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A framework for analysing migrant health policies in Europe[☆]

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ABSTRACT

Evidence suggests migrants experience inequalities in health and access to health care. However, to date there has been little analysis of the policies employed to address these inequalities. This article develops a framework to compare migrant health policies, focusing on England, Italy, the Netherlands and Sweden. The first issue addressed in the framework is data collection. All four countries collect migrant health data, but many methodological limitations remain. The second issue is targeting of population groups. Countries typically focus either on first generation immigrants or on ethnic minorities, but not both, despite the often divergent needs of the two groups. Another issue is whether specific diseases should take priority in migrant health policy. While communicable diseases, sexual and reproductive health and mental health have been targeted, there may be a lack of attention paid to lifestyle related risk factors and preventive care. Fourthly, decisions about the mix of demand and supply-side interventions need to be made and evaluated. Finally, the challenge of implementation is discussed. Although migrant health policy has been elaborated in the four countries, implementation has not necessarily reflected this on the ground. These experiences signal important policy issues and options in the development of migrant health policies in Europe.

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1. Introduction

A growing body of studies suggests there are inequalities in health between migrants and local populations in Europe [1–5]. This is despite the fact that health services are (almost) free at the point of use in the EU and most countries grant full equality of treatment to third country nationals¹ after awarding them long-term or permanent

residence status. There is therefore increasing pressure at the European level to ensure migrants' access to social services, including health care, reflected for example in the focus of the Portuguese Presidency of the EU in 2007 [6] and the MIGHEALTHNET project which aims to stimulate the exchange of knowledge on migrant and minority health [7]. In light of this, an important question is, to what extent should governments develop policies to reduce migrant health inequalities? Furthermore, if governments do decide to address migrant health, what types of issues and policies might they consider? The lack of systematic analysis of national migrant health policies means there is little information available to help answer these questions. This article starts to address this gap. First, important conceptual and technical issues in migrant health policy are identified in the literature and presented in the form of an analytic framework. In the second part of the paper, the framework is employed to analyse migrant health policies and programmes in four European countries; England, Italy, the Netherlands and Sweden. It is argued that the framework

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¹ People who have the nationality of a state outside the current EU membership (EU citizens are entitled to cross-border health care within the EU and as such are not considered in this analysis).

is a useful tool for the systematic comparison of national migrant health policies, a process which can in turn provide a set of guideposts for policy makers and highlight topics which merit further research.

In terms of the scope of the study, it is recognised that the definition of 'migrants' is not straightforward. This article employs as a starting point a definition of migrants as persons born abroad who are legally working, or permanently resident, in the country in question. Data and policies on illegal or irregular migrants and on asylum seekers are not discussed in detail in this paper since these are complex areas of policy which merit a separate in-depth discussion. Clarifications are made throughout where appropriate.

2. A framework to analyse migrant health policy

While there is a growing body of research into inequalities in migrant health and (to a lesser degree) access to health care [1–5], how to translate this information into health policy has been little explored in a systematic manner. As a first step, the literature was analysed in order to identify possible technical and conceptual issues in the development of migrant health policy. These issues are presented in the left-hand side of Table 1. Particular attention was paid to various trade-offs and options, presented in the right-hand side of the table. The framework is organised into five categories (data collection, population groups targeted, health issues targeted, part of the health system targeted, and implementation).

As the EU's focus on migrant health care increases, governments will need to decide on the appropriate balance in their policy response to each issue, given their specific national context. The options are not mutually exclusive, but rather represent a continuum along which policies can be situated. The next section turns to four country case studies which are employed to populate the analytic framework. This allows a systematic comparison of how governments have responded to each policy issue in different national contexts.

3. Migrant health policies and programmes in Europe

In the second part of the study, a questionnaire on migrant health was sent to health policy experts from 15 European countries (Belgium, Denmark, England, Estonia, Finland, France, Germany, Ireland, Italy, Lithuania, Netherlands, Poland, Spain, Sweden, Turkey). The experts were asked to report on: national surveys that include health indicators and identify whether respondents are a migrant and/or ethnic minority; official reporting of information on health status and health care of migrants/ethnic minorities; the collection and reporting of data on health status and health care of migrants/ethnic minorities by non-governmental organizations; government policies, programmes and legislation relating to the health of, and access to health care by, migrants/ethnic minorities; and related projects by non-governmental organizations. Results were received in April 2007.

