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## **chapter** one

# **Migration and health in the European Union: an introduction**

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### **Introduction**

This book explores key features of health and migration in the European Union (EU). The increasing diversity of populations in Europe creates new challenges for health systems, which have to adapt in order to remain responsive. These challenges are increasingly recognized with regard to migrants, who comprise a growing share of European populations. Eurostat data on the size of the population in the EU without EU citizenship provide indications of the scale of migration to Europe: in 2009, 4.0% of the EU's total population were citizens of countries outside the EU (Vasileva 2010). However, citizenship is an imprecise measure of migrant status, since it does not include naturalized migrants who have assumed the citizenship of their host country (Castles and Davidson 2000; Nielsen et al. 2009). In addition, there is an unknown number of irregular or undocumented migrants, believed to account for 0.39–0.77% of the population in the 27 EU member states in 2008 (Vogel 2009), although other estimates suggest that this proportion could be as high as 4% (Karl-Trummer et al. 2009). Taken together, this means that the size of the migrant population in the EU is considerably higher than the Eurostat data indicate.

Another complicating factor is that the very definition of migrants differs from country to country (IOM 2010). While the UN Recommendations on Statistics of International Migration define a long-term migrant as a “person who moves to a country other than that of his or her usual residence for a period of at least a year” (United Nations Department of Economic and Social

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Affairs 1998: 18), not all countries follow this definition. This makes it difficult to compare data from different countries. It should also be noted that there is a need to look beyond the generation that has moved from one country to another. Although the term “second-generation migrant” is a contradiction in terms (Kobayashi 2008), the challenges for the health of the descendants of migrants are sometimes greater than for those who migrated (Ingleby 2009; Gushulak 2010; WHO 2010b).

While a number of publications on migrant health in Europe have appeared in recent years (Fernandes and Miguel 2009; Peiro and Benedict 2009; Björngren-Cuadra and Cattacin 2010), comprehensive information on different aspects of health and migration, and how these can best be addressed by health systems, is still not easy to find. This volume attempts to fill this gap in the literature. We hope that the book will be of value to researchers, policy-makers and practitioners.

### **Information on migration and health**

While migrants are often comparatively healthy, a phenomenon known as the “healthy migrant effect”, they often face particular health challenges and are vulnerable to a number of threats to their physical and mental health. However, all too often, the specific health needs of migrants are poorly understood, communication between health care providers and migrant clients remains poor, and health systems are not prepared to respond adequately. The situation is compounded by the problems migrants face in realizing their human rights; accessing health and other basic services; and being relegated to low paid and often dangerous jobs, with the most acute challenges being faced by undocumented migrants, trafficked persons and asylum-seekers.

One major reason for this lack of understanding is the scarcity of data. Apart from the above-mentioned lack of clarity about who constitutes a migrant – and how many migrants there are in any given country (Aung et al. 2010) – high-quality data on health determinants, health status and health service utilization by migrants are not available in most EU countries (Rafnsson and Bhopal 2008; Ingleby 2009; Padilla and Miguel 2009). For example, registry data on health care utilization that allow for identification of migrants at a national or sub-national level are only available in 11 of the 27 EU member states (Nielsen et al. 2009).

Where data on migrant health are available, they often point in contradictory directions, due to the diversity of migrants in terms of age, gender, country of origin and destination, socioeconomic status and type of migration. In general, many health discrepancies disappear after controlling for socioeconomic status (WHO 2010b), though poor socioeconomic status may itself be a result of migrant status and ethnicity. This is related to processes of social exclusion and illustrates that migration is an important social determinant of health (Davies et al. 2009; Ingleby 2009; Davies et al. 2010). Research into migration and health is further complicated by the complexity of the relationship between migration and health; the health of migrants is shaped by many factors throughout the migration process, including ethnic identity and genetic characteristics (Ingleby et al. 2005), and health needs change with time of residence in the host country.

It has therefore been described as “foolish to attempt any generalisations about the general level of health of all migrants” (Ingleby 2009: 11).

