

Explanatory Memorandum of the draft Recommendation CM/Rec(2011)13 of the Committee of Ministers to member states on mobility, migration and access to health care



INTRODUCTION

1. The background to this recommendation is the increase in recent decades in the numbers of migrants in the 47 countries of the Council of Europe. In 2005 there were nearly 66 million migrants in the countries of the Council of Europe, representing one-third of the world's migrants and 8.1% of the total population of these countries.¹ (These figures relate to foreign-born citizens residing in each country and do not include irregular or unregistered migrants.) The demographic significance of migration to these countries can be gauged from the fact that migration contributed to almost 85% of Europe's population growth. The present recommendation is also relevant to the children of migrants, including those born in the host country, as well as to IDP's (internally displaced populations).

2. Recent migration is characterised by increasing mobility and diversity: this presents a new challenge to health services, which in the past had to deal with a limited number of relatively stable immigrant groups.

Why a new instrument?

3. The Council of Europe is primarily concerned with the ethical and human rights dimensions of social and health issues, rather than just the economic aspects. It addresses concerns about equitable access to health care of appropriate quality, including in the context of mobility and migration.

4. The High Level Task Force on Social Cohesion in its report (published in November 2007) calls for solidarity and intercultural dialogue components to be included in making European health services able to operate in multicultural societies, taking all migrants into account.

5. The European Health Ministers Conference "People on the move: human rights and challenges for health care systems", Bratislava 22-23 November 2007, invited the European Health Committee (CDSP) to take into account, in its future work, the ethical and human rights dimension of migration. The Conference recommended that the Committee of Ministers entrust the CDSP to develop a programme of work on the current health challenges of vulnerable groups including migrants, refugees, asylum seekers, and Roma and Travellers.

Background

6. The field of migration itself is well studied, but the role of international cooperation and the influence of migration on health and on access to health care is not fully examined.

7. There is a need to connect up the research and policy agendas on migrant health with those concerning health equity and social determinants of health. Strengthening the links between these two domains would further the development of both.

Working method

8. In 2008, the European Health Committee (CDSP) set up a Committee of Experts on mobility, migration and access to health care. The committee was asked:

- to review existing Council of Europe and other relevant international mechanisms for the protection of patients' rights and safety in the context of mobility;
- to address the issue of access to health care for people on the move, based on human rights, equity and participation, with particular emphasis on the health of women, children, refugees and Internally Displaced Persons;
- to identify appropriate ways to address health needs of irregular migrants taking into account national policies and practices.

¹ Statistics from the United Nations Department of Economic and Social Affairs. More recent data are only available in the form of estimates.

Drafting process

9. This Committee of Experts was composed of 11 independent specialists selected by the European Health Committee (CDSP) on the basis of their personal expertise in health and migration, while respecting a specialisation balance as well as a geographical and a gender balance. The Committee was composed as follows: Chair - Mr Harald Siem (Norway), expert members Ms Nata Avaliani (Georgia), Mr Ramazan Salman (Germany), Mr Istvan Szilard (Hungary), Ms Marloes Vorderman (Netherlands), Mr José Marques Robalo (Portugal), Mr Felix Vartanian (Russian Federation), Mr Eugen Nagy (Slovakia), Mr Thomas Spang (Switzerland), Ms Fimka Tozija ("the former Yugoslav Republic of Macedonia"), Mr Michael Swaffield (United Kingdom); Consultant – Mr David Ingleby (Netherlands).

10. A wide range of observers, including representatives of leading international intergovernmental and non-governmental organisations (e.g. International Organisation for Migration (IOM), World Health Organisation (WHO), Office of the High Commissioner for Human Rights (OHCHR), the Platform for International Cooperation on Undocumented Migrants (PICUM) and Doctors of the World), also contributed to the work of the committee.

11. In this Explanatory Memorandum, individual items within the Recommendation are grouped under the six topics (A-F) which they deal with. The Appendix contains a list of legal and policy instruments relating to health in general or specifically to migrant health. Comprehensive recent overviews on migrant health in the European region are available in WHO (2010)² and Rechel et al. (2011).³

A. IMPROVING KNOWLEDGE ABOUT MIGRANTS AND THEIR SITUATION

Collection and use of personal data on the demographic, social, educational and economic characteristics of migrants and their legal situation in the host country

12. In order to monitor migrants' state of health, to discover the health risks they are exposed to and to provide them with effective health services, it is essential to have information about their numbers, demographic characteristics and living situation. In many countries, this information is at present lacking. Where a significant proportion of migrants are unregistered, the task of collecting such data is particularly difficult. Data collection and research on migrants should be stimulated by public authorities and academic organisations, while interdisciplinary collaboration between social scientists and health researchers should be encouraged. Both quantitative and qualitative information is valuable.

