

European Research on Migration and Health

International Organization for Migration (IOM)

Background Paper

*Developed within the framework of the IOM project
“Assisting Migrants and Communities (AMAC): Analysis of
Social Determinants of Health and Health Inequalities”
Co-funded by the European Commission DG Health and Consumers’ Health Programme,
the Office of the Portuguese High Commissioner for Health and IOM*



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Executive Summary

This paper reviews the different kinds of research that are required in order to identify, analyse and remedy problems in the field of migrant health. It is divided into five sections (A-E).

Section A explains why research in this field is so important. International migration has increased steadily and health is an important factor affecting the well-being and successful integration of migrants. Conversely, migrants' health suffers when the transition to a new society is problematic or unsuccessful. A sound knowledge base is crucial for developing enlightened and effective policies and practices in this area.

Section B describes the different topics that need to be investigated, explaining the specific importance of each of them. These are as follows:

1. Background information on migrants and their situation: demographic characteristics and the social, historical, political and legal situation of (different groups of) migrants.
2. Migrants' state of health: particular areas of vulnerability and increased risk, as well as strengths.
3. The entitlement of different categories of migrants to health care: gaps in coverage, discrepancies between policies and their implementation.
4. Accessibility of health services: linguistic and cultural barriers, methods for reaching migrant populations more effectively.
5. Quality of health services (prevention, health promotion and care): identifying problems and evaluating solutions.
6. Measures for achieving change: monitoring interventions of different types and at different levels. What are the levers for change?

Section C examines which agencies carry out research on each of these topics, what methods they use and what difficulties they encounter.

1. The collection of background information on migrants and their social situation is the task of national, local and municipal authorities, as well as researchers in the field of 'migration studies'. In itself it is not health research, but it is an essential foundation for health research. Researchers may encounter both practical and political objections and obstacles to the collection of such data.
2. Migrants' state of health can be monitored and analysed using data from clinical or population-based samples. Here too, however, there are barriers to data collection.

3. Migrants' entitlement to health care can be surveyed on the basis of official policies, but implementation is sometimes at variance with these. Migrants may not know their rights; some health workers may ignore these rights, while others may turn a blind eye to restrictions on care.
4. Accessibility can be analysed using quantitative data on health service utilisation, but qualitative studies are indispensable for the interpretation of these data. Such research investigates migrants' experiences of health care, the cultural and linguistic barriers they may encounter, as well as conflicting expectations and ideas about health and health care.
5. Investigating the quality and effectiveness of services involves similar issues and methods. There is a serious shortage of studies examining the effectiveness of different treatment methodologies for migrant patients: so much so that it is doubtful to what extent 'evidence-based' health care for migrants exists at present. 'Good practices' are far too seldom evaluated.
6. The study of policy development and levers to change is in its infancy.

Section D argues that international collaboration is essential, particularly within Europe, to make progress on all these fronts. Since 2000, collaborative efforts have multiplied, and the European Union (EU), Council of Europe (CoE), International Organization for Migration (IOM) and the World Health Organization (WHO) have all promoted the topic of migrant health.

Finally, in Section E some important gaps in existing knowledge are identified and the current lack of coordination of research efforts is criticised. It is argued that the establishment of a single European agency to oversee activities in this area – a 'European Migrant Health Observatory' – would go a long way to furthering a more effective research effort in this field.

A. Why is research on migrant health important?

In many parts of the world, particularly in Europe, an increased rate of immigration is confronting host societies with challenges and opportunities – the most familiar being in the labour and housing markets, inter-ethnic relations and the educational system. Until recently, much less attention has been paid to the consequences of migration for the health system, but this omission is hard to justify. Health is an extremely important factor in the lives of migrants¹ and their families. To begin with, it is closely linked with *integration*:

Migrants who are burdened or handicapped by health problems are hampered in the task of integration. [...] Illness exacerbates marginalisation and marginalisation exacerbates illness, creating a downward spiral.

At the same time, integration is a prerequisite for effective health care delivery, which is often impeded by inadequate access. Access to effective health care should be seen as no less important than housing and education for the well-being, and thus the integration, of migrants.

(Ingleby et al., 2005, p. 1)

Access to good quality health care is an important aspect of the social inclusion or exclusion of migrants. Existing service provisions are the outcome of a long process of adaptation to the needs of the majority native population: it is only to be expected that they often fail to meet the needs of other groups (Watters, 2002). Most concern with migrant health therefore focuses on the topic of care provision.

However, health is not only determined by the quality of health care – far from it, in fact; most experts regard the environmental factors that influence health as even more important. As the slogan “health in all policies” implies (Stahl et al., 2006), almost all aspects of social life can have an impact on the health of citizens. Poverty and marginalisation are factors which often affect migrants to a disproportionate extent, and in the WHO report on the Social Determinants of Health (CSDH, 2008), particular attention is devoted to the health risks of migrants. Not only poverty, but also bad housing, discrimination and work-related health risks can have a serious negative impact on the health of migrants.

In present-day Europe we can observe increasing efforts to improve the health of migrants and ensure that they have good access to appropriate care. The level of effort in a given country or region is related to the proportion of migrants in the local population, as well as to prevailing attitudes to migration. Where public opinion is hostile to migrants, only religious or charitable organisations are likely to show concern about their health. In such countries, the dominant attitude is that migrants must learn to stand on their own two feet and the host

society has no obligation to adapt to their presence. At the other end of the spectrum, more ‘migrant-friendly’ attitudes are accompanied by greater willingness to accept the host society’s responsibility for the social conditions of migrants and to tackle the threats to their health.

Such activities may be justified on humanitarian or human-rights grounds (“health as a fundamental human right”, cf. Pace, 2002), or on the more utilitarian grounds associated with public health policies since their inception in the nineteenth century (“health as a service of general (economic) interest”, cf. Huber, Maucher et al., 2008). In a few countries, migrants and ethnic minorities have enough political influence to be able to lobby directly for healthier conditions and better care.

The importance of a sound knowledge base

The topic of migrant health encompasses two main issues: on the one hand the state of health of migrants, on the other the quality and accessibility of the care available to them. Obviously, any practical initiatives in these two areas need to start from a sound knowledge base. We need to know how healthy or unhealthy migrants are, and what special risks they are exposed to. In what respects do health services fail migrants, and what can be done to remedy these shortcomings? We also need to know which strategies are effective for getting things changed. All this points to the fundamental importance of good research on migrant health.

The knowledge and insights generated by such research can be used at different levels:

- **Policy makers** (governments, health care authorities, or individual health care providers) need research in order to make informed decisions. Politicians, administrators and managers must know where the problems are, how they can be remedied and how urgent they are.
- **Service providers** (doctors, nurses, clinics, hospitals, public health agencies etc.) need research to learn about the special needs and requirements of migrants, in order to provide better care.

¹ In this paper, the term ‘migrant’ will be used in the broadest sense, to refer not only to those who change their country of residence voluntarily but also to asylum seekers, refugees and victims of trafficking. Since the consequences of migration may also extend to the second generation or even further, we also use the term to cover the descendants of migrants, rather than referring each time to “migrants and ethnic minorities”.



Today's health care is increasingly dominated by the principle that all interventions must be 'evidence-based'. It is not enough to have wisdom and professional experience: facts and figures are required, based on reliable and valid research data. However, these demands are sometimes hard to meet in the field of migrant health, where research is to a large extent still in its infancy. The lack of a sound knowledge base is one of the chief obstacles to progress in this area. Fortunately, at the present time many initiatives are under way to improve this situation. In some countries a substantial knowledge base has already been built up, and there has been a dramatic increase in the number of research projects at European level concerned with migrant health.

In this paper we will review European research on migration and health, focussing on the situation in host countries. Of course, issues related to health also arise in the countries of origin: for example, the effect of remittances on household health expenditures, the entitlements of returning migrants, infectious diseases and the effect of separation from the breadwinner on the family left behind. In research up to now these topics have been largely neglected, but with increasing internal migration in the EU more attention needs to be paid to them.

B. What kinds of research are needed?

In order to reduce a topic to manageable proportions, it is first necessary to break it down into different components. Ingleby et al. (2005) identified six main areas in which research on migrant health is needed. We will examine each of these below.

