular migrants are granted 'essential care' or

'emergency health care' only. Due to the absence of a uniform interpretation of these concepts there is a lack of clarity on migrants' entitlements, which may spawn discriminatory practices. As a result, undocumented migrants may seek medical care only when they are severely ill.⁸

Medical pluralism and migrant friendly health systems

European health systems are for the most part based on Western medical knowledge and practices. Health policies implicitly assume that migrants will adopt the health practices and beliefs of the host society. However, access to and usage of health services can be obstructed by differences in health beliefs and knowledge. In order to become more migrant friendly, national health services need to invest in overcoming the language barrier and training health service providers to ensure accessibility and acceptability of all services to migrants. Health service providers need to be informed about the cultural background and particular barriers that different types of migrants in different situations may face.

Migrants as health professionals and service users have skills to contribute to a pluralist medical system. Migrants' participation in health service provision will improve the accessibility of these services for migrant communities. The understanding of different medical traditions will enhance the cultural appropriateness of health and social services.

Conclusion

The specific health challenges which migrants' experience, both throughout the migration process as well as in the country of destination, illustrate why migration itself should be considered a social determinant of health. The management of migrants' health goes beyond the traditional management of diseases among mobile populations and is intrinsically linked with the broader social-determinants of health and unequal distribution of health and social services. It is for this reason that multi-disciplinary and multi-sector stakeholders should work in partnership to avoid social exclusion and improve the health of all people including migrants.

The health of migrants is a public health issue that takes social equity and development into account. Evidence-based policies need to address disparities within and between different populations. Further research is needed on the influences of

social and economic factors, as well as migrants' epidemiological profiles, health seeking behaviours and performance of health systems in countries of origin, transit and destination. The benefits of including migrants in public health strategies have been seen in Thailand where the Ministry of Public Health, in partnership with the International Organization for Migration, has introduced the concept of migrant-friendly in health service delivery with an overarching theme of 'Healthy Migrants, Healthy Thailand'. This helps to improve the health literacy of migrants and thus their access to basic public health services.⁹

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Access to health care for undocumented migrants in the EU: A first landscape of *NowHereland*

Ursula Karl-Trummer, Sonja Novak-Zezula and Birgit Metzler

Summary: Undocumented migrants are gaining increasing attention in the EU as a vulnerable group exposed to high health risks. Access to health care is subject to national regulations that differ within the EU27. Accordingly, practice models on how to ensure the human right to health follow different logics. The article provides a first view of the landscape on policies/regulations within 20 EU Member States and highlights examples for related practices. Access to health care ranges from none to full access. This corresponds with policy contexts that range from ignorance to acknowledgement. One practice element decisive in all contexts is the level of structural compensation provided by non-governmental organisations (NGOs).

Keywords: Undocumented migrants, access to health care, practice in context, functional ignorance, structural compensation

Undocumented migrants (UDM) in the EU are gaining increasing attention as a vulnerable group exposed to high health hazards. The health of UDM is greatly at risk due to difficult living and working conditions which are often characterised by uncertainty, exploitation and dependency. At the same time, UDM face considerable barriers in accessing health services. Reviews ask for “greater transparency in countries’ approaches to responding to the health and health care utilisation inequalities experienced by this population, within the framework of human rights.”¹

Irregular foreign residents in the EU27 account for between 0.39% and 0.77% of the population, or some 1.9 to 3.8 million people. This equated to somewhere between 7% and 13% of the foreign population in 2008.² Routes to becoming inhabitants of what we coin here as *NowHereland*, a land that is nowhere and at the same time part of a European “here and now”, roughly can be outlined as endogenous – legal entry into a country but losing legal status (for example, from

overstaying or not leaving when asylum is rejected) and exogenous (for example, when crossing borders undetected).³ An irregular migrant has been defined as “someone, who owing to illegal entry or the expiry of his or her visa, lacks legal status in a transit or host country. The term applies to migrants who infringe a country’s admission rules and any other person not authorised to remain in the host country (also called clandestine/illegal/undocumented migrant or migrant in an irregular situation).”⁴ To date, only estimates are available;² there is no official data on the number or characteristics of the inhabitants of *NowHereland*.

Health care in *NowHereland*: a management of paradox

Access to health care is defined as a fundamental human right, irrespective of legal status or financial capital,⁵ a right that should protect particularly socioeconomically disadvantaged and vulnerable groups from extreme hardship.⁶ All EU Member States recognise this human right. At the same time, access to health care for UDM in Europe is a national competence. Regu-

lations are heterogeneous, in most cases access to health care is related to specific documented status. This creates a paradox with contradictory demands of inclusion within the health care system seen as a human right and exclusion from health care through national definitions of inclusion like citizenship, insurance contributions, or a specific status such as registered asylum seeker or refugee.

In practical terms, these contradictory demands create uncertainty for health care organisations and their personnel: if they provide care, they may act against legal and financial regulations; if they do not provide care, they violate human rights and exclude the most vulnerable. This paradox cannot be resolved at a practice level but has to be managed in such a way that neither human rights nor national regulations are violated.

This article therefore provides a first insight into the European *Nowhereland*, painting a landscape on health care regulations in twenty Member States as a frame of reference for emerging practice strategies on how to cope with the challenge of including the UDM within health care systems.

A first landscape of *NowHereland*

From a bird’s eye view, countries can be grouped into three different categories

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concerning regulations on health care for UDM (See Figure).

Countries with no access to health care for UDM

This includes countries without entitlements for UDM to access health care, but where UDM do have access to emergency care. This is done for two reasons: firstly, obligations to provide emergency care exist in general and are, in most cases, not linked to any kind of status. Secondly, access to emergency care only is seen more as a kind of 'death prevention', rather than as health care in the curative sense. Countries with no access to health care for UDM make up a large part of Central and Eastern Europe, Scandinavia and the Baltic states. These countries are: Austria, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, Germany, Greece, Hungary, Ireland, Latvia, Lithuania, Luxembourg, Malta, Poland, Romania, Slovakia, Slovenia and Sweden.

Countries with partial access to health care for UDM

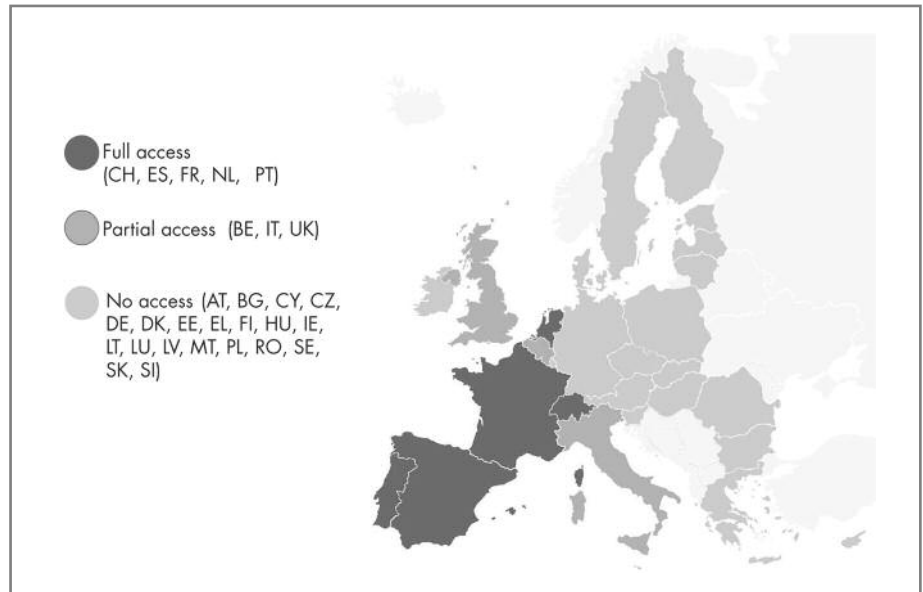
This includes countries where there are either explicit entitlements for specific services, and/or for specific sub-groups of UDM (for example, children, pregnant women) and/or for a specific diagnosis (for example, medically necessary treatment) in place. These countries are: Belgium, Italy and the UK.

In Italy, entitlements are in place for a range of services and for specific groups. In the UK, for a limited number of services access is free of charge, whereas for a range of hospital treatments and diagnoses, payment of the full cost is required (for example, for inpatient care, ante and postnatal care and medicines). In Belgium, for some specific groups of UDM (for example, unaccompanied minors) it is possible to obtain compulsory health insurance. UDM who do not fall under these groups, have the right to apply for 'urgent medical assistance' (AMU – *Aide Médicale Urgente*) free of charge. A broad range of medical services fall within this category, albeit with some minor exceptions, as in the case of some prosthetics and medications.⁷

Countries with full access to health care for UDM

Four countries that had the same range of services/entitlements to health care for UDM and nationals were included: France, the Netherlands, Portugal and Spain. In all four countries, full access is tied to a variety of pre-conditions including: proof

Figure: Undocumented migrant access to health care services across Europe



of identity, residence, destitution and minimum duration of stay.

In Spain, UDM have to register in the local civil registry with a valid passport, residence proof and declaration of extreme poverty. In situations where UDM cannot meet these requirements and for certain diseases (for example, HIV and diabetes) it is still possible to access essential treatments in some regions through a specific health care document (DAS – *Documento de asistencia sanitaria*) that does not require a valid passport.

In Portugal, full access requires UDM to provide documentation indicating that they have been living in Portugal for more than 90 days. With this proof of residence it is possible to obtain a temporary registration at a health centre. For UDM who have been residing in Portugal for less than 90 days or who fail to prove residence or lack of financial means, free access is possible for a limited range of services (emergency care, treatment of contagious diseases, ante and postnatal care, vaccinations and family planning). For other services however, they have to pay the full costs of care.

Since January 2009 a special government fund has been in place in the Netherlands to pay for medical care for UDM. Under this new scheme UDM are entitled to 'directly accessible' services (primary care practitioners, midwives, dentists, physiotherapists and hospital emergency departments) and 'not directly accessible' services (in hospital departments, nursing homes and outpatient clinics). For 'directly accessible' services UDM may make use of

any provider available. For 'not directly accessible' services only a limited number of specially contracted providers are able to claim back the costs of providing treatment. Between 80% and 100% of service costs (100% in respect of pregnancy and childbirth) can be reimbursed to the service provider. For the reimbursement of these health care costs service providers have to prove that the UDM patient is unable to pay, and thus must send an invoice and a reminder to every UDM.⁸

France requires eligibility to the AME (*Aide Médicale État*), a parallel administrative system that allows UDM access, free of charge, to the same health care services as nationals. To obtain the AME, UDM have to provide proof of residence in France for at least three months, proof of identity and evidence on their lack of financial means. UDM who do not succeed in obtaining the AME are only entitled to emergency care, screening for sexually transmitted diseases and HIV/AIDS, vaccinations, family planning, as well as screening and treatment of tuberculosis.

An important point is that although entitlements may be in place, this does not necessarily mean that access is ensured in practice. Even under conditions of full entitlement, for various reasons UDM may find it difficult to obtain health care. Conversely, countries with limited entitlements may nevertheless develop practices to provide health care services to UDM. Mapping the landscape on these different level of entitlements provides a picture of legislative contexts, but not actual practice in accessing health care services.

Practice in context

Policies and regulations are the frame of reference where practices emerge. Without knowing this frame, practice cannot be understood and evaluated in terms of its sustainability and transferability across countries. Looking at the level of practice, it appears that in different contexts different strategies have developed to manage the paradox of health care for UDM. Examples are given here from country contexts where there is no access and partial access.⁹ Further examples will be available by the end of 2010 (see <http://www.nowhereland.info/>).

Context: no access.

Practice: functional ignorance

Austria serves to illustrate emerging practice in a system where there is no entitlement to services. Austria has a compulsory social health insurance system regulated by law, financed through income-related contributions based on occupation, supplemented in some cases by additional private health insurance. If someone without insurance undergoes medical treatment, in principle this works on a fee-for-service basis. Regardless of financial considerations, the Austrian Federal Hospitals Act obligates every hospital to provide immediate care in the case of emergencies.

Austrian legislation does not include any specific regulations for health care provision for UDM. Thus, on a regulatory level, undocumented migrants do not exist. Consequently, there are no organisations which explicitly offer health care for undocumented migrants.

Nevertheless, there are ways in which they can obtain health care, and we have already noted that hospitals can be accessed for serious life threatening emergencies. NGOs also play a critical role in providing access to a range of services. For these NGOs, the criterion for provision of health and social care relates to poverty and socioeconomic vulnerability. UDM are not mentioned as a specific target group, but instead are integrated into a definition of socially disadvantaged and particularly vulnerable people.

Since 2004, AMBER-MED (see <http://amber.diakonie.at>), a joint project of the refugee service of Diakonie, Austria and the Austrian Red Cross, provides outpatient treatment, social counselling and medication for people without insurance coverage in Vienna. Services are offered free of charge and anonymously and can

include general medicine, gynaecological examinations, paediatric care and diabetes care among others. In 2008, 754 patients, the majority of whom were asylum seekers, refugees and homeless people, made use of AMBER-MEDs services. The work of this organisation is mainly made possible due to the volunteering of doctors, nurses and interpreters, as well as through the support of a large network of medical specialists and institutes. AMBER-MED is financed through donations/subsidies from the Federal Ministry of Health and the Fund for Social Affairs in Vienna (*Fonds Soziales Wien*), and the Vienna Health Insurance (*Wiener Gebietskrankenkasse*).

To access this service, there is no need to provide information on legal status. Monitoring on the number of UDM among patients therefore does not systematically take place. This ignorance concerning legal residence creates a paradox-free space for action that allows providers to act in accordance with the principles of human rights and professional ethics. The benefit of this strategy is that regulations, as well as practices concerning health care for UDM, need not be discussed and/or revisited. The disadvantage is that it is challenging to engage in evidence based development of policies and practices because of the lack of data.

Context: partial access.

Practice: partial acceptance

Italy can be used to illustrate emerging practice in a country with partial entitlements to health care for UDM. It is a tax-based health care system with universal coverage, with considerable regional differences following a north-south divide. Since 1998, all migrants without permission to stay have had a right to urgent or primary hospital and outpatient treatment in the case of sickness or accidents, as well as for preventive treatments. Due to the Italian legislation on "health care for foreign nationals who are not registered with the National Health care System (NHS)" (Decree 286, Article 35, 25 July 1998) access is specifically guaranteed to emergency/urgent care, prenatal and maternity care, vaccinations, preventive medicine programmes and the prevention/diagnosis/treatment of infectious diseases. Additionally, there are three categories of undocumented patients with entitlements to health care: minors up to eighteen years, pregnant women up to six months after birth and patients with diagnosed infectious diseases.

To gain access to public health and health

care services, UDM need to obtain the so-called regional 'STP-Code' (*Straniero Temporaneamente Presente* – foreign national temporarily present). This anonymous code, available from a hospital administration department or the regional authority any time and free of charge, is valid for six months and can be renewed. It serves to identify the patient to all the health care services that he or she is entitled to and is recognised throughout Italy (Decree 394, Article 43, 31 August 1999). Together with the *Dichiarazione di Indigenza* which states that UDM have no economic means to pay for treatments, this in effect means that they can receive medical treatment free of charge.

One regional practice example is Reggio Emilia, where two services work in close cooperation to provide health care services for UDM.

1. Dedicated service: centro per la salute della famiglia straniera

Located within the Local Health Authority in Reggio Emilia, the Centre for the Health of Foreign Families provides outpatient care and medical treatment for UDM and foreign nationals without registration in the NHS (see <http://tinyurl.com/39mfh5t>). Services include gynaecological examinations and counselling, prenatal care and paediatric care. Services for specific target groups are offered on a project basis, for example, psychosocial support and health care for prostitutes. Health care provision is supported by cultural mediators.

The centre keeps precise statistics on patients, made possible through the STP-Code. It shares its database with the Caritas surgery *Querce di Mamre* (see below) which enables both services to make appointments for patients in the appropriate centre. In 2007, the centre had 3,189 patients; 53.7% were first time service users. For emergencies, the centre can refer UDM to the emergency unit of a local hospital, after calling the responsible doctor there in advance. Continuity of care is an important factor in these services, especially during pregnancy. Staff members therefore try to fix all appointments and steps through pregnancy in advance to assure the continuity of care.