13. Health care must address not just disease, but illness – not just pathology, but the people who suffer from it. 'Disease' refers to a physical process, whereas 'illness' refers to the way this process is experienced by the sufferer and the social environment: its personal and social meaning, and its practical and psychological consequences.

14. However, the collection of background information is hampered by the following obstacles, which need to be energetically addressed:

Lack of consensus regarding concepts and categories

14.1 There is no international agreement about the way in which information on migrants should be collected. Nationality is not a satisfactory indicator of migration status because migrants sometimes adopt the nationality of the country they move to; in Germany, 'nationals' may also have returned to the country after living for years or even generations outside it (Aussiedler). The term 'culture' can be operationalised in many different ways and forms an insufficient basis for objective categories. Even the term 'migrant' is used in different ways in different countries. To facilitate the sharing of data, efforts should be made to reach a higher level of international consensus concerning both the concepts to be used and the way category boundaries are defined.

² WHO (2010) *How health systems can address health inequities linked to migration and ethnicity*.

Copenhagen: WHO Regional Office for Europe.

http://www.euro.who.int/__data/assets/pdf_file/0005/127526/e94497.pdf

³ Rechel, B., Mladovsky, P., Devillé, W., Rijks, B., Petrova-Benedict, R. & McKee, M. (eds.) (2011) *Migration and health in the European Union*. Maidenhead: McGraw Hill / Open University Press.

Obstacles to collecting data on migrants

14.2 In the interests of discouraging discrimination, many member states, institutions and individuals are opposed to the collection of data on people's origins or ethnicity. There are often good reasons for such reservations, and stringent precautions should always be taken to ensure privacy and avoid misuse of information. Nevertheless, it should be recognised that action to help particular groups cannot be undertaken without relevant information about who their members are.

B. MIGRANTS' STATE OF HEALTH

Monitoring of migrants' state of health and investigating the causes of discrepancies

15. Monitoring implies that studying migrants' state of health should be a continuous, routine process, rather than a matter of incidental, 'one-off' research projects. In most developed countries the health of the population is subject to regular monitoring: what needs to be done is to ensure that these procedures are fully inclusive and capable of identifying migrants as a distinct group. Regular surveys of population health may need to be supplemented by special studies. In some countries monitoring of migrants' health can be facilitated by linking different data sets with each other.

Clinical versus population-based studies

16. Although population-based or epidemiological studies may be less subject to bias than other methods of collecting health data, the type of information they can provide tends to be limited. Clinical studies based on contacts with health care providers may offer more detail, but of course such studies give no information about people who do not seek treatment for their problems. In the case of irregular migrants, the only information available about their health may be that which is provided by clinical studies. Clinical and population-based studies are both essential and should be used in conjunction with each other.

Health problems associated with migration

17. Very few generalisations can be made about the health of migrants. In statistical terms, there are few main effects but many interactions, depending on the country studied and the type, sex, age and origin of migrants. The health of migrants is not necessarily worse than that of the rest of the population. Indeed, the "healthy migrant effect" refers to the fact that in some circumstances migrants have better health on arrival, but after years of living in the host country their health deteriorates to the level of the majority. Nevertheless, some health problems are persistently reported among many migrant groups. These include:

17.1 **Self-reported (subjective) health:** these differences often reflect the socio-economic status and living conditions of migrants. However, the cross-cultural validation of such data may present problems.

17.2 **Non-communicable diseases:** the main problems reported concern cardio-vascular disorders, diabetes, maternal health, and perinatal mortality and morbidity. The incidence of cancer is in general not raised, but the disease is often diagnosed at a later stage when treatment is less effective. Many of these problems are related to shortcomings in health promotion and preventive programmes for migrants. Such interventions are usually designed for the majority population and fail to reach (or adequately influence) migrants. As a result, migrants may be unprepared to deal with the risks that accompany a Western life-style.

17.3 **Communicable diseases:** raised incidences, where they are found, may reflect conditions in the countries from which migrants originate, but they may also concern the environments in which migrants live and the lack of effective health promotion, screening and primary care. Higher rates of tuberculosis, hepatitis A and B, and HIV/AIDS are found in some migrant populations and some countries. It should be noted that migrants form a very small proportion of all international travellers; general measures to contain imported diseases may have more importance for public health than measures directed only at migrants.

17.4 **Mental illness:** studies here are sometimes hampered by problems of cross-cultural validity, but higher rates of common (depressive and anxiety-related) mental disorders are reported in many studies. Asylum seekers and Internally Displaced Persons may retain post-traumatic symptoms from their experiences in the country or region of origin, though recently increased attention has also been paid to severe psychological stress resulting from asylum procedures and reception conditions (including detention). Increased rates of psychotic disorders have been found among some groups of young male migrants (as well as members of the 'second generation'), particularly those suffering considerable social disadvantage and exclusion. These disorders also tend to be detected later and to be responded to by more restrictive measures (e.g. compulsory treatment).