The results of the questionnaire suggest that in 2007 policies relating to migrants in the countries studied mostly aimed to control the importation of communicable diseases and to provide health care to asylum seekers and refugees. In most countries the health and access to health care of legal, long term migrants was not addressed by any specific policy, beyond the normal granting of the right to access health care according to resident status. For example, France had no national policies relating to migrant health and access to health care. Notably, some countries such as Spain, Germany and Ireland were in the process of launching specific national plans to improve the access of migrants to the social welfare system, including the health system, at the time of the study. However, only four countries included in the study had already established national policies aimed at improving migrant health: England, Italy, the Netherlands and Sweden. The former three countries introduced such policies in the 1990s and Sweden more recently in 2003. These countries were selected for comparative analysis relating to the five key issues outlined in Table 1.

3.1. Data collection

The study collected information on census data, health surveys, living standards surveys and health care utilization data. The main sources of data on migrant health in each country are summarized here. In Italy, hospital discharge data and DRG (Diagnostic Related Group) data by migrant status are collected and analysed by the Statistics Office of the Ministry of Health, although it is not clear how complete they are. There is no regular collection of data through national surveys, with a reliance instead on ad hoc studies. For example, the *Istat* (Italian Institute of Statistics) has conducted one-off surveys which allow for analysis of health data by migrant status [62]. There are obvious problems with this approach, most notably a lack of trend data and a narrow focus on specific health topics or specific geographic localities. Furthermore, the indicator of migrant status is citizenship, meaning that migrants with Italian citizenship are not identifiable.

In England, currently the collection of ethnicity data is mandatory in secondary care, except in outpatient, Accident and Emergency, and community settings, although the Department of Health's Quality of Outcome Framework recently introduced a small financial incentive to general practitioner practices that have complete ethnicity data on their patient profiles. The 2002–2003 data show that only 68% of Hospital Episode Statistics records have a valid ethnic code [63]. The absence or poor quality of ethnic group data collection in primary, secondary, and tertiary care frequently precludes reliable audits of access to health care. Unlike in Italy, national survey data on health disaggregated by indicators of migrant and ethnic status (ethnic origin and country of birth) are regularly collected in the annual cross-sectional 'Health Survey for England'. The use of the two different indicators allows the identification of first, second and third (and subsequent) generation migrants in the data, though a distinction between second and subsequent generation migrants is not possible. Launched in 1991, the Health Survey combines face-to-face and self-completion

Table 1
Migrant health policy issues and options.

Policy issues	Policy options
<p>(i) Data collection</p> <p>Without data, it will be very difficult for countries to assess the needs of migrants and evaluate which policies are effective. However, collecting migrant health and health care utilization data is a major challenge. Several difficulties are summarized here:</p> <ul style="list-style-type: none"> • Medical research favours homogenous samples, resulting in ignorance about the effectiveness of treatments on ethnic minorities • Ethnic minorities often have low response rates in epidemiological surveys [8] • Monitoring undocumented immigrants is difficult [2] • Measuring equity in quality of care is particularly challenging [9] • Recording ethnicity in clinical records can be politically sensitive, and could be perceived as unsound, discriminatory or even racist [9] • Some indicators might provide inaccurate information on migrant status • It is questionable whether terminology used in surveys (e.g. 'health') has the same meaning for different population groups 	<p>There are several instruments available to governments for collecting migrant health data, including:</p> <ul style="list-style-type: none"> • Household surveys • Longitudinal surveys • Clinical records <p>Indicators of immigrant status include:</p> <ul style="list-style-type: none"> • Citizenship • Country of birth • Maternal country of birth • Paternal country of birth • Grandparents' country of birth • Ethnicity
<p>(ii) Population groups targeted</p> <p>The definition of 'migrants' is challenging. There are many sub-categories of 'migrants', including students, economic migrants, asylum seekers, irregular migrants and displaced persons [7] and these are all likely to have different patterns of health and health care utilization. Furthermore, it is unclear how long before a group of people thought of as 'migrants' cease to be defined as such and begin to simply constitute a socially or culturally distinct or ethnic group of residents (e.g. 'black British') [8]. Countries currently introducing migrant health policies will need to consider these issues when deciding what population groups to target. Targeting is likely to reflect:</p> <ul style="list-style-type: none"> • The history and type of immigration in the country • The overall welfare regime [10] • Current political realities 	<p>Policies might focus specifically on migrants, or on broader group which is likely to encompass migrants. Such groups might include 'ethnic minorities', 'vulnerable people' or 'low socioeconomic groups'</p> <p>Interventions that specifically target migrants might involve:</p> <ul style="list-style-type: none"> • Training providers in culturally sensitive care • Health mediators, communicators or translators • Language-adapted and culture-sensitive programs [11], such as tailored web based health information [12] • Tailoring the content of language lessons to immigrants' likely health needs [13] <p>Policies addressing health inequalities affecting vulnerable groups in general include:</p> <ul style="list-style-type: none"> • Initiatives to increase patient empowerment such as improving patient information, patient rights, choice, complaints procedures and participation in the design of health services • Improved quality of care • Removal of financial barriers to care such as user charges, deductibles and copayments • Simplification of administrative processes relating to accessing care • Increased multisectoral coordination • Programmes to reduce smoking, alcohol consumption and poor diet • Mental health promotion
<p>(iii) Health issues targeted</p> <p>According to the literature, migrants in many European countries contexts tend to be more affected than the general population by the following diseases/risk factors:</p>	<p>In order to meet the goal of equal access for equal need, there might be a need to design programmes which target not only specific population groups, but also specific high-burden diseases. This may include treatment as well as prevention programmes. In order to preserve the 'healthy migrant effect', there may also be a need for programmes to help migrants maintain rather than change certain health related behaviours, such as diet</p>

