

Health in Europe 5



Migration and health in an increasingly diverse Europe

Bernd Rechel, Philipa Mladovsky, David Ingleby, Johan P Mackenbach, Martin McKee

The share of migrants in European populations is substantial and growing, despite a slowdown in immigration after the global economic crisis. This paper describes key aspects of migration and health in Europe, including the scale of international migration, available data for migrant health, barriers to accessing health services, ways of improving health service provision to migrants, and migrant health policies that have been adopted across Europe. Improvement of migrant health and provision of access for migrants to appropriate health services is not without challenges, but knowledge about what steps need to be taken to achieve these aims is increasing.

Introduction

Europe needs migrants to make up for its shrinking birth rate but it seems increasingly unwilling to welcome them. This attitude was all too apparent from the way in which the flight of migrants from the upheaval in north Africa in spring, 2011, led to the reinstatement of national passport controls in the European Union (EU)

and political wrangling over so-called burden-sharing schemes.¹ Although accounting for only a small share of migrants to Europe and taking place at a particular moment of time, these reactions illustrate the politically loaded nature of migration. Indeed, since the 1990s, many European countries have witnessed political backlash over immigration, with a particularly hostile reception for asylum-seekers and a rise in anti-Muslim rhetoric. Anti-immigrant parties have made electoral gains in several countries, while France made headlines by establishing a Ministry of Immigration, Integration, National Identity and Codevelopment of France and deporting Roma originating from central and eastern Europe.² Worryingly, the deaths of migrants trying to reach Europe every year, reaching about 2000 in 2011,³ do not make headlines any more.

These attitudes contrast with the continued need for immigration, resulting from falling birth rates and ageing populations in many European societies. Although demand exists for migrant labour in many sectors, the health and social sectors are especially prominent, with migrants needed to fill both low-skilled jobs, such as those providing basic domestic care for sick and elderly people,⁴ and high-skilled positions. A shortage of about 1 million health workers in the EU is expected by 2020.⁵ This figure emphasises the crucial contributions that migrants make to the functioning of both health and

Key messages

- Migrants make up a growing share of European populations, but immigration is politically controversial and the need for continued immigration to Europe is still poorly recognised.
- Although some exceptions exist, most health information systems in Europe still have a long way to go to improve data collection for the health differences between migrants and non-migrants. Improvements in this respect will be crucial to assess health disparities and improve equity of service provision.
- Although migrants are often, at least initially, relatively healthy compared with the non-migrant population in the host country, available data suggest that they tend to be more vulnerable to certain communicable diseases, occupational health hazards, injuries, poor mental health, diabetes mellitus, and maternal and child health problems. Some groups might be at particular risk of non-communicable diseases arising from obesity and insufficient physical activity.
- Undocumented migrants face the greatest problems in accessing health services and are expected to cover the full costs of their medical treatment in many European countries.
- Legal entitlements need to be expanded, but health systems also need to become more migrant-friendly in other ways—eg, through overcoming language and cultural barriers, improving the competencies of health workers and organisations, and increasing the health literacy of migrants.
- We argue that explicit migrant health policies are needed in all European countries with a substantial proportion of migrants in their population.

Search strategy and selection criteria

This paper synthesises and updates findings from our study on Migration and Health in the European Union, which was undertaken by the European Observatory on Health Systems and Policies, the International Organization for Migration, and the European Public Health Association Section on Migrant and Ethnic Minority Health, in 2010–11. The study, reported elsewhere,³¹ brought together the latest available evidence for key aspects of health and migration in the European Union through a series of comprehensive literature reviews. Search strategies differed according to topic area, and included databases such as Medline, PubMed, and Google Scholar. For this article, we updated these findings and extended the geographical scope to the rest of Europe (covering the whole WHO European region, including the Commonwealth of Independent States), although we stress that information on migrant health in these countries is scarce.

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European Observatory on Health Systems and Policies (B Rechel PhD, Prof M McKee MD), and European Centre on Health of Societies in Transition (B Rechel, Prof M McKee), London School of Hygiene & Tropical Medicine, London, UK; European Observatory on Health Systems and Policies, London School of Economics and Political Science, London, UK (P Mladovsky MSc); Centre for Social Science and Global Health, University of Amsterdam, Amsterdam, Netherlands (Prof D Ingleby PhD); and Department of Public Health, Erasmus MC, University Medical Center Rotterdam, Rotterdam, Netherlands (J P Mackenbach PhD)

Correspondence to: Dr Bernd Rechel, London School of Hygiene & Tropical Medicine, 15–17 Tavistock Place, London WC1H 9SH, UK bernd.rechel@lshtm.ac.uk

long-term care systems in Europe—a fact that is often forgotten in misguided discussions about the perceived burden of migrants on European welfare systems.