17.5 **Occupational health and safety:** the work which migrants often carry out is associated with higher rates of accidents and ill-health, while industrial safety legislation is sometimes poorly implemented in the sectors where they work.

Investigating the causes of health discrepancies

18. A wide range of factors may underlie the health discrepancies that have been found, while research on this topic is in its infancy. Some problems may result from inadequate health care provisions; there is a particular need for increased attention to health promotion and education, preventive programmes and primary care. Whereas earlier research focused on presumed genetic and cultural causes, attention has recently focused on the social determinants of ill-health.

Reviewing all policies and practices affecting migrants' living and working conditions in order to minimise risks to their health

Health impact of policies affecting migrants

19. As we have just seen, some health problems of migrants can be traced to shortcomings of the health services provided for them. However, policies in other areas may also have a major impact. An 'intersectoral' approach is required involving not only health ministries but all other sectors of governance, in accordance with the principle of 'health in all policies'.

19.1 **Social disadvantage and social exclusion**, which may be reflected in levels of income, education, type of work, housing and environment, constitute a major health risk for migrants. Sometimes the effect of these factors is sufficient to completely explain differences in their state of health. This does not mean, however, that tackling only socio-economic disadvantages and ignoring migration as such is justified. All aspects of the situation of migrants which keep them in a disadvantaged position should be considered if we want to tackle the underlying causes of health problems. This entails critical attention to policies on education, employment, social protection, social services and housing.

19.2 **Discrimination** (whether institutional or individual) is a particularly serious obstacle for migrants, which may also have direct negative effects on their health. Anti-discrimination legislation should be comprehensive and effectively implemented.

19.3 Improvements in the field of **health and safety at work** should be backed up by legal sanctions, effective inspection, and information campaigns aimed at both employers and (migrant) employees.

19.4 The conditions under which **asylum seekers** are held pending a decision on their claim, as well as the uncertainty and slowness of the procedures, can result in health problems.

C. ENTITLEMENT TO HEALTH SERVICE PROVISION

Providing migrants with adequate entitlements to use health services and ensuring that these entitlements are known and respected

The nature of entitlement

20. In this document we have broken down the notion of 'access to health care' into two components: first, 'entitlement' to services – the right to use them – and second, the 'accessibility' of these services, i.e. the ease with which they can be located and reached. 'Entitlement' is usually laid down in the law, rather than being determined by health service providers themselves. Moreover, 'entitlement' does not simply mean being able to obtain treatment; people who can afford to pay for treatment themselves will nearly always be able to get it. It means being included in the statutory framework (tax- or insurance-based) for payment of treatment.

21. At present, migrants' health-care entitlements vary considerably between countries and according to the category of migrant concerned. Sometimes migrants only qualify for health care after they have been residing in a country for a certain length of time, or if they are in registered employment. Even then, they may not be entitled to the full range of services, and the 'out-of-pocket' financial contributions there are required to make (whether formal or informal) may impose a heavy burden. They are also countries in which migrants are included in the national system of health coverage, but their children are not – and vice versa. Private insurance is of course a possibility for those not covered by the national system, but applicants may be refused and the premiums for people with raised health risks may be prohibitive.

22. *Asylum seekers* are often covered by special schemes, most of which include a reduced range of services. The most problematic and controversial case is that of *irregular* (undocumented) migrants: here, there is a tension between two opposing sets of principles.

22.1 **Supporting the right to health care** are many international conventions, declarations and covenants, as well as basic principles of medical ethics.

22.2 **Opposing the right to health care** are a number of political and pragmatic arguments. The most commonly-heard argument is that welfare states have to limit the assistance they give to those in need in order to avoid over-stretching their resources. Considerations of solidarity require that benefits should be confined to the population which has contributed to the welfare system. If health services are made freely available to everybody regardless of their status, so the argument runs, the system will be overwhelmed with sick people from all over the world.

23. In the attempt to strike a balance between these two sets of principles, governments have adopted a variety of positions. A recent inventory⁴ of policy in the EU27 has shown that irregular migrants are entitled only to emergency medical care in 12 member states; 10 states provide them with a lower level of entitlement, and 5 states with a higher one.

24. Providing only emergency medical care, while it may satisfy minimal human rights requirements, is an ineffective form of service provision because it excludes preventive care, screening and early detection of problems and makes continuity of care impossible.

25. Intensive research in the last few years by both NGO's and academic researchers has also shown that even when irregular migrants enjoy entitlement to services in theory, several factors may prevent them from benefiting from these entitlements in practice:

25.1 Procedures for accessing care may be complex, difficult to understand and hard to comply with.

25.2 Both irregular migrants and health workers may be poorly informed about the entitlements which exist and the procedures required. Irregular migrants may be turned away, or required to pay large bills, by health care workers (including receptionists and administrative staff) who either do not know or do not respect the rules.