2. NGO: Caritas surgery 'Querce di Mamre'

Querce di Mamre is an outpatient clinic run by Caritas in cooperation with the Local Health Authority of Reggio Emilia

(see <http://tinyurl.com/35uxm5c>). The target group of the centre are UDM without access to the NHS and itinerant people. In 2008, the surgery had 1,411 visits. It has provision for general medicine, gynaecology, dental and emergency care. It is well equipped with various instruments like ultrasound devices and electrocardiographs. It has a well stocked pharmacy, supported by a network of several medical surgeries that offer assistance directly at their private facilities. A large number of volunteers (sixty volunteering doctors – GPs and specialists – and fifteen volunteering nurses) cover nearly all medical fields, including internal medicine, general surgery, obstetrics and gynaecology, paediatrics, otorhinolaryngology, ophthalmology, psychiatry and dental care. Communication and information are facilitated by mediators and written information materials.

The Italian case demonstrates, in contrast to Austria, a strategy of partial acceptance of UDM. Regulations are in place, and a system established that allows for the organisation and provision of health care services. Through the STP-Code, the course and history of diseases can be recorded and routes of UDM within the country can be reconstructed (given the case that UDM access services in different parts of Italy). The assignment of this specific status also facilitates the organisation of service provision, as the STP-Code serves as an administrative and organisational instrument that ensures continuity of care. The context of partial access allows a systematic approach with benefits both for UDM – who can regularly access a wider range of services – and for public health – through the systematic monitoring of patient needs, routes of patients and prevention of infectious diseases.

Conclusions and outlook

Practices in access to health care for UDM show considerable variations that can be related to the context of regulations on the national level. Two approaches that can be identified are:

Functional ignorance where the legal status of somebody who needs health care is not asked for and/or monitored;

Partial acceptance where temporary access to services is systematically provided and monitored following completion of administrative and organisational steps to obtain temporary status in connection with a declaration of extreme poverty.

A common element in both contexts is the decisive role of civil society organisations. NGOs are important service providers that compensate for the lack service provision structures within the public health system. Health professionals work as volunteers in the organisational framework of these NGOs. Both under conditions of functional ignorance and partial acceptance, support from such NGOs, as well as informal solidarity between health professionals, is needed to follow humanitarian values without violating state-control-demands.

To date, our map of *NowHereland* seems to highlight a vulnerable space, where UDM have limited chances to get the health care they need and where health care providers and policy makers have to cope with the paradoxical demand to act for the inclusion and exclusion of UDM at the same time. However this map also highlights emerging safe places of sanctuary, where UDM can get treatment in accordance with their human rights

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Better health for all in Europe:

Developing a migrant sensitive health workforce

María-Teresa Gijón-Sánchez, Sandra Pinzón-Pulido,
Riitta-Liisa Kolehmainen-Aitken, Jacqueline Weekers,
Daniel López Acuña, Roumyana Benedict and María-José Peiro

Summary: Migration movements in Europe have increased in both size and diversity and have created the need to enhance the effectiveness of health systems by adapting them to today's multicultural and multiethnic societies. Such a transformation cannot take place without a public health workforce that supports and delivers accessible, culturally appropriate, equitable and competent care. Governments and health care and training providers in the European Union have a critical role to play in reorienting the competencies of a public health workforce to improve the health of all people in a diverse Europe.

Key words: migration, health care, public health, health workforce training, cultural competence

Migration movements in Europe have increased in size and diversity in recent times. Migrants are essential for the European Union (EU), both because of its ageing population and to respond to labour market needs. Close to 47 million international migrants¹ are estimated to reside in the EU in 2010, with migrants representing 8.5% of the EU population in 2005 with a further 5.6 million estimated new arrivals between 2005 and 2010.¹ Most migrants coming to Europe are young and the proportion of women has grown considerably. 30% of all migrants in the EU originate from other EU countries.²

These migratory movements cause social, cultural and demographic changes that demand political and administrative solutions from EU Member States. Such solutions are crucially important for all migrant and host communities and benefit public health, social cohesion and economic development. Moreover, they are central to the provision of appropriate and

effective health and social care for migrant populations. Such solutions cannot take place without a public health workforce that supports and delivers accessible, culturally appropriate, equitable and competent care for all.

Public health and migration

The health and welfare of a country's population is, to a large extent, the result of the actions of the government, social agents, the health system, and the training and professional competence of its public health workforce.³ The size and diversity of contemporary migration flows have positioned migration as an important public health issue. Addressing the needs of individual migrants, as well as the public health needs of host countries, requires policies and practices that correspond to the emerging challenges facing mobile populations and diverse societies today.⁴ The approach needs to be comprehensive and cover the full spectrum of the health sector, encom-

passing public health policies, legislation, regulation and development of service provision, as well as the education and training of the public health workforce.⁵

As people move, temporarily, seasonally or permanently, they act as links to individual and environmental health factors between societies. Migrants travel with their health profiles, risks and beliefs. These reflect both their socioeconomic and cultural background and the disease prevalence in their community of origin. Often such profiles and beliefs are different from those in their host countries. The disparities may influence the health of migrants and also impact on the health status of the host communities.⁶

Migrants' health status is determined by many factors which can differ greatly among different migrant groups. Cultural and linguistic factors can impede the effectiveness of appropriate health care delivery. Health conditions and the environment in the home community decide many baseline parameters for the health of migrants. Biological determinants include the predisposition of certain population groups to specific diseases. Certain infectious diseases can have a higher prevalence and incidence in countries of migrant origin. Other conditions may be more prevalent in host communities with some migrants acquiring the health profile of the

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host community over time.⁷ The migration process itself can affect health, with people migrating in clandestine ways or forced by conflict or disaster, being at the greatest disadvantage. Socioeconomic conditions and lifestyle in countries of origin and destination are further determinants.

Access to health services, which includes services that promote health, prevent illness and provide diagnostic and therapeutic care, is fundamental to maintaining and improving the health of migrants. The level of access to appropriate services and how migrants' particular health needs are taken into account are greatly dependent on health policies, health service organisation and the extent to which migration associated factors are incorporated in training of the public health workforce. Access barriers can be legal, administrative, organisational or socioeconomic. Those at greatest disadvantage continue to be migrants in an irregular situation and trafficked persons. Furthermore, migrants' own health beliefs, health seeking behaviour, awareness about available services, and cultural and linguistic factors may challenge access.

Towards a migrant-sensitive health workforce

The increased population-diversity and the consequent diversity in patients' health perspectives, beliefs, culture and linguistic background are changing the day-to-day work of health professionals. Epidemiological challenges associated with migration place new demands on health professionals. Increasingly, health workers find themselves treating patients with unfamiliar symptoms. Delayed or deferred care and lack of appropriate preventive services are associated with the progression of disease and illness and the subsequent need for more extensive and costly treatment. This can be particularly important in situations that involve mother-and-child health and the management and control of some communicable diseases.

The prevalent health care model has failed in many countries to guarantee fair, equitable and culturally appropriate health care for everyone. The provision of effective, efficient and quality care to the entire population, including migrants, requires a redirection of the current health care model so that it best responds to the experiences, expectations and health needs of a diverse society. Transforming the old health care model will not succeed, however, without developing a migrant-

sensitive public health workforce.

A migrant-sensitive workforce requires new competencies. It needs to:

- Have appropriate intercultural competence, language and communication skills;
- Know how to manage change, cultural diversity and values;
- Be sufficiently knowledgeable of other cultures and customs to be able to develop professional practice with respect to the autonomy, beliefs and culture of the patient;
- Understand migrant health determinants and be able to contribute to reduce social and health care inequalities;
- Recognise the disease profile of migrants and its epidemiology;
- Manage competently the clinical manifestation of disease in different ethnic and population groups;
- Know the rights of migrants to health services;
- Be able to advise migrants on how to access and what to expect of health services.

Health training traditionally centres on diagnosis and treatment of prevalent disease, rather than maintenance of health or management of newly emerging conditions. More importance is given to the scientific basis of medical practice than to recognition of population health determinants or socioeconomic and cultural dimensions. Training does not sufficiently address understanding the social and cultural context of patients, their possible migration background and different health environment in their home community.

A web-based survey was undertaken by the authors of this article, covering key aspects of training a migrant-sensitive public health workforce in six selected countries: Malta, Poland, Portugal, Spain, Sweden and the UK. The key respondents worked for government institutions, universities and continuing education centres. The findings indicate that existing training programmes in migrant health are too scarce, scattered and poorly evaluated, and those developing them lack avenues of information exchange.

Key documents guiding health professional training in Europe

Three major documents are particularly important for guiding health professional

training in the European context:

The Bologna Declaration (1999) set up a framework for graduate and post-graduate training in Europe through the European Higher Education Area (EHEA). The EHEA aims to establish the competencies required for performance of professional duties.⁸ As regards training for health professions, it gives insufficient attention to skills required for inclusion of socio-economic, ethical and cultural dimensions in health care and for improving the health of the population.

The European Parliament and Council Directive 2005/36/EC established an automatic recognition of qualifications in medicine, general care nursing, dentistry, veterinary surgery, midwifery and pharmacy.⁹ For each of these professions, basic training must assure "the acquisition of knowledge and competencies regarding the relationships between the state of health of human beings and their physical and social environment". No reference is made to recognising differences in the population or specific competencies necessary to adapt health care to this diversity.

The European Commission's Green Paper on the European Workforce for Health (2008) does not list health care to migrants/diverse populations among the challenges faced by health staff today.¹⁰ However, the President of the European Commission's 2009 "political guidelines for the next Commission" suggest that mapping the skills and competences needed for European health systems will be important.¹¹

Recommendations for action

Migration flows in Europe have increased in size and complexity. They respond to demographic changes and labour demands in Europe, political upheavals and economic disparities within as well as between European countries and their neighbours. The consequent increased diversity in health determinants, vulnerability levels and needs among society members is challenging the capacity of health care delivery systems. This increased diversity calls for a more migrant-sensitive workforce.

Migrant-sensitive training approaches are good public health practice because they increase access of all populations to health care and improve the quality and effectiveness of services. These improvements, in turn, reduce health inequalities in the society and promote health for all. The following actions, strategies and policy

changes are recommended for adoption and implementation by the European Union, governments and institutions and organisations responsible for training health professionals.

European Union institutions

- Promote and harmonise the inclusion of migrant health topics and intercultural competence in the training of all public health professionals in graduate, postgraduate and continuous medical curricula;
- Support the creation of avenues for exchanging training experiences, approaches and content between relevant actors and institutions of the different Member States; support exchange visits of professionals and their participation in training activities in other Member States and countries of migrant origin;
- Promote, fund and increase research into the effectiveness of training programmes at the European level, including evaluation of learning, as well as impact of training on migrant health. Include common objectives and indicators in the curricula of health professionals to make such evaluation possible.

EU Member States

- Promote health professional training, including continuing education strategies, that strengthen the recognition of diversity and multiculturalism and include migration-related competences and skills for all health professionals. Use incentives, such as accreditation, to encourage participation of professionals and health care providers;
- Examine the main professional training strategies, organisation of graduate, postgraduate and continuing education programmes and the manner in which the new competencies could best be incorporated into training in order to make appropriate changes in the training of public health professionals;
- Ensure that content of undergraduate, postgraduate and continuing education of health professionals supports the fight against social exclusion, discrimination and barriers to migrants' access to health care;
- Take advantage of country-level actions towards a common compulsory curricular design following the Bologna Declaration to ensure that the required competencies for a migrant-sensitive

public health workforce are incorporated in the developing common curricula.

Universities, education centres, professional associations and health providers

- Include curricular content on intercultural competency, communication skills, health determinants of migrants, and public health issues associated with migration and population mobility in health professional training programmes at undergraduate, postgraduate and continuous education levels;
- Design training programmes to be interdisciplinary, use participative methodologies and facilitate theoretical-practical learning;
- Establish online training libraries, including available tools and multimedia courses for self-training;
- Involve migrants, in particular migrant health workers, in the design, implementation and evaluation of training programmes;
- Involve professional associations and other relevant actors in the design, implementation and evaluation of training programmes; promote the exchange of experiences and good practices between members of the associations and between the associations themselves, with the aim to create national and international networks;
- Expand intersectoral coordination in designing and developing training programmes for health professionals, in particular between health, education and social service sectors;
- Encourage and carry out research and evaluation of effectiveness and impact of training programmes on migrant health.

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Health and well-being among child immigrants in Europe

Michal Molcho, Francesca Cristini, Saoirse Nic Gabhainn, Massimo Santinello, Carmen Moreno, Margarida Gaspar de Matos, Thoroddur Bjarnason, Daniela Baldassari and Pernille Due

Summary: This study examines health, well being and involvement in risk behaviours of immigrant children across twelve European countries, using data collected in the 2006 Health Behaviour in School-Aged Children study. Findings suggest that immigrant children are significantly more likely to live in less affluent families, but no other cross-national patterns are evident. The lack of clear patterns suggests that no one-size-fits-all programmes are suitable for working with immigrant children. There is a need for more specific research to increase our understanding of the needs and experiences of migrant children in Europe.

Keywords: Migrant Children, Health Behaviour, Europe

Introduction

The process of immigration has proved stressful for voluntary migrants,¹ and for migrant children the stress may be even greater as immigration is imposed on them. Here, we examine the experiences of child immigrants across a number of European countries.

Previous studies on the health of child-immigrants were carried out primarily in the USA, with fewer studies carried out in Europe.^{2,3} Findings from these studies were equivocal. Some studies found that immigrant children fare worse compared to their native peers in relation to mental health, risk behaviour, academic achievements, health and well being,^{4,5} some reported that immigrant children fare better,⁶ while others found no differences,^{7,8} or that differences disappear when

controlling for socioeconomic circumstances.⁹ However, what is missing is a comparison of the experience of immigrant children across nations which makes use of comparable data with a large number of participants and countries.

This paper uses data that were collected in the 2006 Health Behaviour in School-Aged Children (HBSC) survey, a WHO collaborative cross-national study that is conducted at four-year intervals in a growing number of countries. In 2006, the survey was carried out in 41 countries, from Europe and North America, all following the same research protocol.¹⁰ The HBSC survey provides a unique opportunity to examine health, life satisfaction and involvement in risk behaviours of immigrant children across the participating countries. For these purposes, immigrants

are defined as children who were born outside of the country of residence.

As part of the cross-national HBSC study, national research teams surveyed students from schools and school-classes to produce nationally representative samples of eleven-, thirteen-, and fifteen-year-old children. All participating countries obtained approval to undertake the survey from the appropriate regulatory bodies. In 2006, twelve of the participating countries collected information on participants' country of birth. These include: Flemish-speaking Belgium, Germany, Denmark, Spain, Greece, Ireland, Iceland, Italy, Scotland, Sweden, Wales and Portugal. To explore whether there are general patterns across countries, we have compared immigrant children to their native peers on questions relating to self-reported health, life satisfaction and involvement in risk taking behaviours. We have also looked at family affluence, as differences between immigrant and native children could be attributed to differences in socioeconomic circumstances rather than the immigrant status per se.

Health and life satisfaction

Self-rated health was measured as: "Would you say your health is...?" Response categories were dichotomised to 'excellent' vs. 'good', 'fair' and 'poor'. Children were also

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asked about their perceived life satisfaction: "Here is a picture of a ladder, the top of the ladder '10' is the best possible life for you and the bottom, '0' is the worst possible life. In general, where on the ladder do you feel you stand at the moment?" Answers were dichotomised to 9–10 as high level of life satisfaction vs. 0–8.

Risk behaviours

Five areas of risk behaviour are also considered here. Participation in fights was measured using the question: "During the past twelve months, how many times were you in a physical fight?" This question was dichotomised into 'never' vs. '1 time or more'. Bullying was measured using two questions: "How often have you been bullied at school in the last couple of months?" and "How often have you taken part in bullying another student(s) at school in the last couple of months?" Both questions were dichotomised to 'more than twice' vs. 'twice or less'. Smoking was measured using the question: "How often do you smoke tobacco at present?" This question was dichotomised to 'weekly or more' vs. 'less than weekly'. Students were also asked about their history of drunkenness; "Have you ever had so much alcohol that you were really drunk?" with responses dichotomised to 'twice or more' vs. 'never or once'.