Trends in international migration involving Europe

An international long-term migrant is defined by the UN 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”.⁶ Europe, a source of emigrants to the USA, Canada, Australia, and other parts of the world in the 19th and first half of the 20th century, is now a net recipient of migrants. In 2010, an estimated 72·6 million migrants lived in the WHO European region, 5·1 million more than in 2005.⁷ This represented one in three of all international migrants worldwide, with migrants constituting 8·7% of the total European population.⁷ Increases in net migration between 2005 and 2010 were witnessed in most western and central European countries, with the

largest increases in Cyprus, Luxembourg, Spain, Iceland, and Ireland.⁷ However, these data are based on estimates that did not take into account the effect of the global economic crisis that started in 2007–08, which is likely to have reduced the rate of migration to Europe.

Two-thirds of all migrants in the EU come from other EU countries,⁸ whereas most migrants to Russia originate in the other former Soviet countries.⁷ Notably, many western European countries that have intense political debates around immigration (such as the Netherlands or Denmark) do not have the highest numbers of migrants as a proportion of their population (table⁹).

Within the countries of the EU, migrants from outside the EU (so-called third-country nationals) face particular challenges, with the highest rates of unemployment and the greatest rates of job loss associated with the global economic crisis.^{7,10} The situation of irregular migrants (ie, people who do not comply with national regulations of entry, stay, or employment) is particularly precarious, because they tend to be excluded from social and health services while often being exposed to high-risk working and living environments. Estimates inevitably vary, but the Institute of International Economics suggests that irregular migrants constitute 0·4–0·8% of the total EU population.¹¹ Victims of trafficking are another very vulnerable group. In Russia alone, an estimated 20 000–60 000 women are believed to become victims of trafficking each year.¹²

Data for the health of migrants

Information about the health of migrants in Europe is patchy,^{13,14} which makes it difficult to monitor and improve migrant health.^{15,16} Some of the greatest gaps in knowledge are in the former Soviet countries of the Commonwealth of Independent States. Health information systems in most European countries are generally not designed to identify people by migration status and the information collected in medical files rarely includes such information.¹⁷ The main exception, in many EU countries, are death registers, which often include indicators of migration. A study¹⁸ of the availability of large-scale epidemiological data for cardiovascular diseases and diabetes mellitus among migrants and ethnic minorities in the EU showed that national death registers that allowed for disaggregation according to migrant status were available in 24 countries. Country of birth was used as an indicator in 15 countries, citizenship in eight countries, and nationality in seven countries (some countries used more than one indicator).¹⁸ In 2008–09, registry data for health-care use that allowed for identification of migrants at national or regional level were only available in 11 of the 27 EU Member States: Austria, Belgium, Denmark, Finland, Greece, Italy, Luxembourg, the Netherlands, Poland, Slovenia, and Sweden.¹⁹ Several European countries, including Denmark, the Netherlands, Sweden, and the UK, have done surveys

	1990	1995	2000	2005	2010
Monaco	68·6%	68·2%	68·0%	69·8%	71·6%
Andorra	73·7%	68·3%	63·5%	63·1%	64·4%
Israel	36·2%	35·7%	37·1%	39·8%	40·4%
Luxembourg	29·8%	31·1%	32·2%	33·7%	35·2%
Liechtenstein	37·6%	38·5%	34·1%	34·2%	34·6%
Switzerland	20·5%	20·9%	21·8%	22·3%	23·2%
Ireland	6·5%	7·3%	10·1%	14·8%	19·6%
Kazakhstan	21·9%	20·7%	19·2%	19·6%	19·5%
Cyprus	6·4%	7·5%	10·2%	13·9%	17·5%
Croatia	10·5%	15·4%	13·7%	14·9%	15·9%
Austria	10·3%	12·5%	12·5%	14·0%	15·6%
Latvia	24·3%	21·2%	18·1%	16·6%	15·0%
Spain	2·1%	2·6%	4·4%	10·7%	14·1%
Sweden	9·1%	10·3%	11·2%	12·3%	14·1%
Estonia	24·4%	21·4%	18·2%	15·0%	13·6%
Germany	7·5%	11·0%	12·2%	12·9%	13·1%
Ukraine	13·4%	12·1%	11·3%	11·5%	11·6%
Belarus	12·2%	11·5%	11·2%	11·3%	11·4%
Moldova	13·3%	10·9%	11·6%	11·7%	11·4%
Iceland	3·8%	4·0%	5·7%	7·6%	11·3%
France	10·4%	10·5%	10·6%	10·6%	10·7%
Armenia	18·6%	21·1%	18·7%	16·1%	10·5%
Netherlands	8·0%	9·0%	10·0%	10·6%	10·5%
UK	6·5%	7·2%	8·1%	9·7%	10·4%
Greece	4·1%	5·1%	6·7%	8·8%	10·1%
Norway	4·6%	5·4%	6·7%	8·0%	10·0%
Belgium	9·0%	9·1%	8·6%	8·5%	9·1%
Denmark	4·6%	5·7%	7·0%	7·8%	8·8%
Russia	7·8%	7·9%	8·1%	8·4%	8·7%
Portugal	4·4%	5·3%	6·2%	7·2%	8·6%
Slovenia	9·2%	10·2%	8·8%	8·4%	8·1%
Italy	2·5%	3·0%	3·7%	5·2%	7·4%
Macedonia	5·0%	5·8%	6·2%	5·9%	6·3%