25.3 A powerful disincentive for irregular migrants to seek health care is the fear that they will be reported to the authorities. Even when the law does not require this, or actually forbids it, a migrant may not know the law – and in any case he or she has no guarantee that others will know and respect it.

26. It is clear, therefore, that enacting legislation to give irregular migrants adequate health care entitlements may not be sufficient. Rights on paper need to be backed up with adequate measures for implementation.

⁴ Björngren Cuadra, C. (2011) Right of access to health care for undocumented migrants in EU: a comparative study of national policies. *European Journal of Public Health*, published online June 9th 2011, doi: 10.1093/eurpub/ckr049.

D. ACCESSIBILITY OF THE HEALTH SYSTEM

Promoting knowledge among migrants about issues concerning health and the health system and taking measures to increase the accessibility of health services

27. The term accessibility refers to the ease with which a person who needs help can get it, assuming that they are entitled to use the health care system.

28. Some barriers to obtaining help ('demand-side' barriers) originate with the person who needs help. They may not be aware that they have a health problem, or they may not regard it as requiring attention. A lower uptake of health care among migrants is often ascribed to a lower level of 'health literacy', defined as "the cognitive and social skills that determine the motivation and ability of individuals to gain access, to understand and use information in ways which promote and maintain good health"⁵. However, if migrants do not seek help when health workers think they should, this may be because they have different ideas about health, not because they are simply ignorant. Health educators are likely to be taken more seriously if they acknowledge the existence of divergent views on health and try to engage with them rather than simply telling people what to think.

29. Nevertheless, the fact that the host country may have a health system that is radically different from the one they are used to, based on ideas they are not familiar with, presents a major challenge for migrants trying to look after their own health. Some of the non-communicable health problems that migrants are prone to may result from lack of information about preventive procedures and the importance of early detection (e.g. in relation to sexuality, pregnancy, childbirth, mental illness or screening for cancer). Health education about these issues and about eating and exercise habits, smoking and substance abuse, often fails to reach migrants because it is not provided in a language they can understand or in ways that reach home to them.

30. Targeted health promotion and education can be incorporated in integration programmes and should use linguistically and culturally appropriate materials. It is important, for example, to understand the stigmas and taboos which may surround certain topics. One approach which has been particularly successful involves the use of 'health ambassadors' or 'cultural mediators' from migrants' own communities. Bridging the gap between migrants and the health system is not something that can be achieved at the moment that contact takes place; it should be worked on well in advance. Migrants are often described as a 'hard to reach' group, but the question should be: how hard are health services trying to reach them? In this area, an 'outreaching' approach is essential.

31. As well as 'demand-side' barriers there are also 'supply-side' barriers to access which may prevent migrants from getting the help they need. It is not enough simply to give migrants the right to use the services; in many respects, it may also be necessary to adapt the services.

32. **Language barriers** form one of the most important obstacles to accessible and effective care. In a sense, of course, these barriers originate with the user, not the service provider; yet there are many situations in which a migrant cannot be expected to have learned the local language to the high level that is required in interactions with health care providers. In any case, what matters at the point of contact is not whether they should have learned the language, but whether they have. If a language barrier exists, it should be overcome.

Overcoming language barriers by appropriate measures, including interpreting services and access to translated information materials wherever necessary

33. For migrants who are not (yet) fluent in the majority language, the provision of interpreter services is perhaps the most important single measure that can be taken to improve the accessibility and quality of health services. Interpretation may be provided face-to-face by an interpreter who is present during the encounter, or through a telephone service or a video link.

34. The importance of interpretation is widely underestimated. Inadequate communication undermines the accuracy of diagnoses and makes it less likely that advice and instructions will be understood and correctly followed. Language barriers may have fatal consequences. They can be exacerbated by the fact that specialised terminology is often used in medical encounters, which can also be emotionally charged and stressful for the patient.

⁵ WHO (1998) *Health Promotion Glossary*. Geneva: World Health Organization. <http://www.who.int/healthpromotion/about/HPG/en/>

35. In the USA, the use of interpreters is mandatory under Title VI of the Civil Rights Act for all service providers in receipt of federal funding. It is also increasingly acknowledged by service providers and insurance companies that not hiring an interpreter may be a false economy. Only in a handful of European countries are interpretation services provided free as a matter of course. Often use is made of informal interpreters – family members or friends of the patient, or hospital staff (whatever their function) who happen to speak some of the language in question. This practice, though seeming to be cheap and convenient, is risky and can also create role tensions and confidentiality problems (especially when a child has to interpret for a parent).