To the limited extent that generalizations are possible and information is available across countries and migrant groups, migrants seem to be more vulnerable to communicable diseases, as well as to occupational diseases and poor mental health, which is in part due to patterns of disease in their countries of origin, poor living conditions, precarious employment and the trauma that can be associated with various causes of migration (Gushulak et al. 2010). In terms of non-communicable disease, migrants to Europe seem initially to have a lower risk of cancer but higher risk of diabetes and some other diseases, while the risk of cardiovascular disease varies among different groups (see Chapter 7 on “Non-communicable disease”). Migrants are also at higher risk of maternal and child health problems, with differences in perinatal outcomes persisting between migrants and non-migrants, and evidence that both the utilization and quality of antenatal care is lower among migrant women (see Chapter 9 on “Maternal and child health”).

Where available, utilization rates provide information on how migrants access services. A systematic review of migrants’ utilization of somatic health services in Europe found that they tend to make less use of mammography and cervical cancer screening, have more contacts with general practitioners, the same or higher utilization of specialist care, and higher, equal or lower levels of utilization of emergency care (Uiters et al. 2009; Norredam et al. 2010), although without detailed information on health needs, these findings are difficult to interpret. In general, rather than suffering from exotic diseases, most migrants seek help for “common-or-garden” (Ingleby 2009) complaints that are also common among the non-migrant population.

A much clearer picture emerges with regard to either asylum-seekers (Watson 2009) or undocumented migrants (Karl-Trummer, Novak-Zezula et al. 2010). In 2003, the Council of the European Union outlined minimum standards for the reception of asylum-seekers which include emergency care, essential treatment of illness, and necessary medical or other assistance for applicants with special needs (Council of the EU 2003). However, in 2004, ten of 25 EU countries provided only emergency care to asylum-seekers (Norredam et al. 2006).

With regard to undocumented migrants, there is a tendency in many EU member states to restrict entitlements to health services “to discourage the entry of new migrants” (Björngren-Cuadra and Cattacin 2010). In 2010, nine of 27 EU countries restricted access to health services in such a way to make emergency care inaccessible to undocumented migrants and only five countries (Netherlands, France, Italy, Portugal and Spain) offered undocumented migrants access to health services beyond emergency care, such as including primary care. In only four EU member states (Netherlands, France, Portugal and Spain) were undocumented migrants entitled to access the same range of services as nationals of that country as long as they met certain pre-conditions, such as proof of identity or residence (Björngren-Cuadra and Cattacin 2010, Karl-Trummer, Björngren-Cuadra et al. 2010).

Apart from legal restrictions on entitlements to health care, which are most pronounced for undocumented migrants and asylum-seekers, migrants may be particularly affected by user fees (Nielsen et al. 2009), as well as by impeded

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access to health insurance. Other barriers include language, unfamiliarity with rights, entitlements and the overall health system, underdeveloped health literacy, administrative obstacles, social exclusion, and direct and indirect discrimination.

### **The political response so far**

There is a growing body of knowledge on ways in which to foster health systems' responsiveness to the needs of migrants, including many examples of good practices (Fernandes and Miguel 2009; MIGHEALTHNET 2010). Ideally, the needs of migrants should be incorporated into all elements of health systems, including regulation, organization, financing and planning, to ensure non-discrimination and equal entitlement to health services. Specific steps that can help health systems to meet the needs of migrants typically involve measures to overcome linguistic, cultural and administrative barriers, such as interpretation and translation services; culturally informed models of care; culturally tailored public health programmes; the use of cultural support staff (such as health mediators); training of staff in diversity; diversification of the workforce; and the involvement of migrants in all aspects of health care delivery (Fernandes and Miguel 2009; WHO 2010a). However, more needs to be done to evaluate the effectiveness of "best practices" that are rarely, if ever, subject to rigorous assessment (Ingleby 2009). Furthermore, good practices "do not fix the system" and, for long-term sustainability, structural changes are required that embed good practices in health policy and practice (Fernandes and Miguel 2009; Ingleby 2009).

Yet, health systems in Europe are only slowly waking up to the need to become more responsive to migrant populations by establishing appropriate and accessible health services. In contrast to traditional countries of immigration, such as Australia, Canada and the United States, few European countries have adopted explicit migrant health policies (Ingleby 2006).