Table 1 (Continued)

Policy issues	Policy options
<ul style="list-style-type: none"> • Smoking • Poor nutrition • Illegal drugs and alcohol • Communicable diseases such as TB and HIV • Accidents, injuries and violence • Mental health • Perinatal and maternal mortality [3] <p>However, several studies have found a relative 'mortality advantage' in relation to chronic disease among migrants, compared to non-migrants. For example, some immigrant groups experience lower CHD mortality than the general population, controlling for income and socioeconomic group [14–17]. This is known as the 'healthy migrant effect'. This may be caused by selective migration, but also by health advantages, such as a healthy Mediterranean diet, for example. [18,19]. On the other hand, several studies have found the 'healthy migrant effect' is lost over time (length of stay) and subsequent generations, as migrants acculturate to the less healthy lifestyles of host populations [20,21,22,14]</p> <p>Several studies suggest migrants experience unequal utilization of health care. In particular inequalities have been found in:</p>	<p>However, these approaches may be perceived as too narrow, since focusing exclusively on interventions which target specific diseases may distract from addressing 'upstream' determinants of health inequalities, such as socioeconomic status, housing, education and so on [46]. Indeed, poverty and not immigration may be the most important explanatory factor for observed differences in health and health care access. For example, in a Swedish study, income explains much of the differential in health care expenditure between immigrants and native born populations [47]</p>
<ul style="list-style-type: none"> • Screening and vaccination [23–30] • Out-of-hours primary care [31] • Hospital inpatient and outpatient services [32,33] • Dental care [34] • Access to sexual and reproductive services [35,36,37,38,39] • Mental health services [40] • Long term care [41,42,43,44] <p>However, in other studies, no migrant inequalities were found, such as in duration of stay in Danish hospitals [45].</p>	<p>In order to address barriers to access, governments will need to decide whether to target the supply or demand side of health systems.</p>
<p>(iv) Part of the health system targeted</p> <p>The literature suggests there are likely to be many barriers to migrants in health care utilization. Issues include:</p> <ul style="list-style-type: none"> • Obtaining permanent resident status may take several years during which time full access to care may be denied [48] • In countries with complex registration systems for social health insurance, such as France, administration and bureaucracy is a major barrier • Undocumented migrants in many countries are not granted equality of treatment [5] • In clinical encounters, language, literacy, miscommunication and cultural differences may be an obstacle to providing care [49,50,51], resulting in suboptimal care [52–56] and impacting adherence to medicine [57] • Lack of access to female doctors may be a problem for some migrant women • Lack of knowledge about the health care system [58] • Mistrust of service providers, particularly undocumented migrants fearing detection 	<p>Improving demand, for example by providing better information about the health system to migrants, could help address some of these issues. However relying solely on demand side interventions risks failing to address structural barriers to accessing care, such as prejudiced attitudes among staff</p> <p>On the other hand, a new host of interventions to improve the supply of health care for migrants, such as training, may overwhelm or even alienate providers working in public health services that are often already overstretched and raise objections among local patients</p>
<p>Under-utilization of health care may result in worse health outcomes, as is suggested by the relatively higher rate of avoidable mortality among immigrants compared to native Dutch [38]. Barriers also result in delaying care, resulting in the increased consumption of more expensive emergency treatments [59,60,61]. Barriers may also result in self-medication, again potentially causing inequalities and increased costs to the health system.</p>	<p>Considerations relating to implementation include the following:</p> <ul style="list-style-type: none"> • Policies could aim for uniform implementation throughout the country or targeted implementation confined to localities with high levels of immigration, such as cities • Policies might be confined to a specific time period, possibly linked to the period a specific political party is in government. Policies might be abandoned by subsequent governments, given the highly politicised nature of immigration policy • Data are needed to monitor and evaluate implementation • National level government may need to introduce penalties and incentives to promote implementation in decentralised health systems
<p>(v) Implementation</p> <p>The development and implementation of migrant health policies is a potentially challenging task for government, considering the highly contested and political nature of any public policy relating to immigration in many European countries</p>	<p>Considerations relating to implementation include the following:</p> <ul style="list-style-type: none"> • Policies could aim for uniform implementation throughout the country or targeted implementation confined to localities with high levels of immigration, such as cities • Policies might be confined to a specific time period, possibly linked to the period a specific political party is in government. Policies might be abandoned by subsequent governments, given the highly politicised nature of immigration policy • Data are needed to monitor and evaluate implementation • National level government may need to introduce penalties and incentives to promote implementation in decentralised health systems