36. Even if language barriers are absent or have been overcome, however, migrants may still not feel that mainstream health services are meant for them. They may pick up countless signals suggesting that they do not 'belong' in these services; their experiences may be overwhelmingly negative and they may have low expectations of being helped. As a result, they may prefer to seek help from alternative healers or to save up their health problems for a visit to their country of origin. To counter this requires a widespread change in attitudes and practices within the health system, in order to make services truly 'migrant-friendly'.

E. QUALITY OF HEALTH SERVICES

Improving the adaptation of health service provision to suit the needs, culture and social situation of migrants

Evolution of the concept of 'matching'

37. Much innovative work has been carried out in this area, although there is still a shortage of research evaluating the different strategies proposed. Most of this work has been carried out with the aim of improving 'cultural competence' – a broad concept which has been in use, mainly in the USA, since the 1970's. Four phases can be distinguished in the development of this concept:

37.1 In the first phase the emphasis lay on **knowledge** about the cultural features of different groups. This encouraged the production of guidelines and manuals advising health professionals on how to deal with patients from different cultural backgrounds. It has become widely recognised, however, that this approach easily leads to over-simplifications and stereotyping, which may actually undermine a good working relationship between service users and providers.

37.2 In more recent work, 'cultural competence' is considered to include **knowledge, skills and attitudes**. Caregivers should acquire **skills** of openness, empathy and adaptability in communicating with people with different cultural backgrounds; they should be adept at identifying and resolving misunderstandings. Receptiveness, respect and tolerance are essential **attitudes** in intercultural situations.

37.3 A further development has been the realisation that the social situation of the migrant in the host society may be more relevant than cultural traditions in the country of origin. The current context – for example, the uncertainty of an asylum seeker's legal position and the threat of having to return to their country of origin – may be the most important factor influencing health.

37.4 At the same time it has come to be accepted that it is not only the individual caregiver who needs to become 'culturally competent', but also the organisation (or health care system) as a whole. Organisations may need to undertake far-reaching reforms in order to be able to bridge the gap between them and their migrant users. For example, recruitment policies should be devised which ensure that the diversity of the client population is reflected in the staff of the institution. Ethnocentric attitudes and forms of 'indirect discrimination' should be exposed and tackled.

Strategies for improving the 'matching' of services

38. This is an area of constant experimentation and innovation, but four important strategies will be singled out for attention here:

38.1 Improving the **cultural competence** of individual caregivers. Special training courses may be used to this end, but it is also important that these issues should eventually be dealt with in the basic education of each professional.

38.2 The **whole organisation approach**, as we have seen, regards 'cultural competence' as a property of service providers rather than just individuals. The organisation (health care system) as a whole should be designed with the needs of a diverse client population in mind.

38.3 The use of **cultural mediators** has already been mentioned in connection with health promotion and reducing barriers to access. Many countries (in particular Belgium, the Netherlands, the UK, Spain, France and Italy) employ members of migrant communities in the role of auxiliary health workers.

38.4 Adaptation of **diagnostic procedures** and **treatment methods** to take more account of different cultural frames of reference and 'idioms of distress'. Such adaptation is particularly important in the field of mental health, where the patient's experience and not only laboratory results and scans is an important source of information. A more controversial approach involves expanding the repertoire of treatments to include approaches used in a patients' country of origin. More often, existing ('Western') methods are adapted in such a way as to make them more appropriate to migrant patients.

Providing 'joined-up' care

39. The effectiveness of health services for migrants can be increased by improving collaboration with services in other sectors. One example concerns **better integration of health care and social care**.

Improving the integration of health care with other social services for migrants

40. The first step to be taken is **better integration of health care and social care**. The term '**social care**' includes (among other things) residential care, home care, day centres, rehabilitation, care for addicts or people with physical or mental handicaps, and social work. In many situations, people may need both health care and social care. Modern care systems tend to be highly specialised, resulting in fragmentation of service delivery. Users have to seek different kinds of care along different channels, which may multiply problems of accessibility. Coordination between different services may be poor.

41. Integration of health and social care is particularly important in situations where the health problems of migrants are related to social problems requiring the intervention of non-medical agencies. It may be particularly difficult for migrants to navigate their way through the various care agencies, each with their own procedures.

42. 'One stop services', 'case management' and 'care management' have been proposed as solutions to this problem. Appointing a single care manager is a step toward improving coordination between services, but this does not overcome the problem that care is given by multiple agencies. Moreover, social care has to take into account migrants' needs, culture and social context, just as health care does.

43. The provision of information about social care facilities is highly important, because many care provisions will be little known among people not coming from modern Western welfare states. Some provisions (such as residential care for the elderly) are 'typically Western' and may conflict with other cultural norms.