(Continues on next page)

that contain information about the health of migrants,^{20,21} but much of this information is now out of date.¹⁶ More comparative data across countries is collected through EU-wide surveys, but these have several limitations, with the Survey of Health, Ageing and Retirement in Europe being confined to the population older than 50 years and having small samples of migrants, and the EU Statistics on Income and Living Conditions largely relying on subjective indicators of health, on the basis of self-reporting. The EU has funded several projects designed to improve data collection for migrant health within the EU, but substantial scope exists for enhancement of migrant health research, including increased collaboration at the European level to develop consensus for data collection.¹⁶

Difficulties in gathering information about migrant health include conceptual and methodological challenges, such as different definitions or understandings of who constitutes a migrant.^{16,20,22} Political sensibilities also exist, particularly around collection of ethnic origin data that can be useful to understand health issues affecting the descendants of migrants. For example, in France, in line with the principle of the indivisibility of the republic, routine data collection systems such as the national census only refer to nationality and country of birth and do not ask any questions about ethnic origin or religion.¹⁰ In Germany, no ethnic data are collected officially,²³ partly because of concerns that such data might evoke memories of the categorisations used under National Socialism and could be misused to incite racism and discrimination. An alternative, as used in the Netherlands, is to collect data for the place of birth of parents and grandparents.

The heterogeneity and small size of migrant communities is another challenge, because over-sampling is often required in surveys or clinical studies to yield statistically relevant information, as was done in some waves of the Health Survey for England, for example.²⁴ Access to some populations, such as undocumented migrants, is an additional obstacle.²⁰

Health disparities

Most studies of migrant health focus on differences with the non-migrant population in the respective host countries. Migrants are often (at least initially) more healthy than non-migrant populations in their host countries (the so-called healthy migrant effect), not least because the act of migration usually requires those involved to be in good health. However, migrants do face particular health challenges, although some only become apparent after a lag period.

Where data for migrant health are available, as in several western European countries, they often point in contradictory directions, because of the diversity of migrants in terms of age, sex, country of origin and destination, socioeconomic status, and type of migration (panel 1).²⁵

	1990	1995	2000	2005	2010
(Continued from previous page)					
Czech Republic	4.1%	4.4%	4.4%	4.4%	4.4%
Finland	1.3%	2.0%	2.6%	3.3%	4.2%
Uzbekistan	8.1%	6.4%	5.5%	4.8%	4.2%
Georgia	6.2%	4.9%	4.6%	4.3%	4.0%
Kyrgyzstan	14.2%	10.5%	7.5%	5.5%	4.0%
Lithuania	9.4%	7.5%	6.1%	4.8%	4.0%
Tajikistan	8.0%	5.3%	5.4%	4.7%	4.0%
Turkmenistan	8.4%	6.2%	5.4%	4.6%	4.0%
Malta	1.6%	1.9%	2.3%	2.9%	3.8%
Hungary	3.4%	2.8%	2.9%	3.3%	3.7%
Azerbaijan	5.0%	6.7%	4.3%	3.0%	3.0%
Albania	2.0%	2.3%	2.5%	2.7%	2.8%
Slovakia	0.8%	2.1%	2.2%	2.3%	2.4%
Poland	3.0%	2.5%	2.1%	2.2%	2.2%
Turkey	2.1%	2.0%	1.9%	1.9%	1.9%
Bulgaria	0.2%	0.6%	1.3%	1.3%	1.4%
Bosnia and Herzegovina	1.3%	2.2%	2.6%	0.9%	0.7%
Romania	0.6%	0.6%	0.6%	0.6%	0.6%

Sorted by proportion of migrants in 2010. The estimates for 2010 do not yet take account of the effect of the global economic crisis and are thus likely to overestimate the extent of international migration to Europe. No data are available for Montenegro, San Marino, and Serbia.