Family affluence

Young people's socioeconomic status was measured using the Family Affluence Scale (FAS).¹¹ This scale is based on four material conditions of the households in which young people live, including: family vehicle ownership, having their own bedroom, number of family holidays and number of family computers. The scale was used to create three variables: low, middle and high family affluence.

Findings

The proportion of immigrant children in the sample varies from 4% in Wales to 11% in Ireland (see Table 1). In all countries, except for Ireland and Scotland, the level of family affluence reported by immigrant children is lower than that of their native peers (Table 2), and immigrant children are found to be over-represented in less affluent households and under-represented in more affluent households. This finding stands out as the strongest, most consistent difference between child immigrants and their native peers and is similar to findings previously reported.^{7,12} This suggests that further analyses must control

Table 1: Distribution of foreign-born children by country, gender and age group; percentage (number of children)

Country	All	Boys	Girls	11 y	13 y	15 y
Belgium (Flemish)	4.8 (206)	5.1 (111)	4.5 (95)	3.2 (41)	5.6 (78)	5.4 (87)
Denmark	5.5 (313)	5.6 (153)	5.4 (160)	4.1 (85)	5.4 (110)	7.2 (112)
Germany	6.5 (468)	6.5 (237)	6.4 (231)	5.1 (114)	6.6 (160)	7.3 (187)
Greece	7.2 (265)	6.0 (106)	8.1 (159)	4.3 (47)	7.9 (93)	8.8 (124)
Iceland*	6.5 (122)	6.1 (58)	6.9 (64)			6.5 (121)
Ireland	11.0 (536)	10.5 (260)	11.5 (276)	10.1 (138)	10.5 (187)	12.2 (206)
Italy	4.8 (190)	5.0 (100)	4.6 (90)	3.6 (45)	4.7 (63)	5.8 (77)
Portugal	5.8 (235)	4.8 (103)	5.8 (132)	5.3 (68)	5.5 (82)	5.2 (85)
Scotland	8.3 (515)	8.3 (253)	8.4 (262)	6.6 (111)	8.6 (194)	9.4 (205)
Spain	8.6 (737)	8.2 (358)	8.4 (379)	9.8 (292)	7.9 (223)	7.3 (222)
Sweden	4.7 (207)	5.1 (111)	4.3 (96)	3.9 (58)	4.2 (57)	5.8 (88)
Wales	4.0 (177)	3.9 (84)	4.2 (93)	4.7 (70)	3.9 (59)	3.3 (45)

* data available for 15 year olds only

for these differences in family affluence when comparing immigrant children with their native peers on aspects of health, life satisfaction and risk behaviour.

Once we take the differences in gender, age and family affluence into account, immigrant children do not significantly differ from their peers in their health and life satisfaction in most countries, with the notable exception of Ireland and Wales. In Wales immigrant children are 1.5 times more likely to report excellent health ($p < 0.05$) and in Ireland they were also significantly more likely to report high life satisfaction compared to their native peers. These findings suggest that despite generally reporting lower levels of family affluence, in most countries immigrant children did not report poorer health or lower life satisfaction. This finding could be viewed as counterintuitive, if we consider that many studies have shown the negative influence of socioeconomic hard-

ships on adolescent development.¹³ This phenomenon has previously been labeled as "the immigrant paradox".¹⁴

Another important aspect of immigrant children's life that is often addressed is involvement in risk behaviours. Here too no clear and consistent cross-national patterns emerged. In some countries immigrant children were more likely to report alcohol use and in others they were less likely to report drunkenness or smoking behaviour (see Table 3). Bullying victimisation and bullying perpetration were more prevalent among immigrant children in Ireland, Scotland, Spain and Italy, but bullying was less prevalent among immigrant children in Greece, with no differences in the other countries. Similarly, physical fighting was more prevalent among immigrant children in Germany, Greece, Italy, Spain and Sweden, but not in the remaining seven countries (Table 3). These different patterns in different coun-

Table 2: Distribution of Family Affluence Scale (FAS) by foreign-born status: percentage

Country	Foreign-born			Natives			Significance level
	High FAS	Mid FAS	Low FAS	High FAS	Mid FAS	Low FAS	
Belgium (Flemish)	44.5	37.7	17.8	47.2	42.7	10.0	P<0.01
Denmark	42.9	39.2	17.9	51.4	41.4	7.3	P<0.001
Germany	22.1	47.0	30.9	48.5	39.5	12.0	P<0.001
Greece	11.4	41.4	47.1	28.6	47.7	23.6	P<0.001
Iceland	62.9	28.4	8.6	70.7	27.5	1.8	P<0.001
Ireland	21.5	54.9	21.5	20.0	56.4	23.6	N.S.
Italy	27.0	37.4	35.3	32.2	46.1	20.4	P<0.001
Portugal	22.6	40.1	32.9	32.0	43.4	24.4	P<0.005
Scotland	48.0	38.2	13.8	42.8	40.8	16.3	N.S.
Spain	22.3	42.7	35.0	40.9	46.1	13.1	P<0.001
Sweden	33.5	43.8	22.7	57.0	37.3	5.7	P<0.001
Wales	31.6	41.8	26.6	45.6	41.4	13.0	P<0.001

Table 3: Models of logistic regression: odds ratios of involvement in risk behaviours predicted by foreign-born status, by country

Country	Was in a fight	Been bullied	Bullied others	Weekly smoking	Been drunk
Belgium (Flemish)	1.24	0.89	1.54	1.10	0.93
Denmark	1.20	0.87	1.36	0.88	0.37***
Germany	1.93***	0.79	0.93	0.90	1.27
Greece	1.56**	0.89	0.69*	0.87	1.60*
Iceland	0.78	0.70	0.44	0.64	0.88
Ireland	1.00	1.39*	1.24	1.13	0.85
Italy	1.59**	1.12	1.89**	0.83	1.07
Portugal	1.13	1.33	1.38	1.08	1.10
Scotland	1.02	1.44*	1.05	1.24	0.92
Spain	1.27**	1.98***	1.67***	0.65*	1.08
Sweden	1.50*	1.23	2.53***	1.31	1.05
Wales	0.79	1.30	1.03	0.60	0.54**

*p<0.05; ** p<0.01; ***p<0.001

All analyses are controlled for gender, age and family affluence

tries mean that, despite the similarities in the samples and the way that things have been measured, there is no one story that can be told about the health of immigrant children across Europe.

Limitations

The HBSC study provides a unique opportunity to gain further cross-national understanding of child immigrants, using similar methods and a standardised questionnaire across a range of countries in different regions of Europe. Nevertheless, there are some limitations to these data. First and foremost, the overall study is aimed at the general population and not at immigrants, resulting in relatively low absolute numbers of immigrant children in the study, but also in lack of specific information about the immigrant population. The relatively low number of immigrant children in the sample does not allow stratification by country of origin. Similarly we cannot undertake a more thorough analysis of cultural differences and potential conflicts or interactions between different groups of immigrants and between the country of origin and country of destination, thus preventing us from making recommendations regarding specific minorities. Unfortunately, we also cannot differ between immigrants and returning citizens whose children were born while away from their native country. There is a clear need for specific studies to be conducted to facilitate these more nuanced views to be explored.

Conclusions

Given the absence of general patterns, this study highlights the complexity of the immigration phenomenon. Of all the variables examined, the only consistent finding is the low affluence of immigrant children across countries. This is in itself an important finding, given the widespread influence of socioeconomic factors on the lives of children and families. These findings suggest that there is a need for more focused studies on immigrants, looking at different groups and at country of origin and of residence, but also the need to engage in participatory studies allowing the voice of immigrants to be heard. It is clear that we need to promote tolerance towards diversities in societies and to create mechanisms that allow for better integration of immigrant children in society.

The article also provides insights into issues that could have implications for research, policy and practice. Primarily the

need to use the social determinants of health approach to immigrant child well-being. Two examples are noted:

- Noting that immigrant children are found to be over-represented in less affluent households, it is important that (a) migration policy provide migrant families with equitable access to social protection services, and that (b) social protection policies foster and encourage equitable access to public services and opportunities. Such support and social protection needs to begin in childhood and be provided across the life course.
- Given the complexities of the migration phenomena, international comparison of data on migrant health is challenging and can lead to disparate results. While it is important nevertheless to continue these efforts at international level, it is first and foremost essential to scale up investment in information systems at national and sub-national level that look at health inequities, including by migrant status. Such information can then be taken into consideration in the design of policies and programmes, in the health sector and beyond, with particular usefulness for primary health care level in areas serving migrant communities and other populations that may face higher levels of social exclusion.

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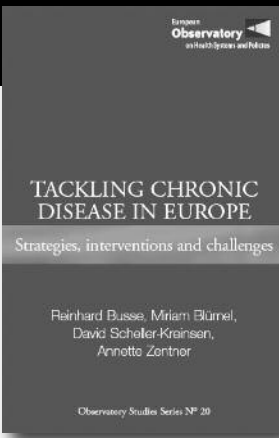
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New citizens, new challenges for the Spanish National Health System

Cristina Hernández Quevedo and Dolores Jiménez Rubio

Summary: The increasing proportion of immigrants in Spanish society places pressure on the National Health System to satisfy their needs while keeping costs under control. This study reviews the literature on inequalities in health and in the utilisation of health services for the immigrant population in Spain, with the aim of informing current health policy measures. The evidence shows the existence of barriers of access to health services for immigrants and suggest that the Spanish health care system has a crucial role to play in designing more effective health care policies to meet their needs.

Key words: inequalities, health, Spain, immigration

Since 1997, Spain has received a higher volume of immigrants annually than any other country in the European Union.¹ In 2007, the foreign born population accounted for 13.6% of the total population in Spain, considerably higher than countries with a long immigration tradition such as the United Kingdom (10.2%), Norway (9.5%) or the Netherlands (10.7%).²

An important proportion of foreigners that usually live in Spain, mainly on the Mediterranean coast, as well as the Balearic and Canary Islands, come from developed countries, such as United Kingdom and Germany. They migrate because of non-economic factors such as the weather, given that the majority of these immigrants are retired. However, a large proportion of migrants to Spain, mainly from Latin-American and non EU-15 European countries are motivated by economic concerns.³

Although most of the Spanish population has a positive perception of immigration, since 2001 there has been a progressive reduction in tolerance towards the arrival of new migrants. For example, several surveys from the Spanish Centre for Sociological Research reflect a slight increase in

recent years in the percentage of Spaniards that believe that immigrants are taking job opportunities away from Spaniards or are receiving too much social support relative to other population groups. In this context, the results of a study conducted by the Economic Office of the President of the Government in 2006 demonstrated the positive effect of immigration in terms of GDP, income per capita and the public surplus. Moreover, in respect of the labour market, an empirical analysis did not find any significant impacts of migrant workers on the rate of unemployment or on salaries received by the Spanish population.⁴ One of the reasons for this is that the local population and new immigrants do not compete for the same jobs, furthermore immigrants tend to occupy jobs that are no longer desired by the Spanish population.⁵

There have been a series of changes in the legal immigration system. In the health care sector, several measures have been implemented since 2000 focused on the foreign population. One of the most important is Law 4/2000 on the rights and liberties of foreigners in Spain and their social integration. According to this law, all individuals, regardless of their nationality, country of birth or legal status, have the

right to use health services provided under the National Health Care System (NHS), in the same way as Spanish citizens. The only requirement for immigrants, whether legally accredited or not, is to be registered on the local population census. Individuals that are not registered on the municipal census can only benefit from emergency care, in addition to which children and pregnant women have their health care needs fully covered, regardless of their legal or administrative situation.

The government also approved the 'Strategic Plan for Citizenship and Integration 2007–2010' that targets the population as a whole, aiming to promote social cohesion through policies based on the equality of opportunities and the equality of rights and duties. In addition, there are also Regional Immigration Plans in the majority of the seventeen autonomous communities (AC) that make up the country. These include, as a priority, the reduction of inequalities in health and equity in access to health care services. However, these policies have been formulated without any sound scientific evidence that actually confirms the existence of such inequalities.

Despite the spectacular growth of immigration in Spain during the last decade, it is possible that the arrival of foreigners to Spain will decrease in future years, given the current economic recession that the country is facing. According to the Spanish Ministry of Home Affairs, the economic

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crisis reduced illegal immigration in the first three months of 2009 by 52.8%.⁶ Given this new reality, the impact of immigration on the economy and Spanish society in future is far from certain.

Disparities in health and access to health services

While there is an abundant literature in Spain that has explored the existence of inequalities in health and in the access to health care services for the Spanish population, the available evidence on the existence of disparities in the level of health, or in the consumption of health care resources, for the immigrant population is limited, mainly due to the lack of data for this population group. Moreover, the majority of empirical studies that are available are taken from just one AC, Catalonia.

One study using data from the 2006 Catalan Health Survey reported that immigrants were less likely to report poor physical health, but more likely to report poor mental health than the resident population.⁷ With respect to the use of health services, the results of this study suggest that immigrants have a lower probability of visiting a specialist doctor and a higher probability of visiting hospital emergency services than Spaniards. Another study analysing the use of services by immigrants at the Hospital del Mar in Barcelona also reported that they tended to use hospital emergency services as a substitute for other health care services.⁸

The 2003 Spanish National Health Survey (SNHS) has also been used to explore the patterns of health, lifestyle and use of the health care services by the foreign population.⁹ Compared to the Spanish population, immigrants had more healthy lifestyles than the national population, including less consumption of alcohol and tobacco. In relation to the use of health care services, immigrants reported higher hospitalisation rates, although there was no evidence of any excessive or inappropriate use of other health services.

More recently, analysis was conducted using a larger dataset taken from the 2003 and 2006 editions of the SNHS.¹⁰ This work shows the existence of different patterns in health and in the use of health care services between nationals and foreigners. In particular, while the level of self-perceived health varied on the basis of the nationality of the individual, all immigrants, regardless of their nationality, seemed to face important barriers in access

to specialised care. The findings of this study support the results of the earlier studies from Catalonia that suggest that emergency hospital services might be used as a substitute for specialised care for this population group.

Regarding inequalities in health, using the SNHS surveys for 2003 and 2006, there is also evidence of pro-rich socioeconomic inequalities in health, both for the national and migrant populations in Spain. However, while socioeconomic inequalities in health limitations and diagnosed mental problems increased for immigrants over this time period, only inequalities in health limitations increased for the national population. However over time, the magnitude of socioeconomic inequalities in health for the immigrant population in Spain tended to converge with that of Spaniards.¹¹ This result is consistent with the international evidence available, which shows that although immigrants are perceived to have better health when they arrive in a country (the so-called healthy immigrant effect), their level of health tends to decrease over time. This could be due to different factors, including the acculturation process, together with the possible existence of barriers in access to health services or in working conditions faced by immigrants. Such factors should be taken into account in the design of health policies that focus on the reduction of socioeconomic inequalities in health for the immigrant population in Spain.

Conclusions

One of the main priorities of any health care system is to guarantee that individuals in equal need, regardless of their country of origin or their nationality, and under equal conditions, have access to medical care. The empirical literature in Spain, as in many other countries with a long tradition as immigrant recipient countries such as the UK or Canada, indicates there are considerable variations in the levels of health and access to health care resources between the foreign and resident populations. In particular, the literature provides evidence of substantial differences in terms of health among the different migrant groups living in Spain. However, one of the most robust results of the Spanish empirical literature on immigration and health is that immigrants tend to overuse emergency services while under using specialist services.^{7,8,10}

The disparities in access to health care services could be explained by a greater rate of non attendance by immigrants at

appointments with specialists, differences in medical practice when referring patients to specialist services on the basis of nationality or country of birth, to the lack of confidence of patients in health care in general, to a lower knowledge of how the health care system works, to problems of communication between doctors and their patients, or even to cultural differences in perceptions of health by the migrant population. Barriers in access to specialist services could increase inequalities in health in the long run and also result in a greater consumption of more costly emergency care services and thus reduce the efficiency of the health care system.¹²

The literature on immigration and health in Spain is however subject to a number of limitations. On the one hand, a large part of the existing empirical evidence relies on data from Catalonia or specific hospitals. On the other hand, nationwide studies that use data from the SNHS also have their own problems. Firstly, the sample of immigrants included in surveys such as those of the SNHS could be under-represented, as they appear to exclude migrants with the lowest levels of income.¹⁰ Secondly, the SNHS does not identify variables that reflect the integration of immigrants, such as their time of residence or fluency in Spanish. Despite these limitations, the literature on immigration and health in Spain generally shows that the health care system has an important role to play in the design of more effective health services for immigrants.