44. A second step towards integrated services involves **intersectoral co-operation between agencies concerned with migrant integration and those concerned with health promotion and education**. Newcomers to a country are particularly in need of information and guidance about use of the health services. Several countries already include this topic in their integration programmes for immigrants. More generally, in keeping with the principle of 'health in all policies' it is important that those responsible for public health monitor the impact on migrant health of policies in all sectors.

F. MEASURES TO PROMOTE CHANGE

Promoting appropriate training and education programmes

45. Education and training for health service personnel should pay special attention to 'cultural competence'. The curriculum should include information about the social situation and cultural background of migrants, and about the health beliefs and behaviour they may display, while taking care to avoid stereotyping. Knowledge about particular health problems and the risk factors underlying them is another major topic area. Finally, the skills and attitudes needed to work effectively in a culturally diverse setting need to be taught.

46. This teaching should take place at two levels:

46.1 In the basic education of each professional group (doctors, nurses, psychologists etc.). 'Cultural competence' already figures in the educational requirements of professional bodies in certain countries. Appropriate training may also be mandated by national or local legislation.

46.2 In supplementary training and education for health care workers already in employment. This education may be provided 'in-house' or in the form of special courses.

47. The 'whole organisation' approach also implies that migrant health should receive attention in the training of researchers, managers and policy makers. In addition, the topic should also be an integral part of courses in epidemiology, public health, social medicine, medical anthropology, sociology of medicine, psychology and migration studies.

Stimulating high-quality research on all aspects of health services for migrants

48. Modern health systems are increasingly 'evidence-based', emphasising a sound knowledge base as the foundation of all policies and practices. In Europe, research on migrant health has been a relatively neglected field, though the last ten years have seen a considerable increase in activity. Such research needs to be informed by a multidisciplinary approach and strengthened by international cooperation, in order that countries may learn from each others' experiences. More research is needed on each of the topics that have been dealt with in this Explanatory Memorandum.

Harmonising efforts to promote the health of migrants at European level

49. At national level, research and practical activities concerning migrant health suffer at present from fragmentation and a lack of coordination. Researchers, practitioners, mainstream health-care organisations, NGOs and professional bodies need to be brought into closer contact with each other.

50. A further task is to foster European cooperation. Because of the principle of subsidiarity, the scope for developing common European health policies is limited. Nevertheless, a great deal can be achieved by improving communication and cooperation between member states. Knowledge, data and expertise concerning migrants' health and their health problems in different countries can be pooled, 'good practices' exchanged and new insights can be gained. To this end, the setting-up of a centre of expertise (a European Migrant Health Observatory) should be considered, in order to coordinate research activities, develop policies and act as a clearing house for information.

51. It would be desirable for projects and initiatives of the Council of Europe, European Union, International Organisation for Migration and World Health Organisation to be harmonised with each other and reinforce the coherence, continuity and sustainability of efforts to improve migrant health. Current policy initiatives to tackle socio-economic inequities in the field of health should pay full attention to the important role of migration and migration-related factors as sources of inequity.

Fostering a closer relationship between migrants and health services, involving them in all activities concerned with their health

52. Whereas steps have been taken in recent years to increase public involvement and participation in health care, the gap between migrant communities and health services has remained largely unchanged. Initiatives to increase migrant involvement in the design and monitoring of health services may therefore start with a handicap and require extra effort. Instruments used to foster user involvement, such as patient organisations, tend to be dominated by members of the majority community and the voices of migrants may not be easily heard.

53. Representation of migrants in the health service workforce – as long as it is not confined to cleaning, cooking and maintenance staff – can be an important vehicle of change within organisations. The participation of migrants in research is also a way to ensure that their voices are heard.

**Supporting the widest possible dissemination of the recommendation
and its explanatory memorandum, where appropriate accompanied by a translation**

54. This recommendation and its explanatory memorandum should be disseminated, if necessary in translation, among all organisations and agencies concerned with migrant health. These include administrators and providers of mainstream health services, professional organisations and accrediting agencies, providers of health insurance, NGO's, private health providers, local and municipal authorities, migrant organisations and users' groups. Where possible the issues should be brought to the attention of the general public by means of documentaries, information and news items on TV, in printed media and via the Internet.

**Necessary steps to implement the guidelines in collaboration with health professionals,
professional bodies, and all governmental and non-governmental agencies
concerned with migrant health**

55. Experience with efforts to improve migrant health in different countries shows that these are likely to stagnate or die out where they do not enjoy government backing. Short-term measures and incidental projects cannot provide the necessary continuity: measures should be structurally embedded in policies. On the other hand, effective changes cannot be implemented in a purely 'top-down' way. The health system comprises a wide range of state and non-state actors, and changes to improve migrant health require concerted action by all parties involved.