At last, however, the issue of migrant health is receiving increasing attention in Europe. Of major importance in this respect were the EU presidencies of the Portuguese in 2007 and the Spanish in 2010. The Portuguese EU presidency held a conference on "Health and Migration in the European Union – Better Health for All in an Inclusive Society" in Lisbon in 2007, with the conference conclusions adopted by the Employment, Social Policy, Health and Consumer Affairs Council (EPSCO) in December 2007. Under the Spanish EU presidency, migration and health were considered within the overarching theme of health inequalities. This led to the adoption, by the European Council, of "Council conclusions on Equity and Health in All Policies: Solidarity in Health" (Peiro and Benedict 2009; Peiro and Benedict 2010).

Other international and European organizations have also contributed to the greater recognition of the migrant health agenda. In November 2007, a conference of ministers of health of the Council of Europe adopted the "Bratislava Declaration on health, human rights and migration" (Council of Europe 2007). In 2009, the project on "Assisting Migrants and Communities" (AMAC), led by the International Organization for Migration (IOM) and

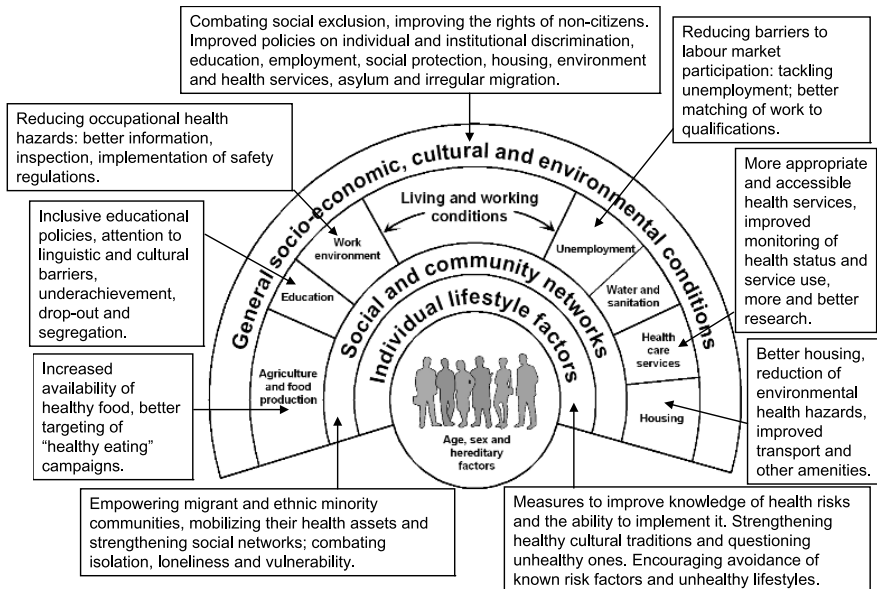
co-financed by the EU and Portugal, ran an EU-level consultation on “Migration Health – Better Health for All” in Lisbon (Peiro and Benedict 2009). In May 2008, the World Health Assembly adopted the resolution on the “Health of Migrants” (World Health Assembly 2008). The World Health Organization (WHO), the IOM and the Spanish Ministry of Health and Social Policy co-convened a “Global Consultation on Migrant Health” in Madrid in 2010 (WHO 2010a). Yet, despite these positive developments, there is the danger that many policies and programmes will be short-lived, as funding by the EU and member states for migrant health initiatives declined between 2007 and 2010 (Peiro and Benedict 2010).

There are wide differences in the extent to which European countries have considered and implemented national migrant health policies. So far, only eleven (including one country from outside the EU) seem to have adopted specific national policies aimed at improving migrant health (see Chapter 12 on “Migrant health policies in Europe”). One obvious reason for the variation across countries is the size of the migrant population, which is still very small in countries in central and eastern Europe. Another issue is the overall political climate. On the other hand, Italy, Portugal and Spain have only experienced large-scale immigration relatively recently but have already adopted national migrant health policies (Vazquez et al. 2010). While some countries with a relatively extended history of immigration, such as the United Kingdom and the Netherlands, have established national migrant health policies, others, such as France, have not.