1. Background information

This topic does not concern health data as such, but other information which is nevertheless indispensable for informed decision-making. Such information includes the number and origin of migrants and their migration history; social and demographic characteristics of migrant populations; the legal position regarding immigration, integration, nationality and citizenship; public opinion and representations of migrants in the media.

Health workers and researchers need such information for two main reasons. Firstly, it is necessary to know the size and structure of migrant and ethnic minority populations in order to reach conclusions about their state of health. For example, general practitioners may have the impression that they see a lot of Turkish men with lower back pain. But how large is the proportion of Turkish men in the area they serve? What is the age structure of this group? In epidemiology, the denominator (the size of the relevant background population) is just as important as the numerator (the clinical data). All too often, information about the background population is simply not adequate for reaching reliable conclusions about migrants' state of health. As we shall see in the next section, this has proved a major obstacle to research.

An additional problem here is the lack of international consensus about how individuals should be categorised in terms of their migrant status or their ethnic, religious or cultural background – or, indeed, whether they should be categorised in such ways at all. On the question of which variables should be used, we may note that British researchers (like their counterparts in the USA) regard ethnicity as the most useful variable for studying health inequalities, while much research on the European continent concerns itself only with migrant status. Since both factors have been shown to contribute to inequalities, it would seem logical to examine both whenever possible.

A problem with 'ethnicity' is deciding which groups to study and how to define them. In the UK this problem is solved by adopting the categories used in census data, which in turn are based on the categories people use when asked to define their own ethnic identity. However, it seems likely that if this method were to be used in every country,

international comparisons would be hard to make because different categories would probably be adopted. This issue does not arise when people are categorised according to their country of birth (or that of their parents); but this in turn is unsatisfactory for countries of origin inhabited by markedly different ethnic groups.

Whichever categories are used, they should include as many as possible of the different groups currently residing in a country. This implies that they should reflect the constantly changing make-up of populations. Recently formed groups tend to be left out when research is based on categories defined several decades ago and never revised.

Indeed, many migration experts would argue that ethnicity itself, in the traditional sense, may become less relevant in defining social identity than religion. Not only does religion feature prominently in contemporary social debates about diversity; it is also an important factor in its own right in relation to health. Religious beliefs can act as a resource for health (Mir and Tovey, 2003), while religious taboos and traditions can have both positive and negative effects on health.

Regarding the desirability of collecting this type of data in the first place, several countries (such as France or Hungary) place quite strong legal restrictions on the collection and storage of such information. These restrictions are usually there for political reasons, e.g. the republican ideology ("all citizens are equal") or the desire to make sure that nothing comparable to the ethnic cleansing and genocide practised by the Nazis ever happens again. The latter concern is by no means redundant today, in the light of the 'moral panics' that arise from time to time in some countries over such groups as Muslims or Roma.

A further objection to laying down hard and fast categories of ethnicity or migration status is this: phenomena that are in essence shifting social constructions should not be treated as if they were timeless facts of nature (the danger of 'essentialism'). Fifty years ago, 'ethnicity' was regarded as an objective biological or demographic characteristic: nowadays, even in census data, it is treated as a personal choice.

Another issue arising in this connection is the importance of collecting data on socio-economic status (SES). To a certain extent, ethnic differences in health can be explained as the consequence of the conditions in which people live (Nazroo, 1998; Lorant et al., 2008). However, this is not to say that ethnicity is therefore irrelevant. The persistently low SES of many ethnic groups may be causally related to their ethnicity (for example, via mechanisms of social exclusion presenting them from improving their position. In that case, SES may be func-



tioning only as an intervening variable in the relationship between ethnicity and health – the fundamental issues concern ethnicity and social exclusion. The report of the WHO Commission on Social Determinants of Health (CSDH, 2008) and the recent EC Communication on health inequality, 'Solidarity in Health', have focussed renewed attention on health inequalities, but both are based on an approach which is almost exclusively focussed on SES differences. There is therefore a danger that the concern over SES differences in health will displace concern over migrant and ethnic minority health, whereas the two should go hand in hand.

A second purpose for which background information is important is to enable health workers to interpret migrants' complaints and to respond in an appropriate way. The importance attached to this issue will depend on one's approach to medicine. A purely 'biomedical' approach, in which the patient is reduced to a bundle of symptoms and causal mechanisms, will not encourage interest in the patient's living situation and cultural background. Such an approach treats only the disease – not the person who has it. A 'bio-psychosocial' approach, by contrast, will insist on viewing patients in their social context, in order to understand what their symptoms might be linked to and what treatment is appropriate. Another word for this approach is 'holistic': the fact that this term is increasingly associated with the alternative circuit indicates how strongly modern medicine is dominated by the biomedical approach.

Spectacular recent advances in 'high-tech' medicine have helped to strengthen the grip of the biomedical approach. Medical anthropologists, however, point out that there is a crucial distinction between 'disease' and 'illness': 'disease' refers to the physiological processes that may underlie the patients' complaints, while 'illness' refers to the experience of these complaints and their impact on the patient's daily life. It is the 'illness' for which the patient seeks help, and awareness of their social context is crucial to understanding and alleviating it.

The contextual information that we need in order to better understand the illnesses of migrants and ethnic minorities involves the demographic, socio-economic, legal, political and historical factors influencing the conditions in which they live. What kinds of work do they do, if any? What education and qualifications do they have and how useful are these in the host country? What is the quality of their living environment? What hardships and deprivations do they experience? Do they have a valid residence permit? Have they claimed asylum, and if so, what will happen to them if their claim is rejected? What is the climate of public opinion concerning their group – are they subject to discrimination? None of these questions are in themselves 'medical', but all of them may be relevant in trying to understand migrant health.

2. State of health

Information about the state of health of migrant and minority groups is needed for two main purposes:

- a) to identify problems that may call for special efforts in the area of health promotion and prevention;
- b) to give health workers insight into the kind of health problems that migrant and minority patients may be particularly prone to, as well as the factors which may underlying these problems.

Before going further, however, it is necessary to dispel two widespread misunderstandings about migrants' state of health. One is that it is necessarily worse than other people's. A contrary notion, the 'healthy migrant' concept introduced by Raymond-Duchosal in 1929 and often confirmed in later studies, suggests that migrants may start off with a health advantage compared with the host population, which they tend to lose over time. However, some of this effect may simply be due to the fact that new migrants tend to be younger than the host population. Another possible explanation is that immigration policies sometimes restrict the admission of people with health problems. Even if there is, among some groups, a 'healthy migrant effect' at the point of arrival, most migrants will occupy an inferior socio-economic position in the host country, and this in itself will undermine their chances of staying in good health.

Nevertheless, there are certain instances whereby migrants may enjoy a health advantage. In the UK, some minority ethnic communities have higher levels of education and employment, and lower levels of disability, than white communities (Aspinall & Jackson, 2004). According to McCormack et al (2008), "breast cancer incidence rates vary six-fold between industrialized and less-developed countries, and migrants from low-risk countries to high-risk countries have an intermediate risk". Cultural and religious practices may offer health advantages over a modern Western life-style: for instance, Muslims who adhere strictly to the ban on alcohol are less at risk for alcohol-related diseases. These examples are sufficient to demonstrate that it is foolish to attempt any generalisations about the general level of health of all migrants. The answer will depend on the condition one is studying and the particular migrant group concerned. Sometimes, indeed, the findings will also differ between men and women, or between first-generation migrants and their children.

A second misunderstanding concerns the importance of health disparities as a reason for focused action on migrant health. Health disparities can indicate areas of special need where extra attention should be paid to research, prevention, health promotion and treatment. However, it is not necessary to show that migrants have partic-

ularly severe or unusual health problems in order to justify providing them with appropriate and accessible health services. Indeed, the assumption that migrants always have unusual health problems is part of an older discourse which has its roots in colonialism, in which the migrant is portrayed as threatening, alien or exotic. More often than not, the health problems for which migrants seek help are 'common-or-garden' complaints that anybody may suffer from.

As we will explain in the next section, research on the state of health of migrant and minority groups usually uses two main methods: clinical studies and population-based (epidemiological) surveys. The former generally take medical diagnoses as their starting-point, while the latter are usually confined to information that can be provided by informants themselves (self-report). Often, respondents are asked to make a subjective assessment of their general level of health. Such assessments often reveal striking differences, but it is difficult to know to what extent the self-ratings correspond to more 'objective' measures of health.