Table: International migrants as a percentage of the population in Europe, 1990–2010^a

Panel 1: Different categories of migrants

The broad term migrant masks the substantial differences that exist in the overall situation and health needs of different migrant groups. At risk of over-simplification, several different categories can be distinguished: asylum-seekers and refugees, victims of trafficking, students, migrant workers, and reunified family members. Of particular importance is whether migrants live and work legally in their host country or whether they live in a situation of irregularity. The situation is further complicated through short-term, circular, and return migration. In view of the vast diversity of socioeconomic and living conditions throughout the WHO European region, the health of migrants also depends to a large degree on the specifics of the host country. While recognising these differences, problems in accessing health services seem to be generally greatest for undocumented migrants and asylum-seekers.

Furthermore, many health discrepancies between migrants and non-migrants disappear after controlling for socioeconomic status,²⁶ though poor socioeconomic status might itself be a result of migrant status and ethnic origin, because of processes of social exclusion.^{20,27,28} Although much of the published work about upstream determinants of health has focused on socioeconomic factors, largely ignoring the role of migration,²⁹ there is beginning to be some recognition that migration itself can be a social determinant of health.³⁰

To the extent that available information across countries and migrant groups allows generalisations, most migrants seek help for so-called common-or-garden²⁰ complaints that are also common among the non-migrant population. However, some noticeable

differences exist between migrants and non-migrants. Migrants seem to be more vulnerable to diabetes, certain communicable diseases, maternal and child health problems, occupational health hazards, injuries, and poor mental health.³¹ These differences can be explained to some extent by risk factors and patterns of disease in their countries of origin (which can include a higher prevalence of communicable diseases), poor living conditions in their new host countries, precarious and dangerous work, and the psychological stresses that can be associated with various causes and processes of migration.³²

In 17 of 28 countries in the WHO European region for which surveillance data include information about the origin of individuals with active tuberculosis, the percentage of all cases that were in people of foreign origin in 2008 was more than 20%.³³ Furthermore, 43% of all heterosexually transmitted HIV infections reported in western Europe in 2006 occurred among migrants from high-prevalence countries.³⁴ However, exposure to both HIV and tuberculosis can result from the migration process itself, and in the countries of destination. This situation has, for example, been described for labour migrants from central Asia in other former Soviet countries, particularly Russia.³⁵ Studies in several western European countries also showed higher prevalence of chronic hepatitis B virus infection among migrants than in the non-migrant population.³⁶

The occupational health of migrants also tends to be worse than that of non-migrants,³⁷ because they tend to be over-represented in low-qualified, temporary, and high-risk jobs,³⁸ with resulting higher rates of occupational injuries,³⁹⁻⁴¹ and sickness presenteeism (the tendency to carry on working despite being ill).⁴² Occupational health is a particular challenge for labour migrants working in irregular employment, such as the many migrants from central Asia working on construction sites in Russia (panel 2^{43,44}).

Although the evidence for mental health problems among migrants in general is mixed,⁴⁵ refugees, asylum-seekers, and undocumented migrants tend to be more exposed to risk factors for mental health (including

exposure to violence in their countries of origin and stress during migration and after arrival in the host countries).⁴⁶ Some studies also suggest that migration might be a risk factor for schizophrenia.⁴⁷

With regard to non-communicable diseases, migrants to Europe seem to have initially lower incidence and mortality rates for cancer than do non-migrant populations, although prevalence rates tend to converge over time.⁴⁸⁻⁵⁴ However, some groups of migrants have much higher rates of cancers related to infectious diseases, such as stomach cancer, nasopharyngeal cancer, hepatic cancer, Kaposi's sarcoma, cervical cancer, and some lymphomas.⁵⁴

Large variations exist in cardiovascular disease between different migrant groups.⁴⁸ Mortality rates and incidence for stroke are high among migrants of African origin, which could be attributable to higher rates of hypertension and diabetes; however, coronary heart disease is less common than among native European populations.⁵⁵ As a result of variable and often lower rates of cardiovascular disease and cancer, migrants often do not have higher all-cause mortality rates than the non-migrant population in their host countries.^{56,57} Generally, much higher incidence, prevalence, and mortality rates have been recorded among migrants for diabetes, which has been attributed to a combination of genetic factors, changing environments, and insufficient medical control.^{48,58-60}

Lifestyle factors such as obesity are a particular concern, because migrants from low-income countries tend to abandon their traditional dietary habits and adopt a westernised, energy-rich diet and more sedentary lifestyle. A systematic review, identifying studies from six western European countries, showed that in most countries for which data were available, overweight and obesity were more common among migrant than among non-migrant children.⁶¹ Another study showed that higher levels of obesity were recorded among Turkish and Moroccan migrant groups than in the resident populations in several European countries.⁶²