56. Stakeholders include, in the first place, not only national governments but also regional and municipal administrations. Policies on health and migration may be devolved to different levels of government: countries differ greatly in this respect. Particular regions and cities tend to become especially concerned with migrant health issues, for the simple reason that most migrants are concentrated in those areas. Other stakeholders are service providers, insurance companies, professional bodies, licensing and regulating bodies and research organisations. Non-governmental organisations and the private sector may have an important role to play in all parts of the health system. Migrants and users' organisations have an especially important task in advocating for improvement.

57. In spite of the great diversity of stakeholders, leadership at the level of national government is essential to provide coordination and support for change at all levels. Moreover, within national governments collaboration between ministries is necessary in order to guarantee the contribution of all sectors to migrant health. Finally, well-informed public opinion is necessary to provide the support that far-reaching policy measures require.

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Appendix

List of legal and policy instruments relating to health in general or specifically to migrant health

i) United Nations

1. *Universal Declaration of Human Rights (1948)*

Article 25:

(1) "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

2. *International Convention on the Elimination of All Forms of Racial Discrimination (1969)*

Article 5:

"[...] Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: [...]"

(iv) The right to public health, medical care, social security and social services"

3. *International Covenant on Economic, Social and Cultural Rights (1976)*

Article 12:

"The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

4. *Convention on the Rights of the Child (1990)*

Article 24:

1. "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services."

5. *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990)*

Article 28:

"Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment."

6. *UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4.*

Non-discrimination and equal treatment

18. By virtue of article 2.2 and article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. The Committee stresses that many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information. The Committee recalls general comment No. 3, paragraph 12, which states that even in times of severe resource constraints, the vulnerable members of society should be protected by the adoption of relatively low-cost targeted programmes.

19. With respect to the right to health, equality of access to health care and health services has to be emphasized. States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities, and to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health. [...]

ii) Council of Europe

1. *Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights) (1950)*

Article 2 – Right to life

“Everyone’s right to life shall be protected by law.”

Article 3 – Prohibition of torture

“No one shall be subjected to torture or to inhuman or degrading treatment or punishment.”

Article 14 – Prohibition of discrimination

“The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.”

2. *European Social Charter (1961, revised 1996)*

Article 13:

The right to medical and social assistance

“With a view to ensuring the effective exercise of the right to social and medical assistance, the Parties undertake:

1. to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;
2. to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;
3. to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;
4. to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953.”

3. *Parliamentary Assembly Recommendation 1325 (1997) on traffic in women and forced prostitution in Council of Europe member states*

6. “The Assembly further recommends that the Committee of Ministers urges member states to:[...]

vi. organise legal, medical and psychological assistance for victims of traffic and forced prostitution, especially those willing to testify in court;”

4. *Parliamentary Assembly Recommendation 1503 (2001) on health conditions of migrants*

6. “The Assembly considers that the right to health associated with access to health care is one of the basic universal human rights and should be equally applied to all people, including migrants, refugees and displaced persons.”

5. *Parliamentary Assembly Resolution 1509 (2006) on human rights of irregular migrants*

12.4 “Detainees should have the right to contact anyone of their choice (lawyers, family members, NGOs, UNHCR, etc.), have access to adequate medical care and access to an interpreter and free legal aid where appropriate;”

13.2. "Emergency health care should be available to irregular migrants and states should seek to provide more holistic health care, taking into account, in particular, the specific needs of vulnerable groups such as children, disabled persons, pregnant women and the elderly;"[...]

16. "The Parliamentary Assembly also invites the governments of member states of the Council of Europe to assure that irregular migrants are able to enjoy their minimum rights in practice, including by:[...]

16.4. dispensing with the duty of certain authorities (for example school authorities, doctors and medical authorities) to inform on the illegal status of migrants so as to avoid the situation where irregular migrants do not claim their rights through fear of identification as irregular migrants and fear of expulsion;"

6. Recommendation Rec(2001)12 of the Committee of Ministers to member states on the adaptation of health care services to the demand for health care and health care services of people in marginal situations

III. Development of specific measures to guarantee a better equity

"When deciding on and implementing specific measures to improve access to health services to persons living in marginal situations or in insecure conditions, governments should pay particular attention to the risk of stigmatisation of these people. In addition, and because the objective is that everyone should have an equal access to health services, positive discrimination measures may be proposed for a limited period of time and be integrated into the normal health system."

7. Recommendation Rec(2006)18 of the Committee of Ministers to member states on health services in a multicultural society

All the provisions of this Recommendation are relevant to the health of migrants.

8. 8th Conference of European Health Ministers. "People on the Move: Human Rights and Challenges for Health Care Systems Bratislava" Declaration on health, human rights and migration (2008)

All the provisions of this Declaration are relevant to the health of migrants.

iii) European Union

The Treaty of Amsterdam in 1997 and the Tampere meeting of 1999 initiated EU policy measures on asylum and migration. Since then, a number of initiatives at EU level have called attention to issues of migrant health.