Investigations of migrants' state of health sometimes go further and attempt to explore the determinants of particular health problems. Stronks et al. (1999) put forward a model in which four basic contextual factors can underlie ethnic differences in health:

1. the process of migration
2. cultural factors
3. socio-economic position
4. the social context

Specific determinants of health or illness which may operate in these contexts are:

1. genetic factors
2. lifestyle
3. physical environment
4. social environment
5. psychosocial stress
6. health care utilisation

3. Entitlement to health care

The next topic for which good research is vital concerns the conditions under which migrants are entitled to receive health care. This question is usually subsumed under the topic of 'access', but we consider it sufficiently important and distinctive to give it separate consideration.

Entitlement to care can be broken down into three components: 'coverage', 'health basket' and 'cost-sharing' (Huber, Stanciole et al., 2008). 'Coverage' refers to whether a person's health expenses are paid for

by a universal State scheme or by an insurance scheme to which the individual has to subscribe. 'Health basket' refers to the range of services that are covered, while 'cost-sharing' refers to the out-of-pocket financial contribution which is required from the service user.

The entitlement of migrants to health care varies between countries and according to the category of migrant concerned (employed, un-employed, asylum seeker, undocumented, etc.)

The rules governing entitlement are often complex, fast-changing and poorly understood by migrants and other users – sometimes even by the people supposed to be applying the rules. Research is needed to clarify the situation in each country and its consequences for health.

4. Accessibility of care

We use this concept to refer to obstacles to obtaining care other than problems of entitlement. In order to access care, a sick person (or someone in their environment) must first of all realise that they need it. This will depend on their level of 'health literacy', in particular their knowledge about the treatments available and the signs that treatment is necessary.

It is sometimes said that health literacy tends to be low among migrants, but it would be more accurate to say that the knowledge that migrants have is often at variance with that of the majority population. Particularly when a person has only recently migrated or has not had much contact with the host society, their knowledge about illnesses and health care is likely to reflect mainly the culture and health system of their country of origin.

Moreover, different cultures may have widely different ways of categorising, describing, assessing and responding to illnesses. Kleinman (1978) introduced the concept of 'explanatory models' to describe these variations. Health care systems also differ enormously across the globe, both in their formal structures and in the unwritten rules governing interactions between health care workers and patients. Because of this, it can easily happen that migrants are perceived by health workers as unaware of basic 'facts' about health, having 'irrelevant' expectations of the health system, behaving in 'inappropriate' ways, and so on, when all they are doing is drawing on the stock of health knowledge they have acquired in their country of origin.

Although one can argue about the relative merits of different medical concepts and systems, it remains necessary for migrants in European countries who wish to use mainstream health services to learn how people in the host society think about health, how the health care system is structured, and what the formal and informal 'rules of the



game' are for both staff and patients. Indeed, everybody has to acquire this knowledge and keep it up to date: it is an important ingredient of socialisation and 'health citizenship'.

A basic task for researchers in this area is to find out whether, and if so in which areas, health care is less accessible for migrants. A crude indication of this is the level of 'care consumption': if fewer people are using a service than would be expected on the basis of the (assumed or measured) incidence of illness, this may be a sign that they need help in order to find their way to the service.

Another explanation of a low take-up of services, however, may be that people know perfectly well that the service is there, but have different views on what is wrong with them and what should be done about it. This is especially likely to be the case when Western medical views differ markedly from those prevailing in source countries.

In the West, the medical domain has expanded enormously in the last 50 years. This has been accompanied by a substantial increase in expenditure on health services – most notably in the United States (US), where total per-capita health spending, adjusted for inflation, has increased eightfold during this periodⁱⁱ. In the larger West European countries, expenditure is currently around 50% of the US level – but in many of the countries that migrants come from the corresponding percentage is far lower (e.g. Afghanistan, 0.4%; Pakistan, 0.7%; India, 1.5%; Morocco, 4%; China, 5%; Turkey, 9%; most African countries, below 1%).ⁱⁱⁱ These figures show that in terms of the amount spent on health care, the contrast between sending and receiving countries can be very extreme (see also CSDH, 2008).

A higher amount spent on health care in a given country will go hand in hand with increased readiness to seek medical help and a broadening of the criteria for 'illness'. In the West, conditions which were previously regarded as natural or inevitable, or not medical conditions at all, now qualify for diagnosis and treatment. The field of mental health is a prime example of this, with a massive increase in the number and variety of problems regarded as signs of 'mental disturbance'. In 1952, the Diagnostic and Statistical Manual of the American Psychiatric Association listed only 60 categories of abnormal behaviour; in 1994 this number had increased to 410. It is therefore understandable that migrants coming from countries where psychiatric provisions are few and primitive, catering only for the most extreme cases, may resist being told that they have a 'mental health' problem. They are likely to associate the term with extreme forms of insanity and will therefore go out of their way to avoid having it applied to them or their family members.

The medicalisation of ageing, sexuality, pregnancy and childbirth provides a further illustration of this Western trend. People brought up to regard these processes as natural ones which should be allowed to run

their course – a belief not confined to migrants, but shared by many Europeans – resist the idea that a pregnant or elderly person should live their lives under constant medical supervision. Poor take-up of antenatal care and low compliance with medical advice may thus be more a result of differing health beliefs and values than of ignorance about the services available. In this connection it is important not to assume axiomatically that modern Western practices are preferable to all others and that the only thing that needs to be done is to educate migrants in 'good' health care attitudes. The massive investment in mental health care services in the West has not been accompanied by a commensurate improvement in the happiness of its citizens; this calls for appropriate modesty about the superiority of Western approaches. Likewise, the medicalisation of childbirth has probably contributed less to the reduction of perinatal mortality than the improvement of nutrition and living conditions. Though the US spends more of its GNP on health care (currently about 17%) than any other country in the world, many other countries enjoy better levels of health.

Besides divergent health beliefs and values, there may be practical barriers to using a particular health service (e.g. location, transport, opening hours), or social barriers in the form of stigma and fear of gossip – particularly, as we have seen, in the case of mental health problems. Another factor that can discourage service use is a lack of consideration for cultural practices and customs (for example, concerning hospital food or contact between female patients and male doctors – although it is worth remembering that many European-born women sometimes prefer a female doctor.) Such barriers to access fall into the category of 'institutional discrimination', a term which gained currency in the context of the American Civil Rights Movement. A recent definition is as follows:

Institutional discrimination occurs when the culture, policies, systems and procedures in an organisation inherently discriminate against a group or groups of people. This happens because the systems and processes were designed without taking into account the diverse needs of groups within the community in relation to e.g. their race, disability or gender (ESCC, 2009).

Institutional discrimination is largely unconscious, but access to health services by migrants can also be undermined by conscious, direct, individual discrimination at any level from receptionist to consultant. Since 2008, the European Union Agency for Fundamental Rights (FRA) has included health care among the areas in which it produces annual reports on (direct) discrimination. In most countries, however, this form of discrimination seems to be much less of a problem than the institutional kind.

ⁱⁱ This figure is based on data from Reinhardt (2002) and other sources.

ⁱⁱⁱ The figures are for 2005 and were obtained from the WHO Statistical Information System (WHOSYS).

One very specific barrier to accessing health care is the threat to undocumented migrants that they will be reported to the authorities if they do so. Some countries require health care staff by law to report undocumented migrants who make use of their services; even where there is no legislation requiring this, such migrants may perceive the risk of denunciation to be greater than the risk of leaving health problems untreated.

As we have seen, 'accessibility' is a broad concept covering many different sorts of factors, and different kinds of research are necessary to investigate it. For example, we need to know whether migrants are adequately informed about illnesses and the health care system, in order to tell health authorities what information is needed and in which languages, and how it can be most effectively presented. We also need to know how migrants' beliefs and values concerning health may be at odds with those presupposed by health care workers. Research is also needed to uncover direct and indirect discrimination.

It is not only the problems that need to be investigated, solutions which are proposed should also be assessed. Research is needed to evaluate the effectiveness of the 'good practices' that are put forward to make services more accessible. In this respect, health education and health promotion are important but often-neglected areas. People's behaviour is notoriously intransigent when it comes to avoiding health risks, and it is a great challenge to devise methods that are actually capable of changing behaviour. In particular, research is needed to identify the most effective methods of encouraging members of migrant and ethnic minority communities to take good care of their health.