Migrants in Europe have also been shown to be at higher risk of maternal and child health problems than non-migrant populations,⁶³ with higher perinatal and infant mortality rates,⁶⁴ which are partly attributable to higher rates of preterm birth.^{65,66} However, availability of data for these issues is poor. Some of the few European countries that have collected information about perinatal health outcomes among irregular migrants and refugees (Ireland, the Netherlands, Norway, and Sweden) have shown these migrant groups to be at particularly high risk.⁶⁴ In Germany, migrant women were shown to be at higher risk of severe illness bringing them close to death (near-miss).⁶⁷ Some evidence suggests that both use and quality of antenatal care is lower among migrant women. In several European countries, foreign-born single women and women from eastern Europe and Mediterranean countries have been shown to be at

Panel 2: Labour migration to Russia

Annually, about 1.5 million labour migrants move to work in Russia, driven by the country's economic growth and a declining and ageing population. Most labour migrants are citizens from other former Soviet countries (in particular the poorer central Asian states Kyrgyzstan, Tajikistan, and Uzbekistan) who do not need a visa to enter the country. Partly because of complex bureaucratic procedures, up to 80% of them do not have formal contracts, but instead reside and work in conditions of irregularity. Most are men and work in construction, trade, and services.⁴³ Working and living conditions are often very hazardous, access to health services is poor, and anti-migrant feelings are fuelled by individuals in state agencies and the media. In November, 2011, Russia's chief public health official even called for a ban on migrants from Tajikistan, whom he held responsible for the spread of tuberculosis and HIV/AIDS.⁴⁴

greatest risk of inadequate use of antenatal services.^{68,69} The quality of antenatal care to migrant women is also a concern.^{66,70}

Whom to compare migrants with?

Most studies of migrant health, including most of those mentioned previously, focus on disparities with the non-migrant population in the respective host countries, providing insights into differences in exposures and access to health services. However, this approach ignores how different factors affect migrants' health at different stages of their lives, preceding, accompanying, and after the migration process.⁷¹ By contrast, a life course approach acknowledges the strong temporal component in migrant health, and aims to unravel the effect of the period before migration (including the factors leading to migration), the migration process, and the period after migration, each with individual, environmental, and contextual exposures.⁷² Some migrants undergo a fourth stage, resettlement in the country of origin.⁷³

Comparisons between migrants and the population in their country of origin can provide insights into the immediate and long-term health effects of migration and how the risk of disease is determined by exposures in early or later life. Migrants moving from a low-income to a high-income country often move from a society in an earlier phase of health transition to one in a more advanced phase, with a declining risk of communicable diseases (attributable to improved hygiene, environmental conditions, and health services), but an increasing risk for chronic diseases associated with the adoption of unhealthy lifestyles.⁷² A comparison of Ghanaian migrants in the Netherlands with their counterparts in urban and rural Ghana, for example, showed a significantly higher prevalence of overweight and obesity among those in the Netherlands, and among the urban as compared with the rural Ghanaians.⁷⁴ Similarly, a study comparing Gujaratis in Britain with their counterparts in rural India showed that fat intake and obesity were higher among those who had moved to Britain,⁷⁵ while a comparison of Punjabi women living in India with Punjabi migrants in Austria showed a higher prevalence of overweight and obesity in migrants in Austria.⁷⁶ A meta-analysis of populations of the South Asian diaspora confirmed that body-mass index almost always increased among those who had migrated, because of different diets and activity levels.⁷⁷

Comparisons between migrant groups from the same country of origin moving to different host countries provide insights into the effect of factors specific to countries of destination.⁷² A comparison of mortality from cardiovascular disease in several European countries (Denmark, England and Wales, France, the Netherlands, Scotland, and Sweden) identified major differences across both migrant groups and host populations (figure⁷⁸). Although mortality was high for migrants from

India in several host countries (England and Wales, Scotland, and Sweden), migrants from other countries (China, Pakistan, Poland, Turkey, and former Yugoslavia) displayed substantial differences between countries of destination, with particularly low rates of mortality from cardiovascular disease among those who had migrated to France. This finding shows the importance of factors that are indicative of the local context.⁷⁸

Barriers to access to health services

One of the most fundamental barriers for migrants in accessing health services in Europe are inadequate legal entitlements and, where entitlements exist, mechanisms for ensuring that they are well known and respected in practice.⁷⁹ The basic human right of access to health services has been enshrined in numerous international and European legal instruments, applicable to varying degrees to all countries in Europe. The 1946 WHO constitution first enunciated the right to health,⁸⁰ and Article 12 of the International Covenant on Economic, Social and Cultural Rights sets out "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".⁸¹ This right has also been recognised by the European Convention for the Protection of Human Rights and Fundamental Freedoms of the Council of Europe and the European Social Charter, adopted in 1961, and revised in 1996. In the EU, the Charter of Fundamental Rights sets out the right of everyone to access preventive health care and to benefit from medical treatment.⁸²