questionnaires and physical measurements as well as other objective measures such as analysis of blood samples, ECG readings and lung function tests. However, the general household sampling method used in most years does not yield sufficient numbers of households from minority ethnic groups to analyse their responses separately. Therefore, in 1999 and 2004 the survey had a special focus on the health of minority ethnic groups. In these years, only half of the sample was selected in the usual way. This provided a representative sample of the whole population (including members of minority ethnic groups who happened to be included in this general sample). The other part of the sample was a 'boost' sample designed to include additional interviews with members of the largest minority ethnic groups in England. The 2004 survey included a multi-stage stratified random sample of 10,114 adults (aged 16 and over) and children (aged 0–15 years) in the general population and ethnic minority groups, living in private households.

In the Netherlands, data on migrant utilisation of primary, as well as hospital care, have been collected in a systematic manner. Primary care data were collected by the Second Dutch National Survey of General Practice, organized by NIVEL (Netherlands Institute for Health Services Research). The last survey was held in 2000–2002 and it was combined with registration data of 104 GPs. The data include background information on patients collected via a census, approximately 12,000 health interview surveys per time point and more than one million recorded contacts of patients with their GPs in both years. Data on hospital registrations among migrants are collected by the National Public Health Compass (developed and co-ordinated at the Department of Public Health Status and Forecasting that is part of the National Institute of Public Health and the Environment (RIVM)). However, as in England, data on migrant health care utilisation are hampered by low levels of response among migrants.

A further source of data is the POLS (Permanent Research Life Situation) survey, introduced in 1997 to integrate the Dutch Health Interview Survey and other social surveys in the Netherlands into one. This annual survey conducted by the Central Bureau of Statistics (CBS) consists of a core interview that is administered to a random sample of non-institutionalised people who have a registered address in the Netherlands (face-to-face and written). Health questions are submitted to approximately 18,500 individuals with a 60% response rate on average. In addition to the POLS, there are three different health monitors which include information on migrants: one that monitors child and youth health, one that monitors public health and one that monitors elderly health. In Dutch health surveys, migrants are usually grouped with all persons who have at least one parent born outside the Netherlands and are referred to as 'allochtonen'. A distinction is made between persons who themselves are born outside the Netherlands (first generation) and persons who are born in the Netherlands with one parent born outside the Netherlands (second generation). Generally, a further distinction is made between western and non-western 'allochtonen'. However, unlike in the English data, third generation migrants will appear in the same category as 'native' Dutch. This is a limitation since for policy reasons it may be useful to be able

to identify data on this group. Other limitations of the data include problems with comparing the outcomes of different surveys, despite the high levels of standardization, and problems with the internal and external validity of surveys with regard to immigrants: for example, there is an under-representation of immigrants in surveys that use written questionnaires in Dutch. Also, the lack of objective measures makes it difficult to account for cultural explanations for observed differences in self reported health [64].