5. Quality of care

While 'accessibility' refers to obstacles on the path to care, 'quality' refers to what happens in the care-giving situation. Of course, many migration-related factors such as language barriers, divergent health beliefs and discrimination, undermine both the accessibility and the quality of care. A wide range of interventions and methods have been put forward as 'good practices' for improving the quality of health care for migrants. The tasks of the researcher are to (a) find out when something is going wrong in the treatment situation, (b) identify what it is, and (c) evaluate the solutions proposed for dealing with it.

To assess the quality or appropriateness of care, a number of measures can be used. Subjective measures set out to measure the degree of satisfaction of clients and their caregivers. This can be asked for directly, or estimated from levels of drop-out or compliance. Objective measures investigate the effectiveness of particular practices. Do the standard procedures lead to worse outcomes for migrant patients? Are particular 'good practices' capable of producing better outcomes? In order to evaluate a procedure or treatment method, researchers need

ideally to carry out a 'randomised clinical trial' (RCT), in which patients are allocated at random to different groups (preferably without them or the researcher knowing which group they are in, i.e. 'double-blind'). However, because of the practical and ethical obstacles to such research, which is usually very expensive, RCT's are hardly ever carried out to establish the effectiveness of treatments or 'good practices' for patients from migrant or minority ethnic groups. It would therefore not be an exaggeration to say that 'evidence-based' care for this group is still a long way off.

6. Achieving change

Under this heading researchers examine all the activities that are undertaken to encourage the development of adequate health care for migrants. At the outset we can make a distinction between 'structural' and 'incidental' changes.

- 'Structural' improvements to health care services as those that are embedded in policy. Policy may be laid down at national, local or municipal levels, as well as by service providers or professional bodies.
- 'Incidental' improvements arise more spontaneously, as a result of the activities of individuals or NGOs responding to perceived needs as they see fit.

However, the boundary between the two may shift overnight: an intervention may start out as a spontaneous individual initiative, but because of its success it receives the blessing of an institution or a ministry and becomes incorporated in official policy. The boundary between 'structural' and 'non-structural' provisions may also be blurred in countries where there is little attention paid by the government to the health needs of migrants, and health services are run by NGOs such as Médecins du Monde, or religious organisations such as the Jesuit Refugee Service, who may become part of the health care landscape and even receive funding from central government. Nevertheless, there is increasing realisation that the structural embedding of measures in policy is essential for sustained progress (see the section "Why 'good practices' are not enough" in the report on Good Practices for the Portuguese EU Presidency Conference (Portugal et al., 2007, p. 17)).

Under the heading of 'achieving change', researchers examine the wide range of activities that may be undertaken to lobby for migrant health, to bring together those interested in it, to form pressure groups, centres of expertise, research networks and 'think tanks'. One of the most important of all these activities is teaching and/or training—educating medical students, professionals, politicians and the public about the importance of migrant health and showing how research findings can be applied.



C. Who carries out this research, what methods are involved, and what are the difficulties?

1. Background information

Much background information on migrants and ethnic minorities is collected by national, regional or municipal authorities. As mentioned in the previous section, the amount of official information concerning such variables as (parental) place of birth, nationality, migrant status, ethnicity or religion can range from non-existent in some countries, to fairly detailed in others. Where official statistics are scarce, researchers on migrant health have to try and collect the missing information themselves.

In spite of the various legal and practical barriers to data collection, it is increasingly common for population data to be collected on people's country of birth (and that of their parents), or their nationality, religion, or ethnicity. Unfortunately, the precise data available vary from country to country, making trans-national studies of migrants' state of health very difficult. As far as demographic data on migration are concerned, Europe resembles a patchwork quilt.

Apart from data which is routinely collected on all inhabitants, both national and local governments often conduct or commission surveys to collect specific types of information, including variables relating to migration or ethnicity, on a particular age cohort or sample of the population. Sometimes these surveys are longitudinal and enable conclusions to be drawn about the factors affecting people over the life course. The UK and Scandinavian countries have perhaps the most extensive collections of such data on their inhabitants. Thanks to this, and to the possibilities for linking different data sets with each other, these countries have been able to undertake some of the most large-scale surveys on the health of migrants of ethnic minorities. A recent review article (Ingleby, 2008) describes Scandinavian and British studies published in recent years on the incidence of schizophrenia among migrants, which have revolutionised views on this topic with the help of databases covering millions of people.

Academic research in the area of Migration Studies provides a copious source of data on topics such as education, housing, legislation, discrimination, public opinion, policy making and (media) representations. To make optimum use of these data it is necessary for researchers in the field of health to collaborate closely with their colleagues in the social sciences. An example is the work of Adam & Devillard (2008), which reports a study carried out by the IOM reviewing immigration laws in the 27 EU Member States.

2. State of health

Two main types of research can be carried out to reach conclusions about the state of health of particular social groups such as migrants and ethnic minorities: clinical studies and population-based studies.

Clinical studies

These studies start from data generated in contacts with health service providers (family doctors, hospitals, well-baby clinics, etc.) For example, the number of patients with a particular diagnosis or receiving a particular type of treatment may be recorded. This can either be done routinely, or at the special request of a researcher. Where such data are collected routinely, existing clinical records will provide a wealth of information for the researcher.

However, the prevalence of a given condition among migrants or ethnic minorities can only be estimated from such data if (1) information about migration or ethnicity has been collected at the same time or can be added later, and (2) data are available on the size of the underlying populations. Data on the underlying populations falls in our category of 'background information', and it will be obvious that the best clinical data in the world is useless for estimating prevalence rates if good statistics are not available about the underlying population.

We can illustrate this point with an example. Consider — once again — general practitioners (GPs) recording the number of male patients of Turkish origin reporting lower back pain. Suppose we have data from all the GPs whose catchment area falls in the city of Rotterdam, The Netherlands. We will only be able to estimate incidence rates from these data if, at the same time, data are available on the ethnic origin and gender of the inhabitants of Rotterdam. It will also be very helpful to have data about the age structure of different groups; if the Turkish inhabitants are older than the average, this could be the reason for the higher incidence, because lower back pain is associated with age.

But there is yet another problem concerning the use of clinical data. Incidence rates in the clinic are only equal to incidence rates in the general population if access is perfect. In this example, it could be that access by Turkish men to health care is limited, for any of the reasons we have discussed above. Figures obtained from clinical practice shed no light at all on the condition of people who do not show up at the clinic. As Goldberg & Huxley (1980) point out, a number of 'filters' intervene between illness and treatment.

In general, we can say that the numbers of people who receive treatment will reflect two things: the proportion who are ill, and the proportion of these who succeed in getting into treatment. If (and only if) one of these variables is known, it is possible to estimate the other. But if we know nothing about accessibility, clinical data can tell us nothing about incidence; and if we know nothing about incidence, we can say nothing about accessibility. For this reason, figures concerning the amount of 'care consumption' by different groups need to be interpreted with great caution.

Many other problems surround the use of clinical data (for example, the reliability and validity of diagnoses), but it will be clear by now that the use of such data to shed light on the state of health of the migrant and ethnic minority population is fraught with difficulties. Many health care providers do not record any information relating to migration or ethnicity. Even when they do, the relevant catchment area may not be known, and there may be no information concerning the size of the migrant or ethnic minority populations in that area – let alone concerning gender and age. Moreover, access may vary between groups. Fortunately, however, there are other types of studies which can be used.

Population-based studies

For epidemiological purposes there are enormous advantages in collecting data on health from the general population, rather from the highly selected sub-sample which is found in clinical settings. By doing this, of course, one immediately loses the advantages of the clinical setting: there, a diagnosis has to be made anyway, often with the help of highly sophisticated procedures. Outside the clinic, the information that can be collected is more basic in nature, and generally depends on self-reported data from the respondent. Only when funds are available for medical screening of a group can population-based studies begin to match the sophistication of the diagnoses that clinical data is based on.

Population-based studies may concern very large populations, or they may be quite small-scale; they may be focussed on a single health problem, or cover a whole range of conditions. Increasingly, governments carry out large-scale surveys that include questions about health, in order to monitor the health needs of their citizens. For our purposes, however, such surveys are only useful if questions are also included about migration status or ethnicity. However, it may also be possible to link health data generated by these surveys with population data from other sources.