Although several measures are being implemented in Spain to improve access to health care services, such as the provision of patient advocates in the Hospital Ramón y Cajal in Madrid and several hospitals in Valencia, as well as the translation of health related information into different languages in Andalusia, these are specific local initiatives that are not as yet available across all of Spain. Some of the policies that could promote the integration of foreigners into the Spanish health care system include: the institutionalisation of patient advocates for migrants in Spanish health centres, the promotion of training programmes in the delivery of culturally sensitive health care for health professionals, the reduction of the administrative barriers required to be eligible for health care, the improvement of information for minority groups on accessing health services, as well as the design of specific health surveys for immigrants that will allow for higher quality research.

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Mapping EC-funded initiatives on health and migration in Europe

Mariya Samuilova, María-José Peiro and Roumyana Benedict

Summary: Based on the recommendations of the EU Advisory Group on Migration and Health, a matrix of European migration health projects was developed as part of the Assisting Migrants and Communities (AMAC) project. The objective was to explore synergies amongst European Commission funded projects and especially those funded under the EC Public Health Programme 2006–2008. Nineteen projects were included in the analysis, covering topics such as different types of lead partner organisation, participating countries, deliverables, objectives, beneficiaries, areas of study/action and stakeholders. The findings suggest the usefulness of such an exercise. They show that effective instruments are needed to keep track, analyse and maximise the results of past and current projects and initiatives at the international, EU and national level in the field of migration and health in Europe.

Key words: migration health, EC-funding, projects, mapping, synergies

At the third meeting of the European Union (EU) Advisory Group on Migration and Health, held in Luxembourg in February 2008, recent policy developments and achievements in migration health at EU and international levels, as well as current projects on health and migration co-funded under the public health programme, were reviewed and discussed. The Advisory Group, created in early 2007 to support the work of the Portuguese EU Presidency, included representatives from Member States, the World Health Organization (WHO), International Organization for Migration (IOM), the Council of Europe, the European Centre for Disease Prevention and Control (ECDC)

and other relevant European-level stakeholders in the field.

The meeting also explored ways to identify overlaps and knowledge gaps among the different European-level projects on migration health funded by the EC Public Health Programme between 2006 and 2008, as well as to ensure wider and effective dissemination of the results to a broader European audience. Discussions led the EU Executive Agency for Health and Consumers (EAHC), charged with managing the projects, to propose the development of matrix of all relevant projects within the framework of the

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Assisting Migrants and Communities (AMAC): Analysis of Social Determinants of Health and Health Inequalities project.¹ This project was co-funded by DG SANCO, the Office of the Portuguese High Commissioner for Health and the IOM, to identify gaps, thematic and activity overlaps and possible synergies, as well as to ensure collaboration.

The results from the mapping exercise were presented at the European Public Health Association (EUPHA) Pre-Conference on Migrant Health (in Lisbon, November 2008) and at the IOM and Portugal-supported EU-Level Consultation on Migration Health “Better Health for All” (in Lisbon, September 2009). In both instances, there was a consensus among the multi-disciplinary and multi-stakeholder audience that effective instruments would be needed to keep track, analyse and maximise the impacts of past and current projects, as well as collate data on general international, EU and national programmes and interventions in the field of migration and health in Europe.

Mapping exercise

The matrix is an instrument mapping European Commission funded projects on the health of migrant and ethnic minorities by means of a statistical analysis of a number of items obtained via self-administered questionnaires: lead and other partners, type of organisation; participating countries; countries of coverage; key deliverables (outputs); main objectives; beneficiaries; target areas of study/action based on a published typology;² and stakeholders (target audience, broad partnership). The matrix analysis compares the migration health and ethnic minorities’ initiatives to, firstly map what has been/is being done in this area and secondly to identify possible areas where common action and collaboration are desirable or suitable.

The matrix is based on the collection of stated or declared information on the researched projects by project managers performed in two rounds, in summer 2008 and summer 2009 respectively. The exercise included a select number of initiatives that meet the following four criteria:

1. focus both on migration and health;
2. EU co-funded (DG SANCO, DG Research or other EU programmes);
3. collaborative initiatives involving various European countries and organisations;

4. recent or ongoing initiatives.

Overall, nineteen projects agreed to share information on the above listed items, which was then aggregated and categorised. These include projects on a range of salient migrant health problems (such as HIV), particular migrant groups (such as Roma, undocumented migrants, asylum-seekers) and other relevant issues (such as legislation and national health systems, good practices on migration and health and developing indicators).

The matrix includes eleven DG SANCO projects (including calls for proposals in 2006 and 2007), six DG Research projects financed through the Sixth Research Framework Programme (FP6) and COST action projects, and two additional projects funded by other EU bodies (See Box 1).

Key findings

The analysis of matrix indicates that the primary types of organisations leading projects are: public bodies such as universities or other academic institutions, private or public research institutes and international bodies and organisations. Three countries dominate co-funded EC research: Austria (4 projects), Germany (4 projects) and the Netherlands (3 projects);

The majority of leading project partners report that they are not the direct beneficiaries of the project outcomes. The key beneficiaries may be migrants’ or ethnic minorities’ associations. The majority of associate/collaborative partners are universities, research centres affiliated to universities and/or independent research institutes. There was relatively low participation as partners by international bodies or organisations, local and regional authorities, hospitals, clinics, medical centres and other health care institutions.

The most active participating countries are the Netherlands, the UK, Germany, Spain, Italy, Austria, Poland and Portugal. In contrast Bulgaria, Romania, Slovakia, Slovenia, Lithuania, Estonia, Malta, Cyprus, Ireland, Latvia and Luxembourg are less commonly represented in projects.

The deliverables usually reported are research and data collection, development of databases, public websites and conferences. Only a few projects report that they provide training courses, educational materials and/or direct support to migrant communities. The most reported project objectives are: knowledge of the political and legal framework, on accessibility of care and on the health status and needs of

target population. Other objectives include the compilation of good/best practice/recommendations, the creation of networks and the exchange of information. Projects have focused much less on the preparation of statistical datasets, training/education work packages, support/care to migrant communities and work related to immigrants’ health and civic engagement;

The principal target health areas reported in projects cover the collection of background information and specific areas such as accessibility of care, entitlement to health care and health status. There is reportedly less work on the quality of health care and other pertinent issues related to achieving change in the field of migration and health. It should though be noted that EC-funded projects develop in response to calls for proposals within different funding mechanisms and thus in the general case the framework is pre-determined.

A broad concept of ‘migrant’ is used in most projects when describing project beneficiaries. However victims of trafficking, mobile sex workers, migrant women and second generation or young migrants were listed less often as beneficiaries within the reviewed projects. Indeed there is often no clear-cut identification of project stakeholders, with the most frequently listed being: partner organisations, European institutions, national governments, international bodies and organisations, researchers and public health experts. The media, social workers and social welfare service providers, as well as health care organisations, are referenced less often.

Policy recommendations

As a result of this analysis a number of policy recommendations for European institutions, EU Member States and project developers can be set out.

- To seek the inclusion of project partners from different spheres of activities and to promote collaboration between academic institutions/research centres, non-governmental organisations, local and regional authorities, hospitals, clinics and medical centres.
- To involve organisations that represent direct beneficiaries, such as migrant communities and hospitals, in project implementation in order to stimulate their early engagement and acceptance of new practices.
- To promote clear identification of targeted stakeholders and dissemination

Box 1: Full list of projects included in the matrix**DG Sanco Public Health Programme**

1. Monitoring the Health Status of Migrants within Europe: Development of Indicators. (led by Erasmus University).
2. Information Network on Good Practice in Health Care for Migrants and Minorities in Europe – Mighealthnet (led by the University of Utrecht).
3. Health Care in NowHereland – Improving Services for Undocumented Migrants in the EU” (led by the University of Vienna).
4. Health and the Roma Community, Analysis of the Situation in Europe – Roma Health (led by Fundacion Secretariado Gitano, Spain).
5. European Network for HIV/STI Prevention and Health Promotion among Migrant Sex Workers – TAMPEP 8 (led by TAMPEP International Foundation, Netherlands).
6. European Best Practices for Improving Access, Quality and Appropriateness of Migrant Health Care – EUGATE (managed by Queen Mary, University of London).
7. Improving access to health care for asylum seekers and undocumented migrants in the EU – HUMA network (by Medecins du Monde).
8. AIDS & Mobility 2007–2010 (led by the Ethno-Medical Centre, Germany).
9. Assisting migrants and communities: Analysis of Social Determinants of Health and Health Inequalities (AMAC) (by IOM Brussels).
10. Increasing Public Health Safety Alongside the New Eastern European Border Line (PHBLM) (by IOM Brussels).
11. Development of Recommendations for Integrating Socio-Cultural Standards in Health Promoting Offers and Services (led by the Austrian Red Cross).

DG Research FP6 Programme and Cost Action

1. International Migration, Integration and Social Cohesion (IMISCOE) project.
2. Integration of Female Immigrants into the Labour Market and Society Policy Assessment and Policy Recommendations (led by the Institute of Social Research Frankfurt/Main).
3. Promoting Comparative Quantitative Research in the Field of Migration and Integration in Europe (Prominstat) (led by the International Centre for Migration Policy Development (International Centre for Migration Policy and Development – ICMPD).
4. Civil Society and New Forms of Governance in Europe – the Making of European Citizenship Network of Excellence (managed by Roskilde University).
5. “Health and Social Care for Migrants and Ethnic Minorities in Europe” (HOME) (led by the University of Utrecht).
6. “Needs for Female Immigrants and their Integration in Aging Societies” (led by the Federal Institute for Population Research, Germany).

Other EC-funded projects

1. “Active Ageing of Migrant Elders across Europe” (promoted by the Ministry of Intergenerational Affairs, Family, Women and Integration of the State of North Rhine-Westphalia, Germany).
2. “HealthQuest – Quality in and Equality of Access to Healthcare Services” (led by the European Health Management association).

activities closely related to short/long-term project outcomes, as well as to stimulate the involvement of social services and health care organisations as essential stakeholders in migrant health related projects.

- To promote capacity building and the development and implementation of training programmes for all professions linked to health care delivery, as well as the dissemination of education materials; the importance of sensitising and training policy-makers and health stakeholders should also be reflected in project implementation.
 - To promote cultural, religious, linguistic and gender sensitivity associated with migrants’ health among health service providers.
 - To develop comparable statistical datasets and standardised migrant health data collection instruments for EU Member States.
- Conclusions and follow-up**
- Despite being a small-scale initiative, the matrix offers a new platform for public debate on the future development of migrant health-related initiatives. To date, nineteen EC-funded projects has been analysed. The exercise has certainly allowed for more meaningful and representative results within the analysis and in external evaluation of the projects’ completed deliverables. It will be used with an increasing number of initiatives in future years. The ultimate goal is to improve the health of migrants, ethnic minorities and their host communities by facilitating the systematic sharing of information and results from initiatives in the field, improving EC-level funding in addressing migration health issues, avoiding duplication of efforts and resources and by enhancing coordination between actors and funders in the field. Additionally, a review of the matrix by all interested parties would assist in recognising knowledge and intervention gaps to help orientate planning by EU and national authorities.
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- To enhance the inclusion of countries with diverse migrant population profiles, in particular those less represented in the field, for example, new EU Member States, such as Malta, Cyprus, Latvia, Lithuania and Estonia.

Towards equity in health: Migrant health policies in Spain

Begoña Merino, Karoline Fernández de la Hoz and Pilar Campos

In September 2009 the Spanish Ministry of Health and Social Policy (Ministerio de Sanidad y Política Social – MSPS) was invited to participate at the EU-Level Consultation on Migration Health, ‘Better Health for All’ held in Lisbon. This was firstly because of the MOH’s collaboration with the International Organization for Migration since the inception of its Assisting Migrants and Communities (AMAC) project and secondly because it would present priorities on health as part of the Spanish EU presidency during the first half of 2010.

The MSPS was also invited to participate at a policy dialogue which took place during the conference. At this policy dialogue, three main questions were discussed: what are the key immigration-related health challenges; how to ensure access to health care for all those who need it; and what role could be played by the EU in contributing to the health of migrants? The Spanish intervention at the dialogue reflected national experience and policy which are drawn upon in this snapshot.

Experience in Spain

Over the last 20 years, Spain has gone from being a country of emigrants to a land of immigration. Over the last five years the proportion of foreigners living in Spain has become one of the highest in the European Union. This phenomenon has occurred in other developed countries but in Spain it has happened in a very short time.

Spanish legislation on migrant rights and entitlements is based on the Constitution and has been developed through national, regional and local laws and ordinances.

The laws also impact on primary welfare systems such as health care and education. All registered foreign nationals have had the same universal access to the health care system as national citizens since 2000. Article 12 of Act 4/2000 on the ‘Rights and liberties of foreigners in Spain and their social integration’ ensures that non-registered aliens have access to services for children and pregnant women, grave illness and accidents and emergencies.

The first plan for the social integration of immigrants was launched in 1994. In 2001, a programme for the regulation and coordination of aliens (known as GRECO) was approved. The MSPS are currently working on the Strategic Plan 2007–2010 for Citizenship and Integration.¹ This includes specific objectives and programmes/activities in cross-cutting areas aimed at improving the social inclusion of migrant groups, thus addressing socioeconomic factors that influence their health and wellbeing.

This national plan is based on the principles of: equality and non-discrimination, citizenship, multiculturalism, universality, normalisation, comprehensiveness, coordination and proximity.

In relation to health the three main objectives are:

- To guarantee immigrants’ right to health protection
- To improve identification of immigrant’s socially related health needs
- To improve the training of health personnel in managing the health of the migrant population

In 2001 a Permanent Observatory on

Immigration was also created under the auspices of the former Ministry of Labour and Social Security (now Ministry of Labour and Immigration). It is responsible for collecting data, undertaking analysis and disseminating information in relation to the movements of migrants in Spain (see <http://extranjeros.mtin.es/es/ObservatorioPermanenteInmigracion/>).

Meantime the MSPS has begun several different measures to help promote equity in health for vulnerable groups, such as migrants, and to reinforce the social determinants of health approach. In fact, one of the main priorities of the MSPS during the Spanish Presidency of the EU during the first half of 2010 was entitled ‘Innovation in public health: monitoring social determinants of health and reduction of inequalities in health’.

A situation analysis on this topic, ‘Moving forward equity in health: monitoring social determinants of health and the reduction of health inequalities’ has been developed.² One of the example areas explored in-depth, through dedicated sub-sections, focused on monitoring social exclusion and structural health inequality. It set out a proposal for indicators to monitor the protection of migrants, the sick, poor, and ethnic minorities, as well as looking at gender, age and indigenous disadvantaged minorities in the European Union.

Furthermore, one of the recommendations that our Ministry wished to highlight during the Presidency was the relevance of guaranteeing migrant children and pregnant women the right to health and full access to health care regardless of their legal situation. This implies facilitating universal access to health in all domains: promotion, prevention and health care.

In this sense, the Council of the European Union’s conclusions ‘Equity and Health in all Policies’, adopted on 8 June 2010,³ reflect the work of the Spanish Presidency in the following way:

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“The Council of the European Union urges all Member states to: consider policies to ensure that citizens, and all children, young people and pregnant woman in particular, can make full use of their rights of universal access to health care, including health promotion and disease prevention services.”

This is the main output of our Presidency priority, along with the situation analysis to be published in July 2010.

Meeting policy challenges

In respect of the question posed on immigrant health challenges at the policy dialogue, Spain noted the importance of guaranteeing universal access to health services; combating existing barriers to implementation that are found in practice despite such guarantees, the importance of including the health of migrants in national policies, plans and strategies, as well as looking at the issue from the perspective of reducing inequalities in health.

When looking at how to ensure health coverage to all those who need it, it is important to develop strategies to ensure better health for all (included in the National Strategic Plan 2007–2010 for citizenship and integration) and empower migrants to participate in all these process.