In Sweden, hospitalization data are linked to migrant data in the MigMed database. This database was compiled using data from several national Swedish registers provided by Statistics Sweden, including the Immigration Register which contains data on immigration, emigration and country of birth of all individuals officially living in Sweden, the Multigeneration Register in which persons (second generation) born in Sweden in 1932 and thereafter are registered shortly after birth and are linked to their parents (first generation) and the Swedish Hospital Discharge Register, which contains complete data on all discharges since 1986, with dates of hospitalization and diagnoses. Most registers in Sweden use a ten-digit personal identification number assigned to each resident, including refugees and immigrants staying in Sweden for more than three months. The personal identification number makes it possible to include the entire population in the MigMed database, leading to a very large and representative sample. This makes the Swedish migrant inpatient hospitalization data relatively complete. A limitation of the database is that it does not include national data on outpatients in hospitals or primary health centres.

Survey data on migrant health and health care utilization are drawn from two sources. Firstly, the 'ULF', is the annual survey on living conditions organised by Statistics Sweden (the central government authority for official statistics and other government statistics). It is an annual survey that has been conducted since 1975. It is based on 7500 interviews (foremost face to face) with a statistical sample of individuals aged 16–84. Secondly, the 'Folkhälsoenkäten' is a survey on public health conducted since 2004, organised by the Swedish National Institute of Public Health (SNIPH), a State agency under the Ministry of Health and Social Affairs. In 2007 it was sent to 10,000 individuals aged 16–84. 5738 individuals answered the survey. As with the Dutch data, in both surveys the statistics are based on the subjective answers of the participants (self-assessed health) and only country of birth of the respondent and their mother and father and not ethnicity is recorded.

3.2. Population groups targeted

An analysis of the different population groups targeted by government policies and programmes in each country reveals some important differences. In England, with the exception of policies relating to refugees and asylum seekers, migrant health policy is largely indistinguishable from policies concerned with 'race' and 'black and minority ethnic' (BME) groups. This is reflected for example, in Sir Donald Acheson's *Independent Inquiry into Inequalities in Health* [65] which made three recommendations for reducing ethnic health inequalities and the *Race Equality*

Scheme 2005–2008 published by the Department of Health (DH). This racial and ethnic categorization does not consider country of birth and therefore does not distinguish between different generations of immigrants. As a result, a potential problem is that the specific health care needs of newly arrived migrants (other than ‘refugees’ or ‘asylum seekers’) might be overlooked.

In the Netherlands the government addresses specific health inequalities of both migrants and ethnic minorities under the broad conceptual umbrella of ‘cultural difference’. In 1997, the Dutch Scientific Foundation (NWO) established a working party on ‘culture and health’ to stimulate research and care innovations in this area and in 2000, the Council for Public Health and Health Care (RvZ) published two reports highlighting the health and health care accessibility problems of migrants and ethnic minorities [66,67]. In response to these developments, the Minister of Health established a project group to develop a strategy for ‘interculturalising’ health care [64].

In Italy and Sweden the focus of health policy and programme development is more specifically on first generation migrants, although Sweden also has a long tradition of addressing health inequalities in general. In Sweden in 2004, government agencies dealing with health and social support, education, employment, integration, and immigration services agreed on a common policy document, *Nationell samsyn kring hälsa och första tiden i Sverige* (*National agreement on health and the first years in Sweden*) [68] which aims at coordinating services in a way that promotes health among newly arrived individuals (asylum seekers and others) during their first 2–5 years in Sweden. In Italy, in the (National Healthcare Plan) PSN 1998–2000 provisions were made to establish a special programme for the health of immigrants, *Salute degli immigrati*. A reference Centre, *Centro di riferimento nazionale per la promozione della salute delle popolazioni migranti e il contrasto alle malattie della povertà* [69] (*Health and immigration and the fight of diseases due to poverty*) was also newly established by the current Ministry of Health at the Scientific Research Institute *Istituto San Gallicano* (Rome). These two countries started to experience large scale immigration more recently than England and the Netherlands so their focus on newly arrived migrants is understandable, but in the near future, if not immediately, policies targeting second and third generation migrants will become relevant.