The following indicators may be used to assess the general health of a group:

- The mortality of the group (i.e. the death rate). Such figures have to be interpreted with great caution. In the first wave of any migration, the people who migrate tend to be fit and healthy, ready to face the hazards of journeying far from home. Some migrant groups keep close contact with their home country and return when they become sick or old. Their deaths are not recorded in the host country, so that official statistics on mortality rates may not give an accurate impression of the health of that group.

Inaccuracies may arise in several other ways. For example, if members of some ethnic groups are inaccurately classified in a national census, but their origins are accurately recorded when they die, then the death rate of these groups will be overestimated. Conversely, if ethnicity is not correctly classified when a person's death is officially registered, then the death rate will be underestimated.

- A widely used indicator of general health is life expectancy, but this can also be difficult to interpret in the case of migrants. For instance, a Dutch study showed that life expectancy for Moroccan-born men is 3.5 years longer than for Dutch natives, while for Turkish and Surinamese-born men it is 1.5 years shorter. The explanation for these differences is very unclear (RIVM 2002). It may have something to do with the tendency of migrants to return home when they become old or sick.

Another indicator that is often used in survey research is subjective health. When asked about their experienced state of health, 79% of the native Dutch population describe this as 'good' or 'very good', compared to 71% for first-generation Western immigrants and only 63% for first-generation non-Western immigrants (CBS 2004). Similar findings have been reported in the United Kingdom, e.g. by Durnell (2008), and in Switzerland (Garbadohino et al. 2007). However, the cross-cultural validity of such self-report measures is unknown (Chandola & Jenkinson, 2000; Brujinzeels, ed. 2004: 89; Menec et al., 2007).

Epidemiological research on migrants and ethnic minorities is in its infancy and most of the information currently available on their health is based on clinical studies – with all their attendant disadvantages. Bhopal (2007) gives an authoritative introduction to this area of research. Such studies belong to the domain of Public Health: they may be carried out by (large) health care providers, municipal authorities, national health research agencies, independent contractors, NGOs and university-based researchers. However, the resources required for epidemiological research are usually substantial, so that only major organisations are able to fund them.



3. Entitlement

Research on the entitlement of migrants to health care is in its infancy, although an appendix to this paper lists a number of comparative studies, most of them carried out on behalf of international agencies or NGOs. In theory, one can learn everything one needs to know about migrants' entitlement to health care by studying documents setting out the policies of state health care schemes or health insurers. In these documents the answers to questions about who is covered, for what kinds of treatment, and how much money they have to contribute out of their own pockets, are set down in black and white. Nevertheless, we cannot assume that theory and practice overlap perfectly when it comes to entitlement. Rules have to be interpreted (for example, regarding the definition of what constitutes 'emergency care') and different service providers may apply different definitions. Moreover, knowledge of the rules may be incomplete or out of date: for example, in response to the current confusion about the health care entitlement of asylum seekers and undocumented migrants in Britain, new guidelines and summaries follow on each other's heels with bewildering rapidity.

'Implementation gaps' between policy and practice seem, in fact, to be inherent to modern organisations (Hogwood & Gunn, 1984). Sometimes service providers will be more permissive than the rules allow; health workers will turn a blind eye to policy restrictions, out of a sense of professional responsibility or concern for human rights. Sometimes, however, they will be more restrictive, and will withhold information about clients' rights because they disagree with the policy, or because of prejudice against the person they are dealing with. In this respect the receptionist at a hospital's front desk can sometimes wield more power than everyone else in the medical hierarchy.

4. Accessibility

Research on accessibility often takes quantitative data as its starting-point and proceeds to investigate it qualitatively. Where there are signs that a given service is being 'under-used', research may be undertaken to find out what is holding people back from using it: generally, the best way to find this out is to ask them in person. In theory, quantitative methods such as structured questionnaires sent by post could be used, but there are doubts about the validity of data gathered in this way. If a person is mistrustful of a service, they will probably also be wary of request for information on behalf of that service.

Researchers often regard migrants and ethnic minorities as difficult groups to investigate. Because relations between these groups and the majority population are often strained, there may not be much willingness to cooperate if the researcher is perceived as representing 'the authorities', or simply looks white and middle-class. Often, people are tired of being approached at regular intervals by researchers.

They may also have misgivings about the use to which the data will be put. The researcher's conclusions will then be based on those who do cooperate, whereas the opinions of those who don't may be much more relevant. One way of overcoming some of these problems is to employ members of migrant or ethnic minority groups to carry out the research. A striking example of this is the book edited by Clarke (2005), reporting research on migrants in Finland carried out entirely by migrants.

Studies on the accessibility of health care for migrants and minorities are a fairly recent phenomenon and are typically small-scale in nature. Whereas epidemiological research is mostly large-scale and expensive, studies on accessibility are often commissioned by individual service providers. Many of these studies are classified as 'grey literature': because, they do not make their way into mainstream scientific literature but instead enjoy only limited circulation. Hundreds of such studies have been undertaken by students for their final-year dissertations, and even these can provide very useful data. In recent years, internet has provided possibilities for disseminating 'grey literature' cheaply and on a wide scale: local authorities and NGOs are making increasing use of this medium to publicise their findings.

5. Quality

Two types of evidence are relevant to assess the quality of care. First, evidence about cultural incompetence – the ineffectiveness of standard approaches that do not take diversity into account; and second, evidence about cultural competence – the effectiveness of measures for dealing with diversity. Who carries out this research and what methods are used?

Regarding the first type of evidence, we have already mentioned the fact that in this era of 'evidence-based medicine', proof of the effectiveness of new procedures and treatment methods is required before they are introduced. However, such studies usually pay no attention to the possibility that effectiveness may vary between different ethnic groups. Worse still, members of minority populations may actually be excluded from clinical trials. Graham (1992) showed that 96 per cent of the studies published in the 1970s and 1980s in four leading journals of the American Psychological Association excluded African American subjects.

There are, in fact, few hard-and-fast data available on differences in the effectiveness of treatments for different ethnic groups. However, some drug companies have begun to highlight this issue, in the hope of identifying products which can be marketed as specially appropriate for particular groups.

Concerning the evaluation of 'good practices' introduced to increase cultural competence, a major report was compiled in the US by Fortier

& Bishop (2003) in which many hundreds of studies were reviewed. Also in the US, Griner & Smith (2006) demonstrated considerable effect in measuring improved cultural competence in a meta-analysis of 76 studies concerned with mental health programmes. However, Bhui et al. (2007), who examined 109 articles describing programmes for improving cultural competence among health care professionals in the UK, found that only nine of these had included an evaluation of the model described.

On the topic of health promotion, even less work has been reported. The research project 'Healthy Inclusion' is currently being carried out in seven countries to improve the effectiveness of health promotion activities for migrants.^{iv}

As noted above, most research in this area focuses on satisfaction or 'procedural evaluation' rather than effectiveness, and much of it is qualitative in nature. Often, such studies are undertaken by the originators of the method and are thus far from impartial. However, the state of the art in this area is continually improving and much current research is published in high-quality, peer reviewed journals.

6. Achieving change

To find out what activities are being undertaken in order to improve health care for migrants and minorities, studies have usually been undertaken by research institutions or universities. Systematic surveys involve contacting service providers and asking them a number of questions about the measures that have been taken to improve the accessibility and quality of services for these groups. Alternatively, a qualitative overview of initiatives taken may be made on the basis of literature reviews, internet searches and 'snowball' sampling methods, in which one informant will suggest other informants.

Concrete examples of research in the above areas

A good impression of the 'state of the art' in the six areas we have discussed can be obtained from the extensive review undertaken by Philipa Mladovsky (2007) of the Health and Living Conditions Network of the European Observatory on the Social Situation and Demography, European Commission. During 2009, detailed information from 17 countries has also become available from the project MIGHEALTHNET (<http://mighealth.net>).

^{iv} See <http://mighealth.net/eu/images/f/f6/Inclusion.doc>.



D. Research at the European (or global) level

Thanks to the activities of bodies such as the WHO, the IOM, the European Commission, the Council of Europe and various international NGOs, opportunities have arisen for carrying out international collaborative research on migrant health. In this section we will discuss the advantages of this kind of research and present some examples.