The EU can play an important contribution by continuing to advocate on the issue with Member States, as well as pushing an agenda for work on the reduction of health inequities and the promotion of monitoring at the EU level of social determinants of health. The EU can also play an important role in supporting the development of evidence and diffusion of information, as well as helping to facilitate the exchange of good practices.

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Approaches to migrant health in Portugal

Maria do Céu Machado, Filipa Pereira and Silvia Machaqueiro

In September 2009, a meeting on migrant health was held in Lisbon by the International Organization for Migration (IOM) to discuss background papers produced for the Assisting Migrants and Communities (AMAC) project, co-funded by the European Commission. Parallel to the thematic sessions, a policy dialogue between countries was conducted. This snapshot highlights Portuguese input into this dialogue and focuses on recent policies, achievements and lessons learned.

The evolution of migrant health care policy in Portugal

Two questions in the policy dialogue were concerned with how countries were coping with immigration-related health challenges at and within their borders, as well as with what strategies needed to be reinforced to ensure health coverage to all those that need it in diverse societies.

Portugal used to be an emigrant country, but since the late 1990s it has become a host country with a sudden 200% rise in the immigrant population. Concerns for the social integration of these individuals acted as a catalyst for both macro and intersectoral strategies, including development of two national programmes.

The first step in this process was the introduction in 2001 of legislation guaranteeing that migrants who had been in the country for more than ninety days would have universal access to health care services regardless of their legal status. Yet, while this legal guarantee has proved to be workable, it alone has not been effective enough in properly tackling the issue of poor migrant health, as indicated in a study of mothers and newborn children between December 2005 and May 2006.¹

Additional initiatives have also been undertaken. In 2002 the Office of the High

Commissioner for Immigration and Ethnic Minorities developed a migrant integration programme that included several areas for action, including labour and professional training, housing, education and health. In those areas where responsibility for action was shared with the Ministry of Health, the main goals were to improve immigrants' knowledge of health care services, to promote access to migrant-friendly health centres and hospitals, and to develop an Immigration Observatory (see www.acidi.gov.pt). A national Plan for Immigrant Integration was subsequently published in 2007.²

In 2002 a new Health Strategy was also being developed. This included the National Health Plan (NHP) 2004–2010 which took a lifecycle approach to health, involving civil society organisations and with an emphasis on promoting equity.³ This NHP included an intersectoral survey committee with representatives from other ministries (Social Affairs, Education, Environment and Youth) in line with the principles of a health in all policies (HiAP) approach. The issue of migrant health is a good example of HiAP because it implies that all sectors in society must work together to reduce inequalities.

The Health Strategy also stated that the best levels of health gains through health promotion and disease prevention would be achieved through a reliance on primary health care centres as the most appropriate way of accessing health care services. This raises challenges concerning some immigrant groups, who have preferred to seek medical attention at hospitals alone. This may be due to cultural beliefs, the lack of perception of the seriousness of the disease or the fact that no questions will be asked about social problems in the hospital emergency department.

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As a consequence, a more comprehensive proximity care strategy through community care teams led by nurses is now being implemented. This is also being provided through mobile care units in identified migrant neighbourhoods. Endorsement of specific skills by those immigrants who are health professionals has also been considered as an important step for integration. Opportunities in this respect have now been created through a partnership between the Gulbenkian Foundation, a non governmental organisation, and the Ministry of Health.

The role of the EU and international community

A third question in the policy dialogue focused on what EU institutions can do for the health of migrants. The EU's role historically has been mainly confined to that of agreeing on common policies, strategies and specific measures to be adopted by European governments with the aim of preventing and controlling disease, as well as on providing access to health care for populations and, most particularly, to migrants as one vulnerable group.

The EU will continue to need migrants for demographic and economic reasons. All Member States would benefit from an increased synergy of sectoral and cross sectoral policies addressing the need for the inclusion of migrants, while at the same time providing development assistance to the countries of origin in order to diminish the need for migration.

Given this context, a conference on *Health and Migration in the EU – Better Health for All in an Inclusive Society* was one of the main initiatives of Portugal's EU Presidency in 2007.⁴ It helped foster the creation of a European Network of Health and Migration focal points with the support of the European Commission. Its conclusions contributed to the Eighth Conference of Ministers of Health, promoted by the Council of Europe in Bratislava and were noted by the EU's Employment, Social Policy, Health and Consumer Affairs Council .

The EU should now take a leadership role and ensure that migrant health becomes a priority in every government's agenda, for it is vital in determining the overall development of European societies and populations. Governments should always be concerned with ensuring that migrants' access to health services in the host country is on an equal basis with every other citizen. This is something which cannot

succeed unless there is effective cooperation and commitment from the Commission, the European Parliament and every Member State for the creation of adequate legislation which might encompass the most important aspects of migrant health.

As such, European institutions should work together towards achieving efficient policies in this field and attaining better health outcomes for migrants; ensuring that their access to health care is provided regardless of their legal status; tackling irregular migration; and promoting improved knowledge and information to migrants on their rights.

Action can also be taken beyond EU level. The World Health Organization approved at its 61st World Assembly a resolution inviting Member States to adopt measures to support the health of their migrant populations.⁵ A Code of Practice concerning immigrant health professionals is now also under discussion.

Portugal is committed to establishing a common approach for managing the migration of health professionals. One example is the very successful agreement between Portugal and Uruguay, wherein a protocol was established for the mutual exchange of expertise and experience among health professionals. Young Uruguayan doctors were able to participate in a three-year programme on the transportation of patients including emergency training. At the same time, surgical teams were trained on organ transplantation in Lisbon and Montevideo. This turned out to be a win-win protocol.

Portugal is now designing its next NHP. The new strategic pillars are citizenship, access, equity, health policy and quality. These are important issues for all citizens, but in particular for immigrant families.

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Access to health care for undocumented migrants in 11 European countries

Pierre Chauvin, Isabelle Parizot and Nathalie Simonnot



Paris: Médecins du Monde European Observatory on Access to Healthcare, 2009

ISBN 978 2 918362 01 2

156 pages

Freely available online at <http://www.doctorsoftheworld.org.uk/lib/docs/121111-europeanobservatoryfullreportseptember2009.pdf>

This report evaluates access to health care for people without a residence permit, termed 'undocumented migrants'. Two surveys, one statistical and the other qualitative, are combined to record the experiences of over 1200 adults in eleven European countries. The report finds that many countries do not adequately provide for children of undocumented parents, and although parents were fully aware of the pressure of migrant living on their children, many felt helpless and without much choice when it came to seeking health care and living healthy lives free from stress.

52% of people surveyed lived in insecure accommodation, short or medium term shelter or were sleeping rough. Only half had a means to earn a living, often working in casual and sometimes dangerous conditions. Socially many felt vulnerable and isolated, uncertain of who they could trust within the system. Contrary to popular belief, migrants do not come to

Europe expecting better health services. In fact, although most countries provide access to health care for migrants, this is at a relatively high cost and many were unaware that they were eligible for health coverage.

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Part 2: qualitative survey on access to healthcare for the children of undocumented migrants

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The health of migrants – the way forward: report of a global consultation Madrid, Spain



Geneva: World Health Organization, 2010

ISBN 978 92 4 159950 4

119 pages

Freely available online at: http://www.who.int/hac/events/consultation_report_health_migrants_colour_web.pdf

With an estimated 214 million international migrants, 740 million internal migrants and an unknown number of migrants in an irregular situation all over the world, governments, societies and public health officials face a formidable challenge in manage the health consequences of migration. Health needs and vulnerabilities differ greatly across migrants, and in recognition of this and other critical issues, a resolution on the health of migrants was endorsed by the sixty-first World Health Assembly in May 2008. This report is a summary of a consultation on health by the WHO, International Organization for Migration and the Spanish Ministry of Health and Social Policy inspired by this Resolution, held in Madrid in March 2010.

Four thematic areas are discussed: monitoring migrant health; policy and legal frameworks; migrant sensitive health systems and partnerships, networks and multi country frameworks. The importance of archiving accurate and standardised data on migrant health, proper dissemination of information and forecasting through modelling are emphasised, in addition to

the vital role of implementing national and international laws and standards to protect migrants' rights to health. The consultation indicates that health services must be accessible to migrants; there is a need for culturally and linguistically sensitive services. Partnerships across and within countries will ensure increased dialogue and cooperation between different groups. The report also contains a series of recommendations for moving the agenda forward and special attention needs to be paid to the role of migrant participation in social protection.

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The International Organization for Migration

www.iom.int

Established in 1951, the IOM is the leading inter-governmental organisation in the field of migration and works closely with governmental, inter-governmental and non-governmental partners. It has 127 member states, a further 17 states holding observer status and offices in over 100 countries. The website provides a wide range of information on activities of the organisation across the globe, as well as downloadable policy briefs, press briefing notes, legal research, regularly updated information on upcoming events and links to partner organisations. Information on publications for purchase and the journal *International Migration* are available within a bookstore. The website is available in English, French and Spanish.

Platform for International Cooperation on Undocumented Migrants (PICUM)

www.picum.org

PICUM is a Brussels based non-governmental organisation promoting respect for the human rights of undocumented migrants within Europe. It aims to provide a direct link between the grassroots level, where undocumented migrants' experience is most visible, and the European level, where policies relating to them are deliberated. The homepage lays out the latest news, publications and prominent projects. The aims and mission statement, key contacts and annual reports are found in the 'about us' section, whilst the 'themes' portal allows users to browse policy briefs and other material by topics such as labour, health care, undocumented children and housing. An outline of important legal documents and terminology are also presented. Users can sign up to receive a monthly newsletter published in seven languages. The site is available in English, French, Spanish, German, Italian, Dutch and Portuguese.

Nowhereland

www.nowhereland.info

The Nowhereland project aims to create a knowledge base for providing, exchanging and developing good practice for health care services for undocumented migrants in Europe. Funded through several Austrian organisations, the project is in its third year of implementation. The website allows users to analyse progress to date, with meeting notes, publications and timelines available for download. Reports for 27 countries can be found in the policy area, in addition to an overall summary report. Search facilities, useful contacts and links allow for easy access. The site is available in English only.

International Centre for Migration and Health (ICMH)

www.icmh.ch

ICMH is a Swiss non-profit institution established in 1995. Its goal is to research, train and advocate in issues related to migration and health, based on the belief that health for all is a fundamental human right. It is a WHO collaborating centre for health-related issues among people displaced by conflict and disaster and also works closely with the United Nations Population Fund. The website outlines their purpose, key players, related links and contact details. Selected publications are available for download. The site is accessible in French, English and Spanish.

NHS Evidence – ethnicity and health

www.library.nhs.uk/ethnicity

This website, part of NHS Evidence provided by the National Institute for Health and Clinical Excellence (NICE), aims to select and provide guidance on the best available evidence for the management of health care services to meet the specific needs of migrant and minority ethnic groups. The site contains a wealth of downloadable reports and links to other relevant web pages. Users are able to browse through material categorised by disease, client group, service sector and clinical profession.

MIGHEALTHNET

<http://mighealth.net>

The two year MIGHEALTHNET project aimed to increase knowledge and networking on the topic of migrant and minority health through the development of an interactive database. Through the portal stakeholders were encouraged to engage in information exchange and the sharing of experiences. Eighteen 'Country wikis' have been created in their official languages. Project summaries are freely available to download.

NEWS

NEWS FROM THE INSTITUTIONS

MEPs back European rules on organ donations and transplants

People needing organ transplants are one step closer to facing shorter waiting times after the European Parliament approved a draft directive on quality and safety standards for human organs used for transplants. The directive covers all stages of the chain from donation to transplantation and provides for cooperation between member states. Members of the European Parliament (MEPs) also adopted a resolution on an Action Plan for organ donation.

The number of organ donations and transplantations has grown steadily across the EU and thousands of lives are saved every year through this medical procedure. Organ transplantation is now the most cost-effective treatment for end-stage renal failure. For end-stage failure of organs such as the liver, lung and heart it is the only available treatment.

Despite this nearly twelve people die every day in Europe while waiting for an organ. The availability of organs varies widely between European countries and we are far from meeting the demand. The lowest deceased donation rate in Europe is one organ donated per million inhabitants. Spain has the highest rate, with thirty-three organs donated per million inhabitants.

The wide variations in quality and safety requirements between member states means that a national approach can not ensure a minimum standard for the organs exchanged between EU countries. The Commission believes a directive is needed to ensure a high level of health protection throughout the EU by establishing common standards of quality and safety of human organs intended for transplantation.

After subsequent adoption by the Council and publication in the *Official Journal* in June 2010, the member states now have twenty-four months to transpose the

Directive into national law. The Directive leaves enough flexibility to member states to accommodate existing systems where these are in place, so red tape and administrative burdens should be minimal. Member states shall report to the Commission every three years on the implementation of the Directive.

The Action Plan runs until 2015 and sets out ten priority actions. It will help increase the number of organs for transplantation. A collaboration between member states, the approach is based on the identification and development of common objectives, agreed quantitative and qualitative indicators and benchmarks, regular reporting and identification of best practices. The Action Plan will promote a number of initiatives aimed at increasing organ donation through organisational changes that have proven effective in some member states. It will also help countries to evaluate the performance of their transplant systems and exchange best practices to improve them.

More information at
http://ec.europa.eu/health/ph_threats/human_substance/oc_organ/oc_organ_en.htm

Employment, Social Policy, Health and Consumer Affairs Council (EPSCO)

In Brussels on 8 June the EPSCO adopted a number of conclusions related to health.

Equity and health in all policies

They called on member states and the European Commission to promote equity and health in all policies. The conclusions invite the European Commission to review the possibilities for assisting member states to make better use of structural funds to support activities to address social determinants of health and help to move forward on equity in health. Noting the wide and persistent differences in health status between EU member states across all the social gradient they called on member states to further

develop policies and actions to reduce health inequalities and to participate actively in sharing good practice, taking into account the need for action across all relevant policies.

The Council recognised that intersectoral actions initiated in some European governance areas have produced some efficient and sustainable actions. They noted that such an intersectoral action approach enables the development of synergies and the achievement of intersectoral co-benefits that may enhance equity in health and the welfare of European citizens. They considered that working conditions, as well as positive relationships between health and productivity, are areas of great interest, since they contribute to ensure the economic efficiency of the system.

Their conclusions also invited both member states and the Commission to promote the strengthening of procedures to assess the health impact of policies. This should include a review of the integrated impact assessment procedure currently being used, so as to improve its usefulness from the equity in health point of view. They also urged member states to implement policies aimed at ensuring a good start in life for all children, including actions to support pregnant women and parents and to consider policies to ensure that citizens, and all children, young people and pregnant woman in particular, can make full use of their rights to universal access to health care, including health promotion and disease prevention services.

Active ageing

Ministers also adopted conclusions to promote active ageing in the EU and to highlight the benefits and opportunities that the economic and social participation of older women and men would provide to society. The conclusions call on member states to make active ageing one priority in the coming years and to further develop active ageing policies by

Press releases and other suggested information for future inclusion can be emailed to the editor
David McDaid
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committing to specific objectives in the context of a *European Year for Active Ageing* in 2012. Moreover, the conclusions also invite the European Commission to support the implementation of new initiatives promoting active, healthy and dignified ageing through the existing policy instruments and programmes of the EU.

Sustainable social security systems

Conclusions on sustainable social security systems to achieve adequate pensions and social inclusion objectives were also agreed by ministers in the EPSCO council. These concerned minimum pensions or minimum income provisions. Ministers gave a political signal that, beyond the broad issues of adequacy and sustainability of pensions, the EPSCO Council wished to concentrate on citizens' concerns from a social protection perspective. The Council also invited the member states to continue paying particular attention to the issue of minimum pensions as a tool for combating poverty.

Advancing inclusion for Roma people

The Council also adopted conclusions on 'advancing Roma inclusion' inviting the Commission and the member states to make progress in mainstreaming Roma issues into European and national policies, to advance their social and economic integration and to ensure that existing EU financial instruments, and especially the structural funds, are accessible to them.

Action to reduce population salt intake

The Council noted that there is strong scientific evidence that the high consumption of salt throughout Europe is a major factor increasing blood pressure and thereby cardiovascular diseases, and may also have direct harmful effects, apart from its effect on blood pressure, including an increased risk of stroke, left ventricular hypertrophy and renal disease. They recognised that tangible and coordinated measures, such as raising public awareness of the problem and reducing the content of salt in foods, are required to address the challenge. They called for action by member states to strengthen and develop national nutritional policies to reduce salt consumption while inviting the European Commission to continue its approach to tackling high salt consumption through the implementation of the EU framework on salt reduction.