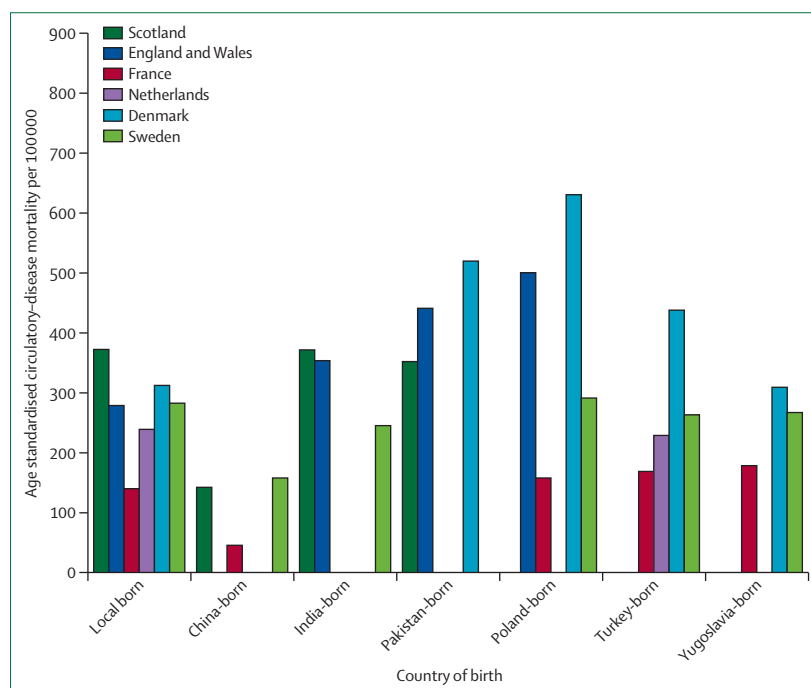


Figure: Total circulatory disease mortality among men aged 34–75 years, by country of birth and country of residence, in six European countries
Adapted from Bhopal and colleagues.⁷⁸

However, much still needs to be done to implement this human right in practice.⁸³ The problems are greatest for asylum-seekers and undocumented migrants.^{84,85} 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.⁸⁶ However, in far too many EU Member States, these minimum standards are still not met. A study of 16 EU countries in 2008–11 showed that two countries (Romania and Slovenia) still requested that asylum-seekers cover the full cost of secondary and hospital care and most drugs (appendix). Huge differences exist within the EU and across the rest of Europe in national asylum policy regimes and how easily countries grant long-term residency status and citizenship, with consequences for access to health and other social services.

See Online for appendix

With regard to undocumented migrants, many countries in Europe restrict entitlements to health services in the belief that this will discourage the entry of new migrants.^{87,88} However, great diversity in entitlements exists. Some countries in southern Europe that have seen major immigration during the past two decades, such as Italy or Portugal, offer better coverage for undocumented migrants than do more wealthy countries in central and northern Europe with longer immigration histories, such as Germany, Sweden, and the UK.⁸² In 2010, emergency care was effectively inaccessible to undocumented migrants in nine of the 27 EU countries and access to health services beyond emergency care (eg,

primary and secondary care) was offered to undocumented migrants in only five EU Member States (the Netherlands, France, Italy, Portugal, and Spain). However, the Spanish central government decided in April, 2012, to substantially reduce entitlements for undocumented migrants (panel 3^{89,90}). Many countries in Europe charge undocumented migrants the full costs of their medical treatment (appendix).

Apart from restricted legal entitlements to health services, migrants might also be particularly affected by user fees,¹⁹ and might find access to health insurance difficult because of administrative obstacles. Language barriers are one of the greatest problems undermining both the accessibility of health services for migrants and their quality. Other barriers include unfamiliarity with rights, entitlements, and the overall health system, gaps in health literacy, social exclusion, and direct and indirect discrimination.^{31,91}

Where available, utilisation rates provide some indication of where migrants might face barriers to accessing services, although information about health needs is necessary to interpret these data. Two systematic reviews^{92,93} of migrants' use of health services in Europe showed that, compared with non-migrants, migrants tend to make less use of mammography and cervical cancer screening, have more contacts with general practitioners, the same or higher use of specialist care, and higher, equal, or lower levels of use of emergency care.

Improvement of health service provision

Migrants should not be unduly disadvantaged in access to health services compared with the rest of the population. Although many of the broader determinants of health lie outside the narrow confines of health systems, they have an important part to play in making health services more accessible to migrants.⁹⁴ One way of doing so is to provide migrants with information about health and the health system of their host country in their own language. Another is to address language barriers in service delivery. Measures to overcome these barriers include the use of easily accessible and free professional interpreting services and the training of health workers in using them (panel 4^{91,95}).