3.3. Health issues targeted

Most countries in the EU have introduced policies aimed at preventing migrants from importing communicable diseases such as TB. Aside from this basic set of provisions, migrant health policies in the four countries diverge in the types of diseases targeted. Broadly speaking, in England and the Netherlands there has been a strong focus on improving mental health care for migrants and ethnic minorities. For example, in the Netherlands in 2000, a 4-year Action Plan for intercultural mental health was approved, to be supervised by the coordinating agency for mental health services (GGZ Nederland). In 2000, an ‘intercultural mental health centre of expertise’ called MIKADO was set up, with financing guaranteed until 2007 [2]. In England, the

Delivering Racial Equality (DRE) in mental health care action plan was published in 2005 by the DH. By contrast in Italy there is no specific mention of migrant mental health in the national plans, the focus rather being on sexual and reproductive health care. For example, a target of a 10% reduction in voluntary abortion rates among immigrant women was set for the 2001–2003 plan [62].

The divergence between countries should reflect differences in need in the country in question, determined by the health problems affecting migrants and deficiencies in the existing supply of services, although it is not clear that this is necessarily the case. Specifically, given the high rates of risk behaviours and low immunization rates among migrants reported in the literature it seems preventive services may be under-utilized in all four countries. The increasing importance of older migrants in the population and the resulting need to develop culturally appropriate long term care also has not been explicitly considered.

3.4. Part of the health system targeted

Across the four countries there is a mix of policies, programmes and projects at all levels of the health system to improve both the supply of and demand for health care for migrant groups, although the focus is mostly on improving health care supply. Some examples are outlined here. On the supply side, the British government has set specific goals under the *Delivering Racial Equality* (DRE) initiative which commits PCTs (Primary Care Trusts) to providing race equality training in their mental health services, and appointing race equality leads and community development workers. The project *Pacesetters, Race for Health*, was established in 2003 to enable PCTs to make the health service in their areas fairer for black and minority ethnic communities. Meanwhile, the *NHS Specialist Library for Ethnicity and Health*, launched in 2006, provides service providers and the public with evidence relating to health care for minority ethnic groups in Britain. In Italy efforts have been made to improve the administrative health information system on immigrants registered with SSN (National Health Service—Servizio Sanitario Nazionale) and registration rates of foreigners with a regular permit of stay. In 2007 the Minister of Health established a new ‘Commission for the Health of Migrants’. The Commission aims, among other things, at monitoring the quality and equity of health care services provided both to regular and irregular migrants [62]. In the Netherlands, supply-side interventions include immigrant health promoters who give patients information in their own language and mediate between care provider and immigrant. Their activities are coordinated by the NIGZ (Netherlands Institute for Health Promotion and Disease Prevention), contracted by the Dutch government [64].

On the demand side, in Italy for example the 2001–2003 plan states that ASL (Azienda Sanitaria Locale—local health offices) should promote information campaigns for immigrants, while the 2006–2008 plan aims to promote education programmes in cooperation with volunteer and non-profit organisations active in Italy [62]. The Swedish *Nationell samsyn kring hälsa och första tiden i Sverige* also

aims to improve the information to migrants on the right to health care.

3.5. Implementation

Finally, there are issues of implementation. The development and implementation of migrant health policies is a potentially challenging task for government, considering the highly contested and political nature of any public policy relating to immigration in most European countries today. In England, the broader context of BME initiatives in the DH and NHS is the Race Relations Amendment Act (2000), which states that all public bodies have a legal obligation to outlaw racial discrimination and promote equal opportunities. However, a review of 300 PCTs found that compliance with the legislation has been strikingly patchy, namely, that a significant minority of PCTs did not appear to have made public their race equality schemes [70].