To read the EPSCO Council conclusions in full, please visit the website of the Council of the European Union.

Council agrees on new rules for patients' rights in cross-border health care

EU Health Ministers have also agreed on a draft directive concerning the application of patients' rights in cross-border health care. They failed to reach an agreement in December 2009 under the Swedish Presidency but a compromise proposal put forward by the Spanish presidency facilitated an agreement.

The draft directive aims to facilitate access to safe and high-quality, cross-border health care and to promote cooperation on health care between member states. The compromise reflects the Council's intention to fully respect the case law of the European Court of Justice on patients' rights in cross-border health care while preserving member states' rights to organise their own health care systems. The draft directive provides clarity about the rights of patients who seek health care in another member state and supplements the rights that patients already have at the EU level through the legislation on the coordination of social security schemes (regulation 883/04).

During the Council meeting the discussions focused on four issues: the definition of the member state of affiliation with regard to pensioners living abroad; reimbursement and prior authorisation; legal basis; and provisions on e-health. The first two issues remained open at the EPSCO Council meeting of 1 December 2009.

With regard to the member state of affiliation (which concerns in particular the reimbursement of health care costs of pensioners living in the EU outside their home countries and receiving health care in a third member state), the Council agreed that as a general rule the member state competent to grant a prior authorisation according to regulation 883/2004 (i.e. the member state of residence) reimburse the cost of cross-border health care of pensioners. If a pensioner is treated in his country of origin, this country would have to provide health care at its own expenses.

Concerning health care providers, the compromise seeks to ensure that patients looking for health care in another member state will enjoy the quality and safety standards applicable in this country, independently of the type of provider. Furthermore, the Council agreed that member states may adopt provisions aimed at ensuring that patients enjoy the same rights when receiving cross-border health care as they would have enjoyed if they had

received health care in a comparable situation in the member state of affiliation.

Concerning the legal basis, the Council agreed on a double legal basis, striking herewith a balance between the case law of the European Court of Justice on the application of Article 114 to health services and the member states' competencies recognised by the Treaty for the organisation and provision of health services (according to Article 168 on public health). As far as e-health is concerned, the ministers agreed on a close collaboration between the member states and the Commission.

More specifically, the draft directive contains the following provisions:

- as a general rule, patients will be allowed to receive health care in another member state and be reimbursed up to the level of reimbursement applicable for the same or similar treatment in their national health system if these patients are entitled to this treatment in their country of affiliation;
- in case of overriding reasons of general interest (such as the risk of seriously undermining the financial balance of a social security system) a member state of affiliation may limit the application of the rules on reimbursement for cross-border health care; member states may manage the outgoing flows of patients also by asking a prior authorisation for certain health care procedures (those which involve overnight hospital accommodation, require a highly specialised and cost-intensive medical infrastructure or which raise concerns with regard to the quality or safety of the care) or via the application of the 'gate-keeping principle', for example by the attending physician;
- in order to manage ingoing flows of patients and ensuring sufficient and permanent access to health care within its territory a member state of treatment may adopt measures concerning the access to treatment where this is justified by overriding reasons;
- member states of treatment will have to ensure, via national contact points, that patients from other EU countries receive on request information on safety and quality standards on their territory, in order to enable them to make an informed choice;
- the cooperation between member states in the field of health care is strengthened,

- for example in the field of e-health and through the development of European reference networks which will bring together, on a voluntary basis, specialised centres in different member states;
- the recognition of prescriptions issued in another member state is improved; as a general rule, if a product is authorised to be marketed on its territory, a member state must ensure that prescriptions issued for such a product in another member state can be dispensed in its territory in compliance with its national legislation;
 - sales of medicinal products and medical devices via the internet, long-term care services provided in residential homes and the access and allocation of organs for the purpose of transplantation fall outside the scope of the draft directive;

The draft directive is part of the social agenda package of 2 July 2008, focusing on a triple objective: to guarantee that all patients have care that is safe and of good quality, to support patients in the exercise of their rights to cross-border health care; and to promote cooperation between health systems. The aim of the second objective is in particular to codify the case law of the Court of Justice relating to the reimbursement of cross-border health care, avoiding a ‘third method’ of reimbursement (in addition to regulation 883/2004 and the draft directive).

After a legal-linguistic revision of the draft directive, the Council will adopt its position at first reading and forward it to the European Parliament for its second reading.

More information at http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/114992.pdf

EU-wide databank for medical devices

The European Commission has adopted a decision which will oblige all EU countries to use, as of May 2011, a European databank for medical devices (Eudamed). Medical devices range from life-supporting devices such as pacemakers through hip implants or X-ray machines, down to products used daily such as syringes or blood tests.

Data which are key to their safety – such as conformity certificates and data on clinical investigations – are for the time being collected only at the national level. The Eudamed databank is a secure infor-

mation technology tool which will ensure rapid access to such data by market surveillance authorities. The databank will also streamline the rules for manufacturers placing in vitro diagnostic devices on the market.

More information at <http://ec.europa.eu/enterprise/sectors/medical-devices/market-surveillance-vigilance/eudamed/>

Pledge to strengthen WHO technical capacity and role in combating cancer

On 5 July Zsuzsanna Jakab, WHO Regional Director for Europe, pledged to strengthen WHO’s technical capacity and role in the field of cancer. Her pledge came at a meeting of health ministers from European Union (EU) countries at a meeting in Brussels, Belgium.

Cancer is the second most important cause of death in the WHO European Region. It accounts for 20% of all deaths, with 2.5 million new cases diagnosed each year. WHO data show that lung cancer is by far the leading cause of cancer mortality, causing nearly twice as many deaths as breast, colorectal or stomach cancer.

In addition to playing a strong role in giving technical guidance in the field of cancer, WHO/Europe is looking for collaboration with other stakeholders, including the EU and WHO Member States, to carry out action plans at the country level. Developing joint strategies (including the exchange of best practices, coordinated research and policy formulation, and transparent collaboration among all stakeholders) will improve cancer outcomes and population health throughout the European Region.

WHO/Europe lists primary prevention, early detection and research – including behavioural research – as the keys to developing an effective public health strategy on cancer. Because cancer shares common risk factors with other non-communicable diseases – such as heart disease, stroke and diabetes – WHO/Europe promotes an integrated approach to prevention and health promotion. Integration provides an umbrella for strategies and action plans to make healthy choices easier for Europeans, particularly on tobacco, food and nutrition, alcohol, environment and health, obesity and physical activity.

Early detection of cancer is vital. In the past three years, WHO/Europe has worked with policy-makers from over 40 countries to develop screening programmes for cervical cancer. This work is

underpinned by broader work to strengthen health systems and improve quality assurance systems. While most European countries have screening programmes for breast and cervical cancer, screening for other types of cancer is only starting to appear.

Research – including study of the interaction of genes, lifestyle and environment – must be stimulated and supported to ensure best practice in health services. WHO/Europe also plans to work more closely with the International Agency for Research on Cancer. Behavioural research is especially needed, as lifestyle choices can help prevent many cancers. Such research needs to be complemented by research on the social determinants of health, as unhealthy lifestyles are strongly associated with social and economic disadvantage.

More information at <http://www.euro.who.int/en/what-we-do/health-topics/diseases-and-conditions/cancer>

Zsuzsanna Jakab highlights importance of looking beyond health in policy-making

Delivering a keynote address to the European Union Open Health Forum in Brussels, Belgium on 29 June, Zsuzsanna Jakab, WHO Regional Director for Europe said that “prevention, promotion and strong health systems are needed to eliminate the main risks to health in Europe, such as tobacco use, alcohol use, high blood pressure, overweight and obesity, high cholesterol, physical inactivity and high blood glucose. Many of these risks are outside the control of the health sector, so a health-in-all-policies (HiAP) approach is essential.”

Improving the health of the WHO European Region’s population requires addressing the causes of disability (which affects a person’s well-being and ability to work) as well as those of death. Disability-adjusted life-years (DALYs) provide an aggregate measure of healthy years of life lost to premature death or disability. Tackling the top seven health risk factors would reduce the total of DALYs lost by 60% in the 53 countries in the European Region, and by 45% in the Region’s high-income countries.

Active, cross-sectoral collaboration – the cornerstone of the HiAP approach – has benefits beyond health. Engaging the health, environment and transport sectors in promoting active modes of transport (such as walking or cycling) benefits all three sectors in different ways. It:

- helps to reduce air pollutants, greenhouse gases and noise (environment and health goals);
- reduces congestion and the need for expensive infrastructure for motorised transport (transport goals);
- reduces road traffic injuries (transport and health goals); and
- improves the accessibility and quality of urban life (a goal for all three sectors).

Finally, it encourages physical activity, the only goal primarily related to health.

Ms Jakab called on the Open Health Forum's participants to continue promoting HiAP, gathering evidence of the effectiveness of the approach and developing practical tools for its implementation.

Slides from Ms Jakab's presentation are available at <http://tinyurl.com/34fbfmm>

Sixty-third World Health Assembly

The Sixty-third World Health Assembly, which brought together 2,800 delegates including Health Ministers and senior health officials from the WHO Member States, concluded in Geneva on May 21. Delegates adopted resolutions on a variety of global health issues including:

Public health, innovation and intellectual property: global strategy and plan for action

The issue of intellectual property is critical for 4.8 billion people who live in developing countries, more than 40% of them living on less than US\$ 2 a day. Poverty affects their access to health products to fight disease. The debate this year focused on financing issues, including the rational use of funds, and conducting research through regional networks. The global strategy proposes that WHO should play a strategic and central role in the relationship between public health and innovation and intellectual property within its mandate. The strategy was designed to promote new thinking in innovation and access to medicines, which would encourage needs-driven research rather than purely market-driven research. A new consultative working group will examine the way to take this work forward and is expected to report back to the 65th Health Assembly in 2012.

International recruitment of health personnel: global code of practice

The code of practice aims to establish and promote voluntary principles and practices for the ethical international recruitment of

health personnel. It provides Member States with ethical principles for international health worker recruitment that strengthen the health systems of developing countries. It discourages states from actively recruiting health personnel from developing countries that face critical shortages of health workers, and encourages them to facilitate the 'circular migration of health personnel' to maximise skills and knowledge sharing. It also enshrines equal rights of both migrant and non-migrant health workers.

Non-communicable diseases: implementation of the global strategy

Non-communicable diseases – mainly cardiovascular diseases, cancers, chronic respiratory diseases and diabetes – kill nearly 35 million people per year. Almost 90% of fatalities before the age of 60 occur in developing countries and are largely preventable. Member states reviewed progress achieved during the first two years in implementing the Action Plan for the Global Strategy on the Prevention and Control of Non-communicable Diseases. Member states highlighted successful approaches in implementing interventions aimed at monitoring non-communicable diseases and their contributing factors; addressing risk factors and determinants supported by effective mechanisms of intersectoral action; and improving health care for people with non-communicable diseases through health system strengthening. Developing countries also underlined that official development assistance in building sustainable institutional capacity to tackle non-communicable diseases remains insignificant.

Strategies to reduce harmful use of alcohol

Each year 2.5 million people worldwide die of alcohol-related causes. Harmful drinking is a risk factor for non-communicable diseases and is also associated with various infectious diseases, as well as road traffic accidents, violence and suicides. For the first time, delegations from all member states reached consensus on a resolution to confront the harmful use of alcohol. In addition to the resolution, member states discussed a global strategy to reduce the harmful use of alcohol which sets priority areas for action and recommends a portfolio of policy options and measures.

Global eradication of measles

Member states endorsed a series of interim targets set for 2015 as milestones towards the eventual global eradication of measles.

Countries were encouraged by the efforts and progress made in controlling measles but also highlighted the challenges that need to be addressed to achieve the 2015 targets. These include competing public health priorities, weak immunisation systems, sustaining high routine vaccination coverage, addressing the funding gap, vaccinating the hard-to-reach population and addressing an increasing number of measles outbreaks particularly in cross border areas. Success in achieving the measles 2015 targets is a key issue if the Millennium Development Goal 4 to reduce child mortality is to be reached.

Implementation of the International Health Regulations (2005)

The first report of the review committee assessing the functioning of the International Health Regulations (IHR) during pandemic influenza was discussed. Delegates stressed that the IHR plays a vital role in global public health, and their countries fully support IHR implementation. Delegates detailed activities that their countries are carrying out to implement the Regulations at national and regional levels.

Member states underscored the need for individual, country-based capacity strengthening, learning from past lessons, the importance of flexibility and of reaching out beyond the health sector. They further expressed their appreciation of the IHR training and awareness raising activities supported by WHO and stressed the importance of monitoring IHR implementation. They also emphasised the need for strong communication and partnerships.

Dr Margaret Chan, WHO Director-General, told delegates that agreement on some items at the World Health Assembly was "a real gift to public health, everywhere". She highlighted agreements on the international recruitment of health personnel and the development of policy instruments and guidance to tackle the rise of chronic non-communicable diseases.

More information at <http://www.who.int/mediacentre/events/2010/wba63/en/index.html>

OECD: Growing health spending puts pressure on government budgets.

In all Organisation for Economic Co-operation and Development (OECD) countries total spending on health care is rising faster than economic growth, pushing the average ratio of health

spending to Gross Domestic Product (GDP) from 7.8% in 2000 to 9.0% in 2008. That is one finding from the OECD's Health Data 2010 database. Factors pushing health spending up - technological change, population expectations and population ageing - will continue to drive cost higher in the future.

In some countries the recent economic downturn, with GDP falling and health care costs rising, led to a sharp increase in the ratio of health spending to GDP. In Ireland, the percentage of GDP devoted to health increased from 7.5% in 2007 to 8.7% in 2008. In Spain, it rose from 8.4% to 9.0%.

Governments of most OECD countries shoulder the lion's share of health care costs. The share of government expenditure devoted to health increased in most countries, rising from an average of 12% in 1990 to an all-time high of 16% in 2008. Given the urgent need to reduce their budget deficits, many OECD governments will have to make difficult choices to sustain their health care systems: curb the growth of public spending on health, cut spending in other areas, or raise taxes.

Health Data 2010 also indicates that while new medical technologies are improving diagnosis and treatment they also increase health spending. There has been rapid growth in the supply and use of computed tomography (CT) scanners and magnetic resonance imaging (MRI) units used for diagnostic purposes. MRI units per capita more than doubled on average across OECD countries between 2000 and 2008, reaching thirteen machines per million population in 2008, up from six in 2000. The number of CT scanners rose to twenty-four per million population, up from nineteen in 2000. The number of MRI units per capita is much greater in Japan, the United States, Italy and Greece than in other countries. These countries, along with Australia and Korea, also have more CT scanners.

More information on access to OECD Health Data 2010 is available at www.oecd.org/health/healthdata

ECJ NEWS

ECJ judgement on financial incentives for doctors

On 22 April 2010, the European Court of Justice announced its decision that public

bodies forming part of a national public health service are not precluded from implementing schemes which offer financial incentives for doctors to switch patients from a named medicine A to a named medicine B in the same therapeutic class. Under such schemes, primary care practices are rewarded for switching patients to cheap unpatented drugs or prescribing them to new patients.

In an effort to reduce public expenditure on medicinal products, health authorities in England and Wales introduced schemes providing doctors with financial incentives to prescribe to their patients medicinal products cheaper than other medicinal products in the same therapeutic class.

The Association of the British Pharmaceutical Industry (ABPI) challenged such schemes as contrary to Directive 2001/83 and brought an action before the High Court of Justice of England and Wales, which decided to pause proceedings and to refer the case to the ECJ for a preliminary ruling on the interpretation of EC rules prohibiting financial incentives offered to doctors and pharmacists in promotional activities of medicinal products.

The ECJ's judgement goes against the Opinion of Advocate General Nilo Jääskinen delivered on 11 February 2010, which supported claims made by the UK's Association of the British Pharmaceutical Industry (ABPI) against the Medicines and Healthcare products Regulatory Agency (MHRA) that the prescribing incentive schemes operated by Primary Care Trusts (PCTs) in England are in fact prohibited under Article 94(1) of European Directive 2001/83.