As far as Europe is concerned, perhaps it would be more appropriate to start by describing the disadvantages of confining research to the national level. Imagine what the state of research would be in the US if each of the 50 states spoke a different language and there were no nation-wide arrangements for organising research, sharing knowledge and regulating professional organisations. Imagine also that few researchers moved from state to state. Yet, this is the baseline situation in Europe. While not wishing to underestimate the richness of Europe's enormous cultural and social diversity, the fact that health research is mainly carried out on a national basis is a great obstacle to progress. It reduces the scale of efforts and limits the possibilities for sharing data, methods and insights. For this reason, the emergence of health research at a European level is greatly welcomed – especially in relation to migrants and ethnic minorities.

Particularly important is the possibility of joining forces to increase the 'critical mass' of the research community. In each country, migrants and ethnic minorities form a small segment of the population whose interests easily get overlooked. As a result, research on migrant health often occupies a highly marginal position. On a European or interna-

tional level, such research relates to far more people and can therefore claim more resources.

Apart from these advantages, cross-national comparisons of patterns of migrant health or approaches to health care can yield new insights; for example: are the higher rates of cardiovascular disorders among some Asian communities in the UK also found in the rest of Europe? What does the distribution of these disorders tell us about the causes? What are the relationships between national health-care philosophies and provisions for migrants? Under what conditions are particular methods effective? The use of data from several different countries introduces greater variability in the factors studied, making it easier to disentangle the influence of different factors.

An appendix to this paper describes a number of international collaborative research studies. The matrix of DG SANCO projects constructed by the IOM in the context of the AMAC project represents an important step towards obtaining an overview of current efforts.

E. Conclusions

Though research on migrant health has shown remarkable growth during the last decade, there still remain many 'blind spots' where more research is urgently needed:

1. An inventory needs to be made of legal, ideological and practical barriers to the collection of data on migrant status or ethnicity in each country. The MEHO project (Migrant and Ethnic Health Observatory), co-financed by DG SANCO, has a special project on "Data sources and indicators", but this does not investigate legal restrictions. A study is urgently needed which would clarify the situation and explore ways of overcoming the obstacles.
2. As noted above, 'good practices' to improve the accessibility and/or quality of health care delivery are seldom evaluated. More attention to this question is required. The methods used to do not have to be RCTs – in fact in many cases it would be impossible or unethical to satisfy the conditions for an RCT. As Fortier and Bishop (2003) show, many other research strategies (e.g. 'process evaluations') can be used to assess the value of these approaches. The participation of migrants themselves in the design, implementation and evaluation of interventions is of course crucial. Mir (2008) discusses the issues that arise when people from ethnic minority communities carry out research on those communities.
3. Closer collaboration is desirable between those investigating socio-economic inequalities in health and researchers working on migrant health. The role of socio-economic factors in determining the state of health of migrants and ethnic minorities should be more closely examined. This means that both variables should be looked at simultaneously, rather than separately (as is usually the case at the moment).
4. Finally, as we noted at the beginning of this paper, hardly any attention has been paid to health issues connected with migration in the countries of origin. Thanks to successive enlargements, the EU itself contains many such 'sending' countries. Research in this area needs to be expanded.

We have seen that international collaborative projects are of great value in this area, and it is encouraging to note the substantial increase in funding for this type of work. However, these efforts suffer from a lack of cohesion and a systematic research policy. A rigidly centralistic, top-down policy would perhaps have greater disadvantages as it would stifle creativity, innovation and diversity. Yet the philosophy of "let a thousand flowers bloom" can lead to wasting of scarce

resources. At present, new projects arise in a fairly haphazard way: different agencies do not coordinate their efforts with each other and there is little synergy between different projects, with the result that efforts are not spread in a rational way. Moreover, knowledge does not seem to develop in a cumulative fashion. Considering that the first studies were undertaken as long ago as 1983, there is a great deal of repetition of the same findings and recommendations ('reinventing the wheel').

One illustration of the lack of a cohesive policy is the fact that it is often very unclear why certain countries get included in an international project or network while others are not. Inclusion probably has mainly to do with the international contacts that the initiator of the project happens to have in his or her address book or simple opportunity for collaboration.

Coordination of efforts is required not only within funding agencies, but also between them. For example, the European Commission's DG SANCO, DG Research and DG Employment, Social Affairs and Equal Opportunities have all commissioned pioneering studies in this area; yet there is no sign that efforts have been coordinated between these agencies. The same remarks apply to the lack of harmonisation between EC-funded projects and those initiated by the WHO, the IOM and various large private foundations.

In conclusion, we may observe that while diversity in research is in itself a good thing, more attention should be paid to the need to develop shared approaches and to avoid unnecessary duplication of research effort. Projects such as the COST Action HOME (Health and Social Care for Migrants and Ethnic Minorities in Europe) can help to reduce the fragmentation of research efforts, but a more coordinated ('joined-up') approach by the EC and other international bodies is also urgently required. The establishment of a single European agency to oversee research activities in this area – a 'European Migrant Health Observatory' – would go a long way to furthering a more effective research effort.



Note about the Author

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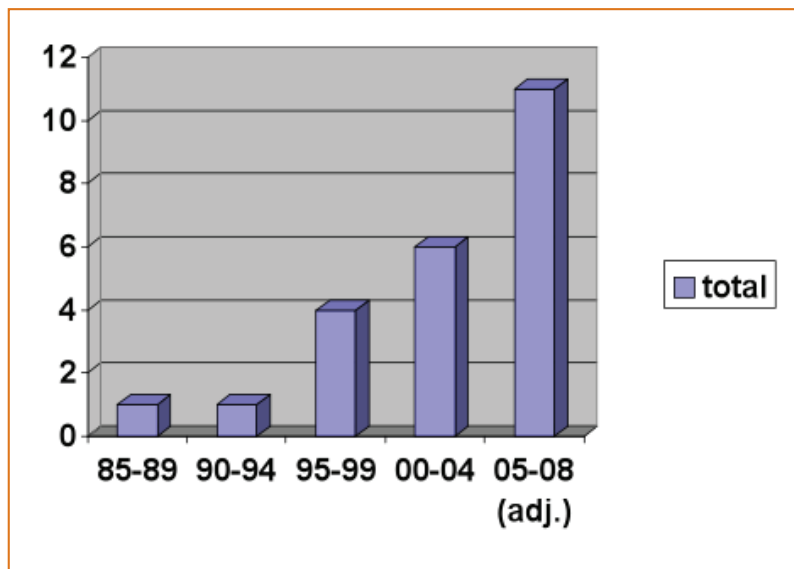


Appendix

Published reports on migrant and ethnic minority health in Europe

This Appendix lists reports published in English in which issues concerning migrant and ethnic minority health are examined in a number of European countries simultaneously.

Fig 1. Increase in number of published reports, 1985 – 2008



Note: the total for 2005-2008 has been adjusted to take account of the fact that it is a four-year period, not a five-year one.

Which countries have been surveyed?

For some reports – not all – it has been possible to list the countries which have been surveyed. In this table you can see which countries are mentioned in which reports.

Table 1. Countries covered in each report

Country		1	2	5	7	8	9	13	15	16	17	18	19	20	21	Total
Austria	AT										1				1	2
Belgium	BE	1		1	1				1	1	1		1		1	8
Bulgaria	BG														1	1
Cyprus	CY														1	1
Czech Republic	CZ														1	1
Denmark	DK								1						1	2
Estonia	EE								1						1	2
Finland	FI								1				1	1	1	4
France	FR		1	1					1	1	1		1		1	7
Germany	DE	1		1					1	1	1		1	1	1	8
Greece	EL							1		1			1	1	1	5
Hungary	HU										1				1	2
Ireland	IE								1						1	2
Italy	IT		1		1				1	1	1	1	1		1	8
Latvia	LV														1	1
Lithuania	LT								1						1	2
Luxembourg	LU														1	1
Malta	MT												1		1	2
Netherlands	NL	1		1	1	1	1	1	1	1	1	1	1	1	1	13
Norway	NO														1	1
Poland	PL													1	1	2
Portugal	PT	1					1	1		1	1		1		1	7
Romania	RO												1	1	1	3
Slovakia	SK												1		1	2
Spain	ES			1	1	1	1		1	1	1	1	1	1	1	11
Sweden	SE		1	1	1	1			1		1		1		1	8
Switzerland	CH		1					1								2
United Kingdom	UK		1	1			1		1	1	1		1	1	1	9
Countries covered		4	5	7	5	3	4	4	13	9	11	3	14	8	27	
Report >>		1	2	5	7	8	9	13	15	16	17	18	19	20	21	Total



Summary table

Please note that it is not certain whether this list of reports is exhaustive. However, we have tried to make it as complete as possible.