1. On 29 June 2000 the Council adopted a proposal for a **Directive combating discrimination** on grounds of racial or ethnic origin, to apply in the fields of employment, training, social protection (including health and social security), education and the supply of goods and services, including housing. This is often referred to as the "Race Equality Directive".
2. The **Charter of fundamental rights of the European Union** (signed at Nice in December 2000) contains the following provisions:

Article 35 (Health care)

"Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities."

Article 21 (Non-discrimination)

1. "Any discrimination based on any ground such as sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation shall be prohibited.
2. Within the scope of application of the Treaty establishing the European Community and of the Treaty on European Union, and without prejudice to the special provisions of those Treaties, any discrimination on grounds of nationality shall be prohibited."

3. The Commission's June 2006 **Communication on "Cohesion policy and cities: the urban contribution to growth and jobs in the regions"** contains the following guideline:

"Access to service facilities: Immigrant and disadvantaged populations may suffer from particular health and social service problems. They may also face barriers in accessing these services. An increased participation of persons with different backgrounds and of different ages in the planning and delivery of these services should help prevent discrimination and ensure that the services take account of cultural barriers."

4. Between 2004 and 2008, a considerable number of collaborative European projects concerning migrant health were subsidised by DG SANCO (13), DG ESAEO (4), DG RESEARCH (2) and DG JUSTICE (2).⁶ An important innovation was the inclusion of health care from 2008 onwards in the list of areas surveyed in the annual report of the Fundamental Rights Agency (FRA). The 2009 FRA report contains the following conclusion on health care (p. 57):

Despite many outstanding 'good practice' examples of policies and practical measures that member states and civil society organisations implement throughout the EU, long-term structural changes require a more coordinated action by government, health authorities and medical practitioners, as well as immigrants and the minority ethnic groups themselves, representatives of whom should ideally be directly involved in the implementation and also the design of policies.

5. The October 2007 Council Decision on **Establishing a second programme of Community action in the field of health (2008-13)** does not make any reference to immigrants as a disadvantaged or vulnerable group, although there is an emphasis on reducing health inequalities in general. However, migration is mentioned once in the October 2007 White Paper **Together for Health: A Strategic Approach for the EU 2008-2013** in relation to the mounting pressure EU Health systems are under to respond to the challenges of population ageing, citizens' rising expectations, migration, and mobility of patients and health. The White Paper's companion document states that the health of migrants should have a particular focus.
6. Migrant Health was high on the agenda of the Portuguese presidency of the EU in the second half of 2007. The Conference on **Health and migration in the EU: Better health for all in an inclusive society**" (Lisbon, September 2007) was organised with the support of DG SANCO, the collaboration of all Member States and the contributions of the World Health Organization, the Council of Europe and other relevant stakeholders. The conclusions of this meeting were subsequently endorsed in the Note **Health and Migration in the EU** issued by the Council of the EU in November 2007 (15609/07), which also made a number of practical proposals.
7. The European Commission's June 2008 Communication **A common immigration policy for Europe** stated that the EU and its member states need to "ensure a non-discriminatory and effective access of legal immigrants to health care and social protection".
8. An ad hoc committee, the **Health and Migration Advisory Group**, was formed within the EC at the time when the Portuguese presidency conference in 2007 was being prepared. This body met for the third and last time in February 2008. Its tasks were then taken over by the **EU Expert Group on Social Determinants and Health Inequalities**, which also prepared the **EC Communication on Health Inequalities**⁷. There is a clear emphasis on health equity in EC policy, which has received a boost from the publication of the Final Report of the WHO's Commission on Social Determinants of Health.
9. The European Parliament adopted a resolution on 8 March 2011 on reducing health inequalities in the European Union, which included specific reference to the needs of undocumented migrants and other vulnerable migrant groups.

iv) World Health Organisation

1. The 61st World Health Assembly on 24 May 2008 adopted a Resolution concerning the **Health of Migrants**, the content of which was strongly influenced by the conclusions from the Lisbon Portuguese presidency conference.

⁶ Ingleby, D. (2009) *European Research on Migration and Health*. Background Paper for AMAC project. Brussels: IOM. <http://www.migrant-health-europe.org/background-papers/research-on-migration-health.html>

⁷ EC (2009). *Solidarity in health: reducing health inequalities in the EU*. Brussels, European Commission http://ec.europa.eu/health/ph_determinants/socio_economics/cons_inequalities_en.htm .

2. The Final Report of the WHO's Commission on Social Determinants of Health (2008), entitled **Closing the gap in a generation: health equity through action on the social determinants of health**, has focused renewed international attention on health inequities. In the report, attention was paid to the health problems of migrants and refugees.