The ECJ judgment clarifies that the prohibition concerns primarily the promotional activities of the pharmaceutical industry, as it was designed to prevent promotional practices that may induce health care professionals to act in accordance with their economic interests when prescribing or supplying medicinal products. The prohibition does not apply to national public health authorities because the national public health authorities do not pursue any profit-making or commercial aim when they adopt health expenditure policy (of which the incentives scheme is a part) with allocated expenditures.

However, in its judgment the ECJ sets out a number of considerations to be taken into account when evaluating any financial incentives schemes adopted by national public health authorities. In particular, the

ECJ held that any such scheme must represent no danger to public health, be based on objective criteria and not discriminate between national medicinal products and those from other Member States. Additionally, national public health authorities are required to make such a scheme public and to make available to health care professionals the evaluations establishing the therapeutic equivalence of the active substances belonging to the therapeutic class covered by that scheme. Finally, the ECJ concludes that public health system financial incentive programmes or procedures cannot compromise the objectivity of a doctor in issuing a prescription for a given patient.

As a consequence, upon examining the case at stake in the light of these considerations, the ECJ found the financial incentive system implemented by national public health authorities in England and Wales to be compatible with Directive 2001/83 and non-prejudicial to the objectivity of prescribing doctors.

The preliminary ruling of the ECJ, means that Member States are allowed to introduce public health policies offering financial incentives to induce doctors and pharmacists to prescribe cheaper medicinal products. The ABPI has expressed its disappointment with this judgement. In a written statement, the ABPI stated that it believed patients should have total confidence that when their doctor is making prescribing decisions those decisions are, and are seen to be, completely independent of personal financial considerations and that the ECJ interpretation of the legislation risks this being put in doubt. The ABPI will now consider the implications of this judgement in relation to its case, which is proceeding in the High Court.

COUNTRY NEWS

Scotland: Alcohol bill passes key vote

The Scottish government's plans to tackle the country's historic alcohol abuse problems have passed their first parliamentary hurdle. Members of the Scottish Parliament voted for the principles of the Alcohol Bill, although all the main opposition parties have vowed to remove plans for minimum pricing at a later date. The legislation still needs to pass two further stages of scrutiny before becoming law.

Ministers of the minority Scottish National Party (SNP) administration said radical action was needed to tackle alcohol-related violence and health problems. Opposition parties support other measures in the bill. These include banning drink promotions, the ability to raise the age for buying alcohol, and bringing in a 'social responsibility fee' for retailers who choose to sell alcohol.

The Scottish government estimates that the total cost of alcohol misuse every year is estimated to be around £3.56 billion (€4.3 billion) or £900 (€1090) for every adult in Scotland. On average, Scotland sees 115 hospital admissions every day due to alcohol misuse. The government estimate that alcohol is now around 70% more affordable than in 1980 and consumption has increased by around 20% over the same period.

However, ministers have yet to name their preferred minimum price for each unit of alcohol within a drink.

Health Secretary Nicola Sturgeon called on opposition leaders to "rise above party politics" and back minimum pricing, telling parliament the Alcohol Bill was supported by doctors, nurses, the police, churches and health experts. "We cannot simply sit back and do nothing. That will not reduce the horrific toll – both in financial and human terms – which alcohol takes on our nation. While it's not a magic bullet, we believe that minimum pricing would effectively target problem drinkers – who favour high-strength, low cost alcohol – in a way which neither tinkering with alcohol duty nor adopting a 'below cost' policy would do", the minister added.

Conservative party health spokesman Murdo Fraser said the SNP was "obsessed" with minimum pricing, and called on ministers to await the detail of UK government plans to ban sales of below-cost price alcohol and increases in duty targeted on problem and high-strength drinks.

More information at
<http://www.scotland.gov.uk/Topics/Health/health/Alcohol>

Northern Ireland: Shocking cost of alcohol abuse

Health Minister Michael McGimpsey said that further action is needed to tackle the alcohol misuse problem that costs Northern Ireland up to £900 million per year. The Minister was speaking as findings

of a research study to estimate the cost to society of alcohol misuse to Northern Ireland in 2008/09 were published. The study showed that, based on 2008/09 prices, the cost was estimated to be £679.8 million.

The Minister said: "alcohol misuse is one of the biggest public health issues facing Northern Ireland and its impact cannot be underestimated. This research shows that the cost to the Health Service alone may be as high as around £160 million each year with a further cost of £82 million to Social Services. These figures are particularly pertinent in the context of my Department's very challenging financial situation because this is money that could be spent providing key frontline services." The research also looks at the cost to Fire and Police Services (£279 million), Courts and Prisons (£103 million), and the wider economy (£258 million).

The Minister continued: "too many of our young people are putting their mental and physical health at risk because they are able to buy alcohol at a pocket money price. That is why I strongly support the calls in Scotland and elsewhere for a minimum price for alcohol. My Department's New Strategic Direction for Alcohol and Drugs has a clear focus on young people's drinking and binge drinking. This is also an issue that the Public Health Agency has been active in driving forward. But more needs to be done. We must ensure that alcohol is not easily accessible for young people. Tackling alcohol misuse is not an issue that my Department, or indeed Northern Ireland is facing in isolation, it is a task that runs right across Government. By taking a pro-active joined-up approach we will be able to make a real difference."

The Minister concluded "however alarming these figures are, they cannot bring home the personal tragedies that alcohol misuse has on many individuals, families and communities right across Northern Ireland. Misuse of alcohol fuels mental health problems, anti-social behaviour and domestic violence. We need to continue to challenge the whole of our population on the issue and change our society's attitude and behaviour towards alcohol."

The report prepared by FGS McClure Watters and the York Health Economics Consortium on the social costs of alcohol abuse can be downloaded at
http://www.dbsspsni.gov.uk/social_costs_of_alcohol_misuse_200809.pdf

Baltic States: Research links increased risk of tuberculosis to economic recession

Researchers who studied the effects of recession on rates of the highly infectious disease during the fall of the Soviet Union in the early 1990s found a strong link between the two and said their findings suggest a similar pattern could emerge now.

Nimalan Arinaminpathy from Oxford University and Christopher Dye from the Office of HIV/AIDS, Tuberculosis, Malaria and Neglected Tropical Diseases at the World Health Organization in Geneva studied the quantitative relationship between the lost economic productivity and excess TB cases and mortality.

In a study published by the *Journal of the Royal Society Interface* they compared fifteen countries for which sufficient data were available, finding a strong link between lost economic productivity during recession and excess numbers of TB cases. They suggested that if TB epidemiology and control are linked to economies today in the same way as in 1991 then the Baltic states, particularly Latvia, would be vulnerable to an upturn in TB cases and deaths. Their estimates were for 200 excess cases of tuberculosis per 100,000 people in the population in Latvia, 130 per 100,000 in Lithuania and 75 per 100,000 in Estonia, compared with some 40 per 100,000 in Russia over the period of recession and recovery.

The projections were in accordance with data on drug consumption, which indicate that these countries have undergone the greatest reductions since the beginning of 2008. The authors recommended close surveillance and monitoring during the current recession.

The study is available at <http://rsif.royalsocietypublishing.org/content/early/2010/04/26/rsif.2010.0072.abstract>

Germany: Higher health insurance costs approved

After months of debate, on 6 July the government coalition partners hammered out an agreement to raise the health insurance contribution rate from 14.9% to 15.5% of a worker's gross income. Employers and employees will now contribute 7.3% each of a worker's gross pay; insured workers will continue to pay an additional 0.9% of their gross wages.

As reported by the English language daily *The Local*, health insurers will also be free to charge limitless Zusatzbeiträge, or 'addi-

tional contributions'. This top-up money, which insurers can charge members to balance out extra costs, is presently capped. The insured will have to pay a statutory co-payment up to 2% of their income, compared with 1% previously, and health insurers can demand additional monthly contributions from their members.

The higher rate of 15.5% will take effect from 2011 and is expected to bring in about €6 billion to aid the ailing insurers. Statutory health funds, which insure about nine out of ten Germans, face an estimated deficit of €11 billion over the next year.

"The expected deficit in excess of €11 billion for the year 2011 will be balanced," said Health Minister Philipp Rösler, announcing the new plan in Berlin. "At the same time we will also get the health system on a course of sustainable, solid financing." The minister also announced spending cuts for doctors, hospitals, medicine and administration which will save €3.5 billion in 2011 and €4 billion in 2012.

To compensate for higher 'additional contributions', the government will provide a subsidy for the poor – both workers and pensioners – funded by taxpayers. The reform will also abolish the present upper limit on additional contributions that an insurer can charge members irrespective of their incomes – currently set at €8 per month. The standard for the additional contributions will now be calculated according to average costs in the health sector, which generally has a much higher inflation rate than other industries. The insurers will be able to decide this rate themselves.

The issue of health care financing has proved problematic for the coalition government of the Christian Democrat Union (CDU)/Christian Social Union (CSU) and Free Democratic Party. There is mounting concern that Germany's ageing population will mean that the burden on a shrinking work force, as well as on employers, will rise. The coalition government planned to fund the system more strongly with taxpayers' money, and base contributions on factors independent of personal income, however this was vetoed by the CSU. Critics within Chancellor Merkel's own party have called the measure a short term fix, with Wolfgang Steiger, general secretary of the economic council of the CDU calling for even more cuts in health care costs, structural reforms and greater cost-effectiveness in medical care. Meantime, CDU-CSU parliamentary leader Peter

Altmaier announced it would be the last rise in the contribution rates "for a long time," and would therefore pave the way for more fundamental structural reform.

Ireland: Report on reference pricing and generic substitution published

On 17 June, the Minister for Health and Children, Mary Harney, published the report of the joint Department of Health and Children/Health Service Executive working group on reference pricing and generic substitution. The report sets out a proposed model for the operation of a system of interchangeable medicines and reference pricing. It also identifies the legislative and administrative changes required.

The report follows on the Minister's decision to introduce a system of reference pricing and generic substitution. With reference pricing, a common reimbursement price, or reference price, is set for a group of interchangeable medicines. Eligible patients do not face any additional costs for products priced at or below the reference price. This, the government contend, will result in a more sustainable system of pharmaceutical pricing and reimbursement and will help to ensure that patients continue to access innovative and affordable medicines.

The Minister said, "due to our ageing population and increased usage of medicines, we can expect upward pressure on our drugs bill for our health services. It is essential, therefore, that we maximise value for money in this area of expenditure and use all methods to ensure that the right drugs are used, at the right time for the right conditions, and that the cost of drugs is kept as low as possible".

The move is the latest in a number of cost cutting moves, including off-patent price cuts and a reduction in wholesale and retail mark-ups introduced in February 2010.

Minister Harney added that "the new system of generic substitution and reference pricing will promote price competition and deliver greater value for money. Over the next five years a number of high volume medicines are expected to come off patent. These reforms will ensure that lower prices are paid for these medicines resulting in significant savings for taxpayers and patients."

Currently, when a specific brand of medicine is prescribed for a patient, a pharmacist can only supply that particular brand, even when less expensive versions

of the same medicine are available. Under the proposed model set out in the report, pharmacists would be permitted to substitute medicines which have been designated as interchangeable. Decisions about the interchangeability of medicines would be evidence-based and take into account best practice elsewhere. It is envisaged that an expert group would provide guidance on this matter. Legislation will be drafted and a regulatory impact analysis undertaken. Both will include consultation with all relevant stakeholders.

The report is available at http://www.dohc.ie/publications/reference_pricing.html

England: Direct payments under personal health budgets

In England, the government plans to give National Health Service (NHS) patients more power over their own care have shifted up a gear with the launch of personal health budget pilot schemes. Eight pilot projects will see primary care trusts (PCTs) give patients with conditions, such as stroke or diabetes, direct payments (possibly in monthly payments or a lump sum) to enable them to make their own decisions on services and treatments. This differs markedly from previous personal health budgets, which could only be held by the PCT or another third party.

Under the scheme, patients will be able to use their personal budgets in various ways, with a view to ultimately creating a much more personalised health service. After being given the agreed sum, patients can decide whether to use NHS or private care services. They could also choose to employ a personal assistant in their own home.

The Department of Health has now confirmed that more trusts will be authorised to offer direct payments to patients to help inform decisions around how to proceed with a wider, more general roll out. Earlier in 2010, the British Medical Association stated that giving patients their own cash to pay directly for national health services could potentially "undermine some of the fundamental principles of the NHS and their very existence appears at odds with the workings of the system" and might also raise significant equity concerns.

England: The widening health gap

A recent report from the National Audit Office evaluates the Department of Health's attempts to reduce health inequalities across England. It found that the gap

in life expectancy and other health measures has in fact widened since initial government targets were set in 2000.

Despite the fact that the NHS budget has doubled over the last ten years to £98 billion in 2009, there remain significant differences in the health of local communities. Although teenage pregnancy, infant mortality and life expectancy have improved overall, richer areas still have better health than poorer ones and the disparity has increased.

The report found that local NHS organisations do not have enough power to introduce their own initiatives to tackle health inequalities as there is a lot of guidance and initiatives from a range of organisations. Local commissioners were given £21 billion in 2009 for public health, but most of the money was spent on central directives and programmes, such as immunisation and screening, with little left for local priorities.

One fifth of the country is classified as being a 'spearhead area' where there is deep deprivation and local authorities are given extra finances and help to improve health. There also remains a critical shortage of GPs in spearhead areas, despite 5,700 more GPs working now than ten years ago. The report recommends a revised set of quality indicators and payments so that general practitioners actively target their most at-risk and impoverished patients.

Romania has EU's deadliest roads, study reveals

Romania and Malta are the only member states in which the number of deaths from road traffic accidents in 2009 were greater than in 2001, a study published by the European Transport Safety Council on 22 June reveals. Romania has the highest mortality rate in the EU as a proportion of its population. The report indicates that Romanian roads are eight times more dangerous than their Swedish counterparts: the mortality rate on Romanian roads is 130 people per million inhabitants per year, in a country whose population is 21.5 million. The second-worst case is Greece with 129 people per million, followed by Poland (120) and Bulgaria (118). At the opposite extreme, the lowest mortality rates were registered in Sweden (39) and the UK (40).

In 2009, 2,796 people died on Romanian roads, compared to 2,454 in 2001, representing an increase of 14%. The EU has set itself the goal of reducing the annual death

toll on its roads from 54,400 in 2001 to 27,000 in 2010. In 2009, almost 35,000 people were killed on roads across the EU-27, the report reveals. The best performers in improving road safety are Latvia, Spain, Portugal and Estonia – all of which reduced their death toll by over 50% – followed by France and Lithuania.

2009 appears to be a record-breaking year as the number of deaths fell by 11% compared to 2008. Slovakia (36%), Lithuania (26%), Denmark (25%) and Estonia (24%) achieved the greatest reductions in 2009.

The report is available at
<http://www.etsc.eu/documents/ETSC%204th%20PIN%20Report%202010.pdf>

Belgium: Belgian judge seeks EU-wide ban on cigarette sales

The EU court in Luxembourg has lodged two anti-smoking cases which could, in theory, lead to a ban on the sale of tobacco products across the EU. The two complaints lodged in Luxembourg on 28 May, call for the EU to ban the sale of cigarettes and the collection of excise duties on tobacco products in Belgium. They also ask the court to examine if the sale of tobacco products goes against the Lisbon Treaty, the Charter of Fundamental Rights and the UN's 1989 Convention on the Rights of the Child. The EU tribunal will now consider whether the case is admissible.

The EU Commission, which has in the past launched a number of anti-smoking initiatives, such as a ban on advertising and packaging controls, estimates that smoking costs the EU economy €2.5 billion a year in terms of health care and productivity losses and brings in €67 billion a year in terms of tobacco industry revenue.

More information at
<http://euobserver.com/851/30227>

Spain: Extraordinary measures to reduce the public deficit

In March 2010, Royal Decree 8/2010 reduced the price of generic medicines by 25-30% and introduced amendments to several regulations to reduce the drugs bill of the National Health System (Instituto Nacional de la Salud – INS). The government has now introduced additional price reductions and rebates affecting innovative medicinal products and medical devices.