No.	Year	Authors	Topics	Sponsor	Countries*
1	1986	Colledge et al.	General	WHO	4
2	1992	Bollini	Policy	IOM	5
3	1995	Bollini & Siem	Perinatal mortality, accidents/disability and access	IOM	
4	1995	Reitz	Access (international)	Canada	
5	1997	Huisman et al.	General	Academic	7
6	1998	Carballo et al.	General	ICMH	
7	2000	Vulpiani et al.	General	DG Employment	4
8	2002	Watters	Services	Academic	3
9	2003	Watters et al.	General (focus: refugees)	ERF	4
10	" "	McKay et al.	State of health	MRC	
11	2004	Van Dongen**	Discrimination/exclusion	DG Employment	5
12	" "	Stegeman & Costongs	Good practices	DG SANCO	
13	2005	Ingleby et al.	General	DG RESEARCH	4
14	" "	Carballo & Mboup	General	ICMH	
15	2007	Mladovsky	General	DG Employment	
16	" "	Médecins du Monde	Undocumented migrants	MdM	13
17	" "	Picum	Undocumented migrants	DG Employment	11
18	" "	Euro Observer	Policy	WHO	3
19	" "	Portugal et al.	Good Practices	DG SANCO	14
20	2008	Huber et al.	Access & quality	DG Employment	8
21	" "	FRA	Access & discrimination	DG JLS	27

* For some reports it is not possible to determine the number of countries studied

** Second phase of project 7

Abbreviations

DG	Directorate General (EC)	JLS	Justice, Freedom and Security (1)
EC	European Commission	MdM	Médecins du Monde (1)
ERF	European Refugee Fund (DG JLS) (1)	MRC	MRC (UK government) (1)
DG Employment	Employment, Social Affairs and Equal Opportunities (5)	DG RESEARCH	Research (Sixth Framework Programme) (1)
ICMH	International Centre for Migration and Health (2)	DG SANCO	Health and Consumers (2)
IOM	International Organization for Migration (2)	WHO	World Health Organization (2)

List of reports

1. Colledge, M., Geuns, H.A. van, & Svensson, P.G. (eds.) (1986). *Migration and Health: Towards an Understanding of the Health Care Needs of Ethnic Minorities*. Proceedings of a Consultative Group on Ethnic Minorities (The Hague, Netherlands, November 28–30, 1983). World Health Organization, Copenhagen (Denmark), Regional Office for Europe.

Summary: This book addresses the research and policy issues that emerge from the interface of different cultures as a consequence of migration. It includes articles on the following issues: (1) the contribution of the social sciences to an understanding of migrant health needs; (2) health care across cultural boundaries; (3) health care for labour immigrants; (4) philosophical considerations of health care policy and the position of ethnic minorities; (5) health care research and evaluation in a host country: The Netherlands; (6) health care and Moroccan and Turkish immigrants; (7) problems of health and health care research with particular reference to ethnic minorities; (8) health care research and evaluation from the country of origin: Turkey and Morocco; (9) social and health problems of migrant workers; (10) social and health care of Moroccan workers in Europe; (11) aspects of health care intervention in host countries; (12) advocating for migrants' health; (13) migrants' special needs in sexuality and family planning in Belgium and Germany; (14) health care and education aids for foreigners in the Netherlands; (15) mental health of migrants; and (16) psycho-social problems of migrants. The book concludes with recommendations for researchers and practitioners.

2. Bollini, Paola (1992). Health Policies for Immigrant Populations in the 1990s. A Comparative Study in Seven Receiving Countries. *International Migration*, Vol. 30 (Special Issue: Migration and Health in the 1990s), pp. 103–119.

Bollini (1992) who studied the policy regarding Migration and Health in seven industrialized countries (France, United Kingdom, Switzerland, Italy, Sweden, United States and Canada) already indicated that these countries can be divided into two groups: those which have a passive attitude, that is, which expect immigrants to adapt to the health system designed for the native population (Italy, France, Switzerland and the United States); and those which have acknowledged the health problems posed by immigrant groups and who have actively tried to provide alternative solutions, for instance by providing interpreter services during medical encounters (United Kingdom, Sweden and Canada).

[From: Sandro Cattacin and Milena Chimienti, in collaboration with Carin Björngren Cuadra (2007). *Difference Sensitivity in the Field of Migration and Health: National policies compared*. Working paper 1, University of Geneva, p.11]

3. Bollini, P., & Siem H. (1995). No Real Progress Towards Equity: Health of Migrants and Ethnic Minorities On The Eve of the Year 2000. *Social Science & Medicine* (41)6, 819–828.

Abstract—The paper reviews the available evidence on access to health care and two health outcomes, perinatal mortality and accident/disability, for migrant and ethnic minorities in selected receiving industrialized countries. The health of these communities is analyzed using the entitlement approach, which considers health as the product of both the individual's private endowments and the social environment he or she faces. Migrants, especially first and second generations, and ethnic minorities often have reduced entitlements in receiving societies. Not only are they exposed to poor working and living conditions, which are per se determinants of poor health, but they also have reduced access to health care for a number of political, administrative and cultural reasons which are not necessarily present for the native population.

The paper argues that the higher rates of perinatal mortality and accidents/disability observed in many migrant groups compared to the native population are linked to their lower entitlements in the receiving societies. Policies aimed at reducing such health gaps need to be accompanied by a more general effort to reduce inequalities and to promote full participation of these groups in the mainstream of society.

4. Reitz, J.G. (1995) *A Review of the Literature on Aspects of Ethno-Racial Access, Utilization and Delivery of Social Services*. Report was prepared as a joint project of the Multicultural Coalition for Access to Family Services, Toronto, and the Ontario Ministry of Community and Social Services.

<http://ceris.metropolis.net/Virtual%20Library/other/reitz1/reitz4.html>

From the Summary: This review of nearly 400 publications from Canada, the US, Britain and Australia has identified a large number of studies supporting the conclusion that very often, recent immigrant groups experience low rates of utilization of many important social and health services, despite evidence of significant need. The barriers most often identified include those related to language, lack of information about services, cultural patterns of help-seeking, lack of cultural sensitivity by service providers, financial barriers, and lack of service availability.



5. Huismann, A., Weilandt, C. & Geiger, A. (eds.) (1997) *Country Reports on Migration and Health in Europe*. Wissenschaftliches Institut der Ärzte Deutschlands eV, Bonn. Compiled on behalf of the European Commission.

Contains country reports on Belgium, France, Germany, the Netherlands, Spain, Sweden, and the UK as well as other chapters.

6. Carballo, M., Divino, J.J. & Zeric, D. (1998). Migration and health in the European Union. *Tropical Medicine and International Health* 3, pp. 936-944.

Summary of a review requested by the European Commission in 1997.

Abstract - The paper gives a brief overview of a wide spectrum of health issues and problems, ranging from communicable disease to mental health and family formation, which affect migrants and host countries.

7. Vulpiani, P., Comelles, J.M. & van Dongen, E. (2000) *Health for all, all in health*. Cidis/Alisei, Perugia.

First report of the project 'Salute per Tutti' - 'Health for all, all in health' - European experiences and strategies against social exclusion of immigrant people by health care services.

Countries covered: Italy, Spain, Sweden, Belgium and the Netherlands.

8. Watters, C. (2002). Migration and mental health care in Europe: report of a preliminary mapping exercise. *Journal of Ethnic and Migration Studies*, Volume 28 (1), pp. 153-172(20).