The political attention paid to the health of migrants is also related to prevailing attitudes towards migrants and immigration (Ingleby 2009). While there has been an increasing harmonization of immigration policies in EU member states, the dominant emphasis has been on restriction and control (Bendel 2007). The overall political climate in a country is an important factor that can help or hinder health systems in becoming more responsive to the needs of migrants (Ingleby 2006). A number of European countries, including Germany, have historically been reluctant to even consider themselves as countries of immigration. Furthermore, there has been a political backlash against immigration in a number of European countries, with a particularly hostile reception for asylum-seekers and a rise in anti-Muslim rhetoric. In 2010 alone, far-right anti-immigrant parties made electoral gains in Austria, Italy, the Netherlands, Hungary and Sweden, whereas France made headlines by establishing a ministry of national identity and deporting Roma originating from central and eastern Europe. Germany's Chancellor Angela Merkel declared that multiculturalism had “utterly failed” (Chrisafis 2010), and Switzerland voted in a referendum to ease the expulsion of foreigners convicted of crimes. This political environment, in which mainstream parties find themselves in the grip of populism, is made even more challenging as the economic crisis and cutbacks in public expenditure result in growing unemployment, not least among migrant workers. In this general political and economic context it will be crucial to counteract discrimination and not to retreat from efforts to establish and implement national migrant health policies.

The range of areas that need to be addressed by such policies is illustrated in Figure 1.1, adapted from the well-known “rainbow” on determinants of

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**Figure 1.1** Policy measures tackling the determinants of health for migrants

Source: WHO (2010b)

health (Dahlgren and Whitehead 1991). It becomes clear that policies need to go beyond improving health services to encompass actions addressing the social exclusion of migrants and their employment, education and housing conditions.

### Outline of the book

This book is structured in seven sections. Following the introductory section, Section 2 explores the overall context of migration and health in the EU; Section 3 addresses the rights of migrants to health and looks at problems in accessing health services; Section 4 explores challenges and opportunities in monitoring migrant health; Section 5 is devoted to the health issues faced by migrants in Europe; Section 6 discusses the policy response so far, the need for culturally responsive health services and examples of best practice; and the final section is devoted to the conclusions that can be drawn from the material presented in this volume.

Following this introduction, Chapter 2 reviews the scale and nature of migration flows to post-war Europe. The chapter discusses the availability and quality of available data, the stocks and flows of foreign populations, the scale and nature of labour migration, and the challenges related to asylum-seekers and undocumented migration.

Chapter 3 is concerned with asylum, residency and citizenship policies and models of incorporating migrants into Europe. It argues that national provision

of health services for migrants cannot be divorced from broader immigration policies. The chapter finds large variations across Europe in all four policy areas examined.

The next section of the book investigates human rights and access to health care for migrants in Europe. Chapter 4 describes international, European and national provisions on the right to health and how far these are being implemented in practice. It includes a discussion of United Nations, Council of Europe and EU provisions, mechanisms for their enforcement, and evidence on implementation.

Chapter 5 addresses migrants' access to health care. It reviews the current knowledge about health care utilization by migrants in Europe and finds that they tend to have a lower uptake of preventive services (such as for cancer screening and reproductive health care) but higher use of general practitioners; there is inconclusive evidence on emergency care, hospital care and specialist care. The chapter argues that differences in access are due to the formal and informal barriers migrants face in accessing health care, such as legal restrictions, language barriers, sociocultural factors, and migrants' lack of information about their rights and the health system of the host country.

The next section of the book aims to unravel the often diverging health needs of migrants. Chapter 6 is concerned with the questions of what data are available and how much use they are. It finds that there is a lack of high-quality information on the health of migrants, as routine data on migrant health are available in only a few EU countries and the understanding of exactly who constitutes a migrant differs widely from country to country. The chapter explores some of the political and methodological complexities involved, and considers what would be needed to improve the availability of data on health and migration in Europe.