As well as patchy implementation across geographical areas, another issue relating to implementation is sustainability of programmes over time. While the Netherlands stands out in Europe for its sustained and systematic attention to problems of migrant health, there is a danger of these initiatives stagnating. The 'Culture and Health' programme and the Action Plan both ended in 2004, and the subsequent government distanced itself from the active policy on interculturalisation announced by the previous Minister of Health in 2000, following a new approach in which the onus is placed on migrants to adapt to Dutch society [2]. In 2005 the former Minister of Health, Welfare and Sport concluded that there are several well-functioning programs, and no additional government policies would be needed relating to the health of and/or access to health care by immigrants. The reason cited was evidence suggesting immigrants are able to find their way in the health care system (GPs are visited more often in comparison with the Dutch), and that in some cases their health is better in comparison with the Dutch (e.g. higher life expectation among some immigrant groups). The Minister assumed that differences between immigrants and Dutch will reduce by themselves over time as immigrants become accustomed to life in the Netherlands [71]. Following this, however, it was concluded by the Secretary of the State of Health that at least with respect to older immigrants, new programmes may be needed because it cannot be automatically assumed that children will take care of their aged parents [72].

4. Discussion

This article has proposed a framework for migrant health policy analysis. Information from four countries with some of the most developed policies in Europe (England, Italy, the Netherlands and Sweden) was used to populate this framework. The results of the analysis suggest that each country has taken a very different approach and that there may be opportunities for learning across countries. Perhaps most important as a starting point for any migrant health policy is the development of instruments to collect data. All four countries collect inpatient hospital utilisation data by migrant status, but the lack of completeness often makes this data unreliable. One exception is the

linking of hospital inpatient data to immigration data in the Swedish MigMed database. However, this approach would be difficult to replicate in countries which do not use unique person identification numbers. In all countries, except to some extent the Netherlands, there is a lack of collection of migrant primary care utilisation data making the evaluation of policies to improve access to care among migrants at this level difficult. Survey data on migrant health are collected at a national level in three of the four countries, but all experience problems with representativeness. Furthermore, the reliance in most cases (except to some extent in England) on self reported data raises issues in the translation of concepts relating to health across cultures. This means that despite the availability of some of the most robust evidence in Europe, the true extent and type of health and health care access inequalities experienced by migrants in these countries is still not clear. Furthermore, due to weaknesses and differences in survey design and data collection methods, comparison of data across countries is difficult.

The second, third and fourth topics in the analytic framework all address targeting. Across the four countries there seems to be a tendency to focus policy either on newly arrived first generation immigrants or on more established ethnic minorities, when high immigration countries may need to focus on both these groups which may experience divergent health and health care problems. The Netherlands, with its focus on 'intercultural healthcare', is perhaps the country with the most balanced approach in this regard. Another issue relating to targeting is whether there are any specific diseases affecting migrants that should take priority. As discussed, sexual and reproductive health takes priority in Italy whereas mental health has been a particular focus in England and the Netherlands. Research is needed to understand whether such differences in policy focus accurately reflect real differences in need among migrants across these countries. It is conceivable, for example, that migrants in Italy have as much need for targeted mental health care services as those in England and the Netherlands, which would present an opportunity for the transfer of experience from one context to another. There may also be gaps in preventive and long term care for migrants in all four countries, suggesting a need for research and policy development in these areas. This could also be done in a collaborative manner. In terms of the mix of demand or supply-side interventions, there seems to be more activity in improving supply, although some demand side policies are also in evidence. There may also be opportunities for learning across countries in this area. However, it is important to note that in a country such as Sweden, where there is a particularly strong tradition of social welfare policies to reduce health and other inequalities among vulnerable groups in general, the development of certain targeted migrant health policies may be inefficient. Again, research is needed to understand whether this may be the case.

Finally, policy makers will need to consider the process of policy implementation: whether it will aim for uniformity throughout the country and whether it will be confined to a specific time period, and the degree to which national level government is able to ensure this. For even where migrant health policy has been elaborated

at the national level, implementation has not necessarily reflected this on the ground. Implementation is particularly likely to be a problem where there is a lack of data available for monitoring and evaluation. Furthermore, sustaining momentum is problematic in a policy area as politically sensitive and contested as immigration, as evidenced in the Netherlands.

5. Conclusion

By organising policy information in an analytic framework the study has been able to identify some of the important issues and options in migrant health policy. The comparison of four countries' policies through the analytic framework demonstrates that it can be used to develop guideposts for policy makers. This process may assist countries to learn from each others' experiences and may particularly benefit countries currently designing migrant health policies. As a next step, the analysis would benefit from further extension with more information from the four countries considered and from other countries in Europe. Furthermore, even in the four countries analysed here where there are data collection systems in place, there is little evaluation of the effectiveness of migrant health policies. This highlights an important area for future research.

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