The main measures introduced by the Royal Decree include a rebate on medicinal products dispensed by pharmacies to the

INS. Pharmacies must apply a rebate of 7.5% to medicinal products dispensed to the INS. As a consequence, wholesalers as well as pharmaceutical companies, shall also apply a rebate of 7.5%. The rebate will also apply to the direct acquisition of medicinal products subject to reimbursement by the INS (hospitals, health centres and primary attention centres) and to most medical devices. Generics and medicinal products that are included in the reference price system are exempt from this rebate. Orphan medicinal products are subject to a reduced rebate of 4%.

Greece: Price cuts lead pharmaceutical companies to withdraw products

The heavily indebted Greek government has cut the prices of medicines by 25%. At the start of May eurozone members and the International Monetary Fund (IMF) agreed a €110 billion (£95 billion) three-year bail-out package to rescue the country's economy. In return for the loans, Greece has started to make wide-ranging, deep and painful austerity cuts.

In response on 30 May the Danish company Leo Pharma suspended the sale of two of its drugs because it claims that the price reductions will lead to job losses in Europe. The company claims it is owed millions of euros in unpaid bills by Greece. Kristian Hart Hansen, a senior director of the company, said the 25% price reduction would encourage similar moves in other countries with large debt problems such as Ireland and Italy, according to the BBC.

Another Danish company, Novo Nordisk, withdrew sales of one of its products from Greece for the same reason. In response Greek government officials claim that drugs in Greece are too expensive. Stefanos Combinos, the director general of the economic ministry, told the BBC that Greece was one of the three most expensive countries in Europe for medicines. He said pharmaceutical companies had enjoyed great profits out of Greece over the decades and had an obligation to accept price reductions.

Mr Combinos said Greece had been under pressure from the IMF to make severe cuts and he anticipated that a compromise on a price reduction would be reached soon. The Greek government has promised to repay €5.6 billion that it owes to medical companies for hospital equipment and drugs. Speaking to the BBC a spokesman for Novo Nordisk, which is owed €24.4 million by Greece, said that the debt issue was unrelated to the decision not to lower

prices. That decision, he said, was entirely a result of the new price decree

More at <http://news.bbc.co.uk/1/hi/world/europe/10193799.stm>

Italy: Plans to reduce generic drug prices announced

Italy is the latest European country to issue health expenditure cuts in attempts to decrease the budget deficit. Silvio Berlusconi, Italy's Prime Minister, said that the expansion of 'cradle-to-grave' social protection had led to uncontrolled public spending and that, in light of the global financial crisis, it was essential that this spending be curbed.

However, unlike many other EU states, Italy's reductions to health care spending will focus on price cuts to generic drugs and restrictions on reimbursements for more expensive medicines.

Under a package of measures, outlined in a 176-page report published in June, the Italian government pledged to slash the price of generic drugs by 12.5% until the end of the year. Reimbursement of generic drugs will also be limited to the cheapest version of a medicine within four therapeutic categories, with the lowest price established by a tender system.

Until now generic drugs have accounted for 40% of patent-expired drug sales by volume in 2009 according to IMS Health data. Under the terms of the austerity package, any purchases by the state health service which are greater than reference prices will have to be justified. The cuts are intended to save the country around €600 million.

Speaking to the *Financial Times*, Minister for Health, Ferruccio Fazio, said that he would introduce incentives to reward doctors for reducing the overall volume of drugs and increasing the proportion of cheaper generics among those that remain. Mr Fazio also said he hoped to boost efficiency and cut the drug bill by centralising procurement and increasing greater flexibility for the purchase of drugs that have until now only been acquired by hospitals.

But he placed particular emphasis on 'rational prescribing' to persuade doctors to reduce their prescriptions of unnecessary medicines such as antibiotics, and to switch to the cheapest and most beneficial treatments, which he estimated could save €400 million a year.

With this in mind, a tendering process will also be introduced from the beginning of

2011 by the national drug agency (AIFA), under which no more than four equivalent products per active ingredient will be selected for full reimbursement by the National Health Service (NHS), based on the lowest prices. All drugs in each group other than these four which are available through the NHS will be the subject of reference pricing, and patients who wish to receive them will have to pay out-of-pocket the difference in price between their preferred drug and the reference product.

The AIFA will conduct comparisons of pharmaceutical expenditures in each of Italy's 20 regions, in order to ensure that the most efficient cost-containment measures are implemented relevant to each region's particular situation, and will centralise purchasing by hospitals and local health authorities. The agency will also establish a list of regionally-distributed medicines which have in the past been supplied by hospitals but will now be made available through pharmacies instead, making manufacturers rather than the regional authorities liable to cover any overspend.

Bulgaria waters down public smoking ban

Bulgarian lawmakers voted on 20 May to loosen legislation which would have forbidden smoking in all public spaces from June this year. The centre-right GERB party, which won general elections last July, has said a relaxation of the ban will avoid hurting the tourist industry during tough economic times.

Under the changes, restaurants and cafes smaller than 50 square metres in size may decide whether to allow smoking, while larger establishments will be required to designate separate non-smoking halls. Smoking will be completely forbidden on public transport, hospitals, schools, universities, cinemas and theatres. Last year, the Croatian government was forced to ease a smoking ban after only four months because café owners complained it was crippling business.

Bulgaria has the second highest percentage of smokers in the EU after Greece. Almost every third person between ten and nineteen years of age is a regular smoker, data from the health ministry show. Tourism accounts for 8% of GDP, the EU's poorest state. The European Parliament has consistently pushed for a total ban on smoking in the workplace, while the European Commission has indicated that it wants to harmonise minimum taxes

on tobacco products in a bid to cut down on smuggling.

Malta: Food poisoning likelier as climate warms

Incidences of food poisoning are likely to rise with increased global temperatures, according to a report by Dr Anthony Gatt from Malta's Infectious Disease Prevention and Control Unit and Dr Neville Calleja, Director of the Health Information and Research Directorate. According to the report, a study on the health effects of climate change in the Maltese islands warns that rising temperatures increase the likelihood of food-borne diseases like salmonella.

The study found 450 cases of diarrheal illness in Malta occurring each day, at a cost of €16 million. It was also reported that cases of diarrheal illness increase in May, with the rise in temperature, peaking in the summer months. The study looked at an eighteen year period of illnesses from 1990–2008. Part of the increase was blamed on increased outdoor activities involving food such as barbecues.

In view of the increased risks caused by climate change the study called for increased public awareness on food safety, hygiene and food preparation. As reported in *Malta Today*, the authors noted that "food-borne disease outbreaks can be prevented by using safe water and raw materials, keeping food clean and at safe temperatures, cooking food thoroughly and keeping raw and cooked food separated."

More information available at <https://ehealth.gov.mt/download.aspx?id=923>

Wales: New tobacco controls proposed

New measures to protect children and young people from the harm caused by smoking have been unveiled by the Welsh Assembly Government. The proposals include a ban on the display of tobacco products in shops and on the sale of tobacco products through vending machines.

Under the proposed regulations, specialist tobacconists will still be able to display tobacco products within their shops, provided that displays cannot be seen from outside. Restrictions will also be placed on the size of price lists for tobacco products in shops. The move aims to protect children and young people from the dangers of smoking, as research shows that

the display of tobacco products can encourage young people to try smoking.

Chief Medical Officer for Wales, Tony Jewell, commented that “two thirds of adults who have ever smoked say that they started before they were eighteen and the majority of under age smokers get their cigarettes from self service tobacco vending machines. Removing tobacco products from public display and banning cigarette vending machines will reinforce the vitally important public health message that smoking is harmful and addictive and reduce the opportunity for young people to access these products.”

Within the regulations, provisions have been made to ensure that shops and other businesses can continue to serve their customers. These provisions include allowing shopkeepers to still be able to serve their customers and restock their shelves without breaking the new law, as well as using price lists so they can trade efficiently, but not so that they become advertisements.

Subject to the outcome of a three-month consultation, which ends on 6 July, the Assembly Government aims to introduce the regulations in line with other UK countries. It is expected that the ban on vending machines will come into force in October 2011, along with the display requirements for larger businesses, as defined in the regulations. For specialist tobacconists and small stores such as corner shops the regulations are expected to take effect from October 2013.

Tajikistan: Polio outbreak

In April 2010, the Government of Tajikistan reported a sharp increase in cases of acute flaccid paralysis (AFP) in the country. AFP – a sudden weakness, paralysis and loss of muscle tone, with no obvious cause (such as trauma) – is the most common sign of poliomyelitis (polio).

Polio is a highly infectious and sometimes fatal disease, which invades the nervous system and can cause total paralysis in a matter of hours. The disease usually affects children under five years of age. It can be prevented by immunising children with a relatively low-cost, easy-to-administer vaccine.

Laboratory analysis of the AFP cases reported in Tajikistan confirmed an outbreak of wild poliovirus type 1. In response, the Ministry of Health and international partners began a comprehensive

national immunisation campaign consisting of four rounds. The first two rounds focused on immunising children aged under five years of age, and the last two, on children under fifteen, in health centres and house to house nationwide.

On 4 May, Ms Zsuzsanna Jakab, WHO Regional Director for Europe, concluded a two-day visit to Dushanbe, Tajikistan, to support immunisation activities. She took part with the Minister of Health in launching the national polio immunisation campaign. It aimed to ensure that, within a month, health workers and volunteers conduct three rounds of immunisation of almost 1.1 million children under six in health centres and house-to-house visits across the country. The Regional Director and the Minister vaccinated some children at the central polyclinic of Dushanbe, the Tajik capital.

“Tackling the current outbreak and maintaining the polio-free status of the country and the WHO European Region are WHO’s and my highest priority,” said Ms Jakab, addressing journalists at the conclusion of a meeting with President Emomali Rakhmon. “With no cure for polio, we are calling for the full support of all sectors of society to ensure that every child under six years of age receives the polio vaccine during this and other immunisation campaigns, until the country is polio free again.”

Ms Jakab commended the Ministry of Health of Tajikistan for its transparent and proactive action in informing WHO/Europe through the WHO Country Office about the outbreak: “the immunisation campaign starting today was organized within ten days of the confirmation of the outbreak as polio related, which is a record time and a model for response”. Ms Jakab stressed the importance of political commitment and leadership, as well as collaboration with WHO, the United Nations Children’s Fund (UNICEF) and other international partners, to strengthen immunisation and surveillance in the country and to mobilise resources.

More information at <http://www.euro.who.int/en/what-we-do/health-topics/diseases-and-conditions/poliomyelitis>

Psychosocial risks concern most European companies

Four out of five European managers express their concerns about work-related

stress, the ‘European Survey of Enterprises on New and Emerging Risks’ (ESENER) reveals, making stress at work as important as workplace accidents for companies (79%). Work-related stress is very acute in health and social work (91% of companies regard it as of some or of major concern) and in education (84%).

The survey covering all 27 EU Member States, Croatia, Turkey, Norway and Switzerland, was conducted in spring 2009. 36,000 interviews with managers and health and safety representatives were conducted in establishments with ten or more employees from both private and public organisations across all sectors (except for agriculture, forestry and fishing). The survey provides information on how European companies currently manage health and safety issues with a particular focus on the relatively new psychosocial risks, such as work-related stress, violence and bullying.

European Agency for Safety and Health at Work Director, Jukka Takala, said that despite the high levels of concern, it is clearly worrying that only 26% of EU organisations have procedures in place to deal with stress. The survey also shows that 42% of management representatives consider it more difficult to tackle psychosocial risks, compared with other safety and health issues. Sensitivity (53%) and lack of awareness (50%) of the issue are the main barriers.

Measures to deal with psychosocial risks such as violence, stress and bullying are applied twice as frequently by enterprises consulting their employees than those who do not.

Even smaller companies are able to carry out in-house risk assessment if they have access to expert guidance and support.

Further analysis will be carried out in 2010 and four more reports will be following, focusing on success factors related to health and safety management, psychosocial risks management, involvement of workers and actions, drivers and barriers to psychosocial risk management.

The full ESENER report and a summary in 22 languages are available from our website. View the results online with the interactive mapping tool at www.esener.eu

News in Brief

Marc Sprenger appointed as new ECDC Director

Dr Marc Sprenger has been appointed to lead the European Centre for Disease Prevention and Control (ECDC). Prior to taking up his appointment Dr Sprenger was Director-General of the National Institute for Public Health and the Environment in the Netherlands. He took up his post as Director of the Stockholm based EU agency on 1 May for a period of five years. Speaking to members of the European Parliament's Environment, Public Health and Food Safety Committee he said that, as ECDC Director, he would focus on three main challenges. First, ensuring the scientific excellence of the analysis, guidance and technical support provided by ECDC. Second, to continue building collaboration and partnerships with ECDC's national counterparts, the EU institutions and key international players such as the World Health Organization (WHO). Third, to ensure that ECDC operates efficiently and provides value for money to the EU.

More information at
<http://tinyurl.com/3xxpxma>

Factsheet on a human rights based approach to health

The Office of the High Commissioner for Human Rights and the WHO have issued a fact sheet on the right to health. The fact sheet aims to shed light on the right to health in international human rights law as it currently stands, amidst the plethora of initiatives and proposals of what the right to health may or should be. It illustrates implications for specific individuals and groups, elaborates upon States' obligations and ends with an overview of national, regional and international accountability and monitoring mechanisms.

The factsheet is available at
http://www.who.int/hhr/news/brba_to_health2.pdf

New briefing on health and access to health care of migrants in the UK

A new briefing report written by Hiranthi Jayaweera on the health and access to health care of migrant people in the UK has been published by the Race Equality Foundation. It notes that the growing size and diversity of the

proportion of the UK population who were born overseas have important implications for meeting health needs and for planning and delivering health services. While government policy has focused on addressing ethnic inequalities in health, less emphasis has been placed on the possible impact for migrants of factors such as country of birth, language and length of residence and immigration status in the UK. It concludes that there is particular evidence of barriers to health care arising from restricted entitlements for some vulnerable migrants. Political concern over 'health tourism' negatively affects the delivery of, and access to, health care for migrants. These issues require further research and the implementation of specific policies and good practice

The briefing is available at
<http://www.better-health.org.uk/files/health/health-brief19.pdf>

New publication: best practice in estimating the costs of alcohol

Edited by Lars Møller and Srđan Matic this new report published by the WHO Regional Office for Europe aims to summarise best practice in estimating the attributable and avoidable costs of alcohol, and to make recommendations for making such estimates in future studies. It discusses the conceptual basis for such cost studies, and examines the conceptual and methodological challenges for each type of cost in turn. Amongst its recommendations are calls for more sophisticated modelling of the effects of policy on costs and the use of scenarios rather than sensitivity analyses.

The report is available at
<http://tinyurl.com/32tjybj>

Consultation on the health effects of fluoridated drinking water

On 15 June, the European Commission's Directorate-General for Health and Consumers and the Scientific Committee on Health and Environmental Risks (SCHER) launched a public consultation on the draft scientific opinion on the review of new evidence on the hazard profile, health effects and human exposure to fluoride. The SCHER's draft opinion reviews the latest information available on risks and benefits of

using fluoridated drinking water and other intakes of fluoride. Stakeholders are invited to comment on the opinion as part of an online consultation aimed at gathering feedback on the scientific evidence available and on the conclusions drawn by the SCHER. The consultation will run until 15 September 2010.

More information at
<http://tinyurl.com/26xbh6z>

Campaign launched to promote safe maintenance at work

The European Agency for Safety and Health at Work launched a campaign to promote safe maintenance at work on 28 April 2010. Failure to maintain the work environment and poor standards of maintenance are major causes of occupational disease (for example, from exposure to asbestos and biological agents) and accidents. It is estimated that 10–15% of all accidents and 10–15% of fatal accidents at the workplace are maintenance related. The campaign is linked to the EU's health and safety strategy, which aims to achieve a 25% reduction in accidents at work by 2012.

Since 1989, a number of European directives have been adopted, laying down a general framework of minimum requirements for the protection of workers at the workplace. These directives also apply to maintenance activities, first and foremost a 'Framework Directive', including the obligation for employers to carry out a risk assessment at work. On the basis of the 'Framework Directive' a series of individual directives were adopted, all relevant for carrying out maintenance in a safe way and many of them include specific provisions regarding maintenance activities and requirements for maintenance to eliminate workplace hazards.

More information at http://osha.europa.eu/en/campaigns/index_html

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