Health systems should also aim to improve the health literacy of migrants through targeted health promotion interventions that take account of the different ways in which people perceive and experience health problems (eg, obesity might be regarded as a sign of social success by some but as personal weakness by others).⁹⁶ Mechanisms need to be in place to ensure non-discrimination in health service provision and to provide migrants with help to meet administrative requirements. One promising approach to address cultural differences is the development of so-called cultural competence among health workers. Ideally, this development should start in undergraduate education and be part of the in-service training of practitioners. Health managers and service

Panel 3: Migrant health policies in Spain

For some time, Spain was at the forefront of migrant health policies in Europe. Following on from the Portuguese presidency of the European Council in 2007 (in which migrant health was a major theme), Spain emphasised migration and health in a broader framework of health inequalities during its European Union presidency in the first half of 2010. The Council's conclusions on "Equity and Health in All Policies: Solidarity in Health",⁸⁹ adopted in June, 2010, expressed concern about health inequalities in Europe, including with regard to migrants. In March, 2010, Spain also hosted a global consultation on migrant health, convened by WHO and the International Organization for Migration.

In Spain itself, the position of migrants improved through several regularisation programmes, covering about 1.5 million undocumented migrants between 1986 and 2010. Spain's public coverage of health services to undocumented migrants was one of the widest in Europe, almost reaching universal access to health care.⁹⁰ This situation changed in September, 2012, when a new health law entered into force that limited public coverage for undocumented migrants to emergency care, pregnancies, or births. In Spain's highly decentralised health system some regions, such as Madrid, have started to turn away undocumented migrants, but others, such as Catalonia and Andalusia, have defied orders from the central government and continue to provide free primary health care to undocumented migrants. Spain has been one of the European countries worst hit by the economic crisis, but commentators have pointed out that savings that might be made by reducing public coverage to undocumented migrants in the short term are likely to be outweighed by higher costs in the long term, as untreated health problems and absence of prevention result in increased use of more expensive emergency services.

providers need to invest time and organisational resources in the provision of health care to migrants. Importantly, the concept of cultural competence has to go beyond individual health workers and encompass whole organisations, which need to commit to dealing with diversity.⁹⁴

A perennial issue in dealing with the needs of diverse populations is whether provisions should be separate or integrated into mainstream services.⁹⁷ The greater the diversity of the local community, the more impetus there will be to implement change in mainstream services. However, systematic changes have proved very hard to achieve in Europe, even in the rare cases in which governments have taken measures to embed them in national policy. In either case, the involvement of local communities seems to be very important for reducing barriers between health services and their migrant users.⁹⁸

Little evidence has so far been collected for the effectiveness of interventions to improve health service provision to migrants. Of hundreds of interventions designed to increase cultural competence, for example, very few have been assessed.⁹⁹ Part of the problem is the absence of priority assigned by funding agencies to research into improvement of health service provision to migrants.²⁰

Research into migrant health policies in Europe is still at an early stage and the focus has been mostly on EU Member States. In a study of 25 European countries (almost all inside the EU), only 11 were shown to have adopted specific policies for migrant health at the national level.¹⁰⁰ Furthermore, substantial variation exists in these policies as to which population groups are targeted, which health issues are addressed, whether providers or patients are the focus of interventions, and whether policies are actually being implemented, without any indication that these differences are indicative of evidence of varying needs of migrants across Europe.⁸⁷ This variation suggests that a more coherent approach to policy making is required.

A call for action

Although this paper provides a broad overview of migrant health in Europe, it is important to recognise that there are huge gaps in available knowledge. Many countries do not collect registry or survey data for migrants and much of the migrant health research that is available has been done in only a few western European countries, such as England or the Netherlands.¹⁰¹ Research into migrant-related policies and entitlements for migrants has also been focused on western Europe or EU Member States. Consequently, the health problems migrants face in other European countries, such as those in the Commonwealth of Independent States, largely escape the attention of researchers and policy makers.

Furthermore, countries that do collect data use different variables as a proxy for migration status (eg,

Panel 4: Overcoming language barriers in the provision of health services to migrants

Various methods for overcoming language barriers have been identified:⁹¹

- Professional face-to-face interpretation is the most accurate method, but has many drawbacks, such as organisational requirements, training, and costs.
- Professional interpretation by telephone can offer much the same services at lower cost, but is associated with a loss of information associated with face-to-face interactions. However, video links are increasingly used to provide visual information.
- Informal face-to-face interpretation is perhaps the most widely used method, and at the same time the most widely criticised.⁹⁵
- Bilingual professionals with a command of the migrant's language can fill gaps left by the scarcity of professional interpreters.
- Cultural mediators are health workers who not only provide linguistic interpretation, but also mediate between health professionals and service users.