Chapter 7 discusses the issue of non-communicable diseases. While findings vary among different migrant groups, the chapter reports that migrants tend to have a lower risk of cancer, are experiencing steep increases in diabetes and have a higher occurrence of stroke. As integration progresses, with migrants adopting the same lifestyles and facing the same environmental risks as locally born people, the epidemiological profiles of migrants tend to converge towards those of the host country. However, convergence appears to be a slow process.

Chapter 8 presents the available evidence on communicable diseases among migrants in Europe and discusses the practice in several European countries of screening migrants at entry. Migrants coming from high-prevalence countries tend to have higher than average rates of tuberculosis, hepatitis B and HIV/AIDS compared to majority populations in Europe. Of the 27 EU member states, 13 have specific screening programmes for tuberculosis among migrants, with screening most commonly directed at asylum-seekers and refugees.

Chapter 9 discusses maternal and child health. It focuses on the antenatal period and the first year of life, with particular consideration of unfavourable birth outcomes that are at least partly avoidable, such as stillbirths, neonatal and infant mortality, low birth weight, preterm birth and malformations. The authors find persisting differences in perinatal outcomes between migrants and non-migrants in Europe. There tend to be higher rates of stillbirth and infant mortality among migrants, with refugees, asylum-seekers and undocumented



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migrants being particularly vulnerable. There is also evidence that both the utilization and quality of antenatal care is lower among migrant women.

Chapter 10 reviews available research on employment and working conditions and their effects on the health of migrants. The majority of studies conducted in Europe in 1990–2010 found that rates of occupational injury were higher among migrants. However, due to a possible systematic bias in reporting, true differences might be even greater than these studies suggest. Unskilled and undocumented labour migrants working in sectors such as construction, mining and agriculture are particularly at risk.

Chapter 11 explores what is known about the mental health of refugees and asylum-seekers. It examines their psychopathology, ranging from psychological distress to mental disorders (e.g. depressive disorders and depression, and post-traumatic stress disorders), and draws lessons on how mental health providers can meet the needs of refugees and asylum-seekers. In almost every study that has been done, refugees and asylum-seekers who reported exposure to political violence prior to migration were more likely to meet diagnostic criteria for the presence of psychopathology.

The next section of the book is concerned with policy responses and best practices. Chapter 12 reviews the migrant health policies that have been adopted so far in Europe at national and regional levels. It finds that only eleven European countries (one of which is outside the EU) have so far adopted specific policies on migrant health. There is considerable variation in terms of which population groups are targeted by these policies, the health issues addressed, whether providers or patients are the focus of interventions, and whether policies are actually being implemented. In England, Ireland and the Netherlands, for example, migrant policies are integrated into broader policies that also encompass ethnic minorities, while in Austria, Germany, Italy, Portugal, Spain, Sweden and Switzerland, the focus is more specifically on migrants.

Chapter 13 argues that there is a need for culturally responsive health care, in order to overcome differences in language, religion and culture. It examines how language barriers can be addressed through interpretation services, what it means to interact with patients of different cultural backgrounds, and how to address religious concerns. The chapter cautions against common preconceptions and argues in favour of a more open-minded approach that puts mutual understanding at the heart of the dialogue between health workers and patients.

Chapter 14 presents findings on best practice in accident and emergency departments. It is based on in-depth interviews with practitioners in areas with relatively high levels of migrants in 16 European countries. The chapter identifies a number of crucial factors for providing migrants with high-quality services, including the provision of good quality and easily accessible professional interpreting services, the promotion of cultural awareness among health workers, informing migrants about treatment expectations and the health system, ensuring legal and financial access to health services, and investing time and organizational resources.

Chapter 15 reviews good practice in health service provision for migrants generally. It first reviews how concern about adapting health services to the needs of migrants has arisen and then examines how service delivery can be

modified. Among the mechanisms the chapter identifies are ensuring entitlements of migrants to health care, providing information on health and the health system, improving the geographical and administrative accessibility of health services and addressing language and cultural barriers. The chapter also identifies ways of making change sustainable and argues for more research on the effectiveness of interventions in the area of migrant health.

The final section of the book brings together the key findings and conclusions. Chapter 16 pays particular attention to the policy implications of the findings presented in this book and what can be done at the European, national and regional levels to improve migrant health in Europe.

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