Abstract: This paper offers an examination of mental health services for migrant groups in a number of European countries. It draws on a range of recent studies to highlight some of the key and emerging issues in relation to the provision of mental health services within an increasingly multi-ethnic and multicultural Europe. The results of a preliminary mapping exercise of mental health services for migrant groups are presented and their broader implications are considered. The aim of the mapping exercise was to collect and examine information on mental health services for migrant groups against a backdrop of broad policy developments in the mental health field and the emergence of multicultural approaches in public policy. The results of a questionnaire survey of service providers in 16 European countries are summarised, with special attention to three of the participating countries,

Sweden, the Netherlands and Spain. The information from it is placed in a context of current research in the field of race, culture and mental health. In examining the results of the preliminary mapping exercise, key areas for policy development and service provision are identified and an agenda for future research in this area is suggested.

9. Watters, C., Ingleby, D., Bernal, M., De Freitas, C., De Ruuk, N., Van Leeuwen, M. & Venkatesan, S. (2003). *Good practices in mental health and social care for asylum seekers and refugees*. Final Report of project for the European Commission (European Refugee Fund). Canterbury: University of Kent, 344 pp.

Available online at www.ercomer.eu/ingleby

Contains country reports on the UK, the Netherlands, Spain and Portugal, also some material on Canada and Australia.

The results of this project are also summarised in:

C. Watters & D. Ingleby (2004) Locations of care: meeting the mental health and social care needs of refugees in Europe. *International Journal of Law and Psychiatry* 27, 549-570.

10. McKay, L., Macintyre, S. & Ellaway, A. (2003) *Migration and Health: A Review of the International Literature*. Glasgow: MRC Social & Public Health Sciences Unit, Occasional Paper No 12.

<http://www.sphsu.mrc.ac.uk/files/File/library/occasional/OP012.pdf>

(Report not confined to Europe)

From the introduction:

This report is a comprehensive review of primary literature on internal and international migration and health. It is the result of searches using five on-line databases, a list of health and migration related keywords, and strict inclusion and exclusion criteria (see section 2).

These searches produced 362 papers, of which 136 papers met the criteria and were included in the report (see section 5). These papers were summarised and separated into internal migration, and four subgroups within international migration: 'all cause and cardiovascular mortality', 'cancer mortality', 'mental health', and 'morbidity, risk factors and anthropometry'.

The review investigates the morbidity or mortality rates of many immigrant groups from around the world moving between different countries or within a country. Although patterns and profiles vary for different immigrant groups in different countries, general themes were apparent.

Background Paper

Assisting Migrants and Communities (AMAC) Project

11. Van Dongen, E. (2004) *If you are not satisfied, go back to your country: Experiences of discrimination in health care.*

www.salutepertutti.org

Research report of "Partners for Health, Phase II": Combating discrimination in health care.

Extract: A qualitative study on experiences of discrimination and exclusion has been done in the countries of the five participants of the project: Italy, Spain, Sweden, Belgium and the Netherlands. The history of migration, the origin of migrants, the focus of research on migrants and health care in general and development of health care for migrants differ to a large extent between the five countries. Therefore, it was decided to focus on migrant groups that belong to the field of expertise of the participants in the project, or that were determined as groups, which have clear problems of accessibility of health care. In Italy the research population was migrant women, with a focus on reproductive health. In Spain the research focused on migrant users of primary health care and hospitals. In Sweden the researchers focused on women from the Middle East and Somalia. In the Netherlands research was done in mental health care, in particular focused on Cape Verdean migrants. In Belgium, the researchers focused on mental health care for Turkish women with somatic complaints.

12. Ingrid Stegeman and Caroline Costongs (2004) *Promoting Social Inclusion and Tackling Health Inequalities in Europe, an overview of good practices from the health field.* Report by Eurohealthnet.

<http://www.eurohealthnet.eu/>

This publication presents an overview of evidence gathered from 52 good practices that reveal how the health field can foster social inclusion. The largest numbers of good practices focus on ethnic minorities residing in the country for a significant period of time, or illegal or newly arrived migrants.

13. Ingleby, D., Chimienti, M., Ormond, M. & de Freitas, C. (2005). The role of health in integration. In M.L. Fonseca and J. Malheiros (eds.), *Social integration and mobility: education, housing and health.* IMIS-COE Cluster B5 State of the art report, Estudos para o Planeamento Regional e Urbano nº 67, pp. 88-119. Lisbon: Centro de Estudos Geográficos.

<http://www.ercomer.eu/downloads/inglv.doc>

Contains an overview of theoretical issues as well as country reports on the Netherlands, Switzerland, Greece and Portugal.

14. Carballo, M. & Mboup, M. (2005) *International migration and health.* A paper prepared for the Policy Analysis and Research Programme of the Global Commission on International Migration by International Centre for Migration and Health.

General overview of health problems and policy issues associated with migration. Not confined to Europe. Unfortunately, the paper does not include a list of references.

15. Mladovsky, P. (2007) *Migration and health in the EU.* Research note for EC Directorate-General Employment, Social Affairs and Equal Opportunities. Unit E1 - Social and Demographic Analysis.

http://ec.europa.eu/employment_social/spsi/docs/social_situation/m_migration_health.pdf

Very extensive report, containing a range of information on almost all European countries. Some are covered extensively, others only in passing.

16. Médecins du Monde (2007) *Report on the access to health care of undocumented migrants in Belgium, Spain, France, Greece, Italy, Portugal, UK, Netherlands, Germany.*

Available for download from <http://www.medecinsdumonde.org/gb>

17. PICUM (2007) Report: *Access to Health Care for Undocumented Migrants in Europe.*

Available for download from <http://www.picum.org/>

Contains reports on Austria, Belgium, France, Germany, Hungary, Italy, the Netherlands, Portugal, Spain, Sweden, and the UK.

18. *Euro Observer* (Winter 2007 issue). "Migration and health in EU health systems - case studies from the Netherlands, Italy and Spain". Published by WHO European Observatory on Health Systems and Policy

<http://mighealth.net/eu/images/2/29/Euro.pdf>

Three countries' migrant health policies are described, revealing considerable differences. The issue of undocumented migrants and their access to health care systems in those three countries is also addressed.



19. Portugal, R., Padilla, B., Ingleby, D., De Freitas, C., Lebas, J. & Pereira Miguel, J. (2007) *Good practices on health and migration in the EU*. Report prepared for the conference "Health and Migration in the EU: Better health for all in an inclusive society".

Available online at

http://www.ggd Kennisnet.nl/kennisnet/uploaddb/download_object.asp?atoom=44574&VolgNr=574

This report was prepared in the framework of the Conference "Health and Migrations in the EU" (Lisbon, 27-28 September 2007) and aimed at presenting a collection of existing Good Practices in the field of health and migration, including practices in the public sector as well as many provided by non-governmental organizations. The first part of the report analyses common aspects of Good Practices, such as the methodology, the models and aims, and provides a critical overview of the limitations of Good Practices, highlighting the importance of structural change. In conclusion, some national cases of health policies are analysed to illustrate the diversity within the EU, and some recommendations are presented.

The Annexes present the collection of Good Practices divided into chapters: Transnational cases, country cases and Portugal.

20. Huber, M., Stanciole, A., Bremner, J. & Wahlbeck, K. (2008). *Quality in and Equality of Access to Healthcare Services: HealthQUEST*. Brussels: DG Employment, Social Affairs and Equal Opportunities.

http://www.euro.centre.org/detail.php?xml_id=866

The report compares data from Finland, Germany, Greece, the Netherlands, Poland, Spain, Romania, and the UK. Access and quality of care is examined for the following vulnerable groups:

- Migrants, asylum seekers and illegal immigrants
- Older people with functional limitations
- People with mental health problems.

The report begins with an in-depth analysis of the factors which may undermine access and service quality, and shows how these factors may affect each group in turn, using data from the eight countries surveyed.

More detailed country reports are in preparation (see http://www.euro.centre.org/detail.php?xml_id=866)

21. European Agency for Fundamental Human Rights (2008) *Annual Report 2008*.

Vienna: FRA.

<http://fra.europa.eu/fra/index.php>

Starting with 2008, the FRA includes health care as one of the areas covered in its annual report on discrimination in the 27 EU Member States. Data on discrimination and barriers to access in health care is collected by the FRA's 27 RAXEN National Focal Points (NFPs). Attention is also paid to the efforts that have been made in each Member State to improve the situation for migrants and ethnic minorities. In this report, Roma and undocumented migrants are identified as the groups most likely to experience barriers to access to health care.



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