country of birth, self-reported ethnic origin, nationality), so that data often cannot be compared between countries.^{18,20} Also, available data often refer to health status only and do not cover the broader social determinants of health.¹⁰¹ Measures that would improve the availability of data include the standardisation of data categories and definitions across Europe, and inclusion of questions about migration in existing data collection processes, such as censuses, national statistics, and health surveys, and in the collection of routine health information.^{17,101}

Several good reasons suggest why migrant health should move higher up the political agenda in Europe. The first is that migrants, like everyone else, have a right to the highest attainable standards of physical and mental health. Yet even those rights enshrined in international conventions all too often remain confined to paper, because commitment to implementation is weak. A major step forward would be to strengthen the legislative basis for protection of the rights of the most vulnerable migrants (undocumented migrants and asylum-seekers) at the national level and to ensure implementation.

The contribution of health to social wellbeing and economic development is increasingly being recognised.^{102,103} Rather than being a drain on welfare systems, migrants make substantial contributions, including economic ones, to both their host societies and, by sending money to relatives at home, to their countries of origin. Remittances typically far exceed official development assistance,^{104,105} accounting for up to 50% of gross domestic product in Tajikistan, placing this country first worldwide in the economic importance of migrant remittances.⁷ Improvement of the health of migrants will therefore bring wider benefits to the socioeconomic development of both countries of origin and destination.

Finally, equity in health service provision and health outcomes is a major contemporary concern facing health systems throughout Europe and reduction of inequities is now recognised as a core dimension of health system performance.¹⁰⁶ By addressing the health inequities faced by many migrants, health systems in Europe can become

more inclusive, which will benefit not only migrants and other vulnerable or excluded population groups, but also society as a whole.

However, making health systems more responsive to migrants will require attention to several key issues. One challenge is the great diversity that exists across and within different groups of migrants, making generalisations very difficult. Migrants do not form a homogeneous population, but exhibit major variations according to religion, culture, language, ethnic origin, and country of origin and destination. Furthermore, a correlation exists between migration background and lower socioeconomic status, which can make it difficult to identify which of the two factors is dominant in explaining their disadvantage, although migration in itself is increasingly recognised as an important independent social determinant of health.²⁷ Interventions addressing migrant health need to be tailored to the needs of individual migrant groups, taking account of country of origin, legal and residence status, and specific economic and sociodemographic risk factors.

Another challenge is the politically charged nature of migration. In recent years, and exacerbated by the economic crisis, Europe has witnessed a backlash against immigration. This political context makes it difficult to strengthen the position of migrants. Increasing resource constraints will oblige interventions for migrants to show their cost-effectiveness more than ever before.

All European countries with substantial percentages of migrants in their population should consider adopting specific migrant health policies. There seems to be huge potential for cross-country exchanges and learning in Europe about how to develop migrant health policies, in particular in some of the former Soviet countries.^{86,107,108} However, the adoption of national or subnational migrant health policies is not simply one-way traffic. Policy aberrations and reversals are not unusual, as we highlighted with regard to Spain. In the Netherlands too, progressive migrant health policies—and broader policies of multiculturalism—have been undermined or even reversed by political parties reliant on anti-immigration sentiments.⁸⁶ This example serves as a reminder of the need to address the broader political and societal context when researching migrant health, because asylum, residency, and citizenship policies and models of migrant incorporation differ widely across Europe and change over time.¹⁰⁹ There is also complexity within countries, because hostile policies in one area of migrant health can be accompanied by progressive policies in another; the Netherlands is again an example, having established far-reaching entitlements to health services for undocumented migrants in 2009, in a context of otherwise largely regressive migrant health policy reforms,⁸⁶ showing the substantial challenges of improving health service provision to migrants.

International and European organisations, such as the International Organization for Migration, WHO, the

Council of Europe, or the Council of the European Union, can also play a crucial part but they need to muster the necessary political commitment and engagement to do so. Although there have been several attempts to put migrant health on the European political agenda, including the programmes of the Portuguese and Spanish presidencies of the Council of the European Union,¹¹⁰ these did not result in widespread changes in national policies or regulations. Worryingly, in the present context of economic crisis and budgetary constraints, there is a risk that what is left of the momentum will be lost entirely. However, there are also signs of hope. Many initiatives for improvement of health service provision to migrants in Europe, particularly for undocumented migrants and asylum-seekers, have emerged not in a top-down manner, but have built on the efforts of concerned health workers and non-governmental organisations. They are clearly important actors in the struggle to ensure that migrant health remains on the agenda.

Contributors

The authors jointly conceived the structure for the paper. BR wrote the first draft, which the other authors subsequently revised. All authors have seen and approved the final paper.

Conflicts of interest

We declare that we have no conflicts of interest.

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