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Rechel, B.; Mladovsky, P.; Devillé, W.

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chapter **six**

Monitoring the health of migrants

***Bernd Rechel, Philipa Mladovsky,
Walter Devillé***

Introduction

Accurate data on the health of migrants, including health determinants and health service utilization, are an essential pre-condition for providing appropriate and accessible health services to this population group. Yet in many, if not most, European Union (EU) countries, information on the health of migrants is lacking (Rafnsson and Bhopal 2008; Padilla and Miguel 2009), limiting the possibilities for monitoring and improving migrant health, and for conducting comparative studies on inequalities in health and access to health care (Kraler and Reichel 2010b).

There are a number of reasons for this situation, including the lack of any system for routine collection of data on the health of migrants. In contrast to the situation in Australia, Canada, New Zealand and the United States, most countries in Europe do not routinely collect health data by migrant status. While the Netherlands and the United Kingdom have significant experience in conducting population-based surveys that also contain information on migration status or ethnicity, countries such as Belgium, Germany and Spain have only recently started to include such variables in health surveys. The new EU member states generally do not include variables on migration status in health information systems or surveys. Furthermore, even in those countries that do collect routine health data by migrant status, information on the most vulnerable groups of migrants, such as asylum-seekers or undocumented migrants, is generally lacking.

There are conceptual and methodological challenges in collecting data on migrant health, such as different definitions or understandings of who constitutes a migrant – and how many migrants, however defined, there are in a given country (Aung et al. 2010). This chapter reviews current data information

systems and ongoing research activities in the EU and examines how far they make it possible to assess and monitor migrant health.

The collection of data on migration status

The European Commission against Racism and Intolerance (ECRI) of the Council of Europe, an independent human rights monitoring body specializing in combating racism and racial discrimination, has regularly called on countries that are members of the Council of Europe to collect relevant data broken down according to categories such as nationality, national or ethnic origin, language and religion, with due respect for the principles of confidentiality, informed consent and voluntary self-identification of persons as belonging to a particular group (European Commission against Racism and Intolerance 1996).

In the United Kingdom, broader anti-discrimination legislation, in the form of the Race Relations (Amendment) Act of 2000, has been an important driver of efforts to adapt health services to the needs of “black and minority ethnic” (BME) groups (Ingleby 2006). The country now has “a very highly structured system to combat discrimination and promote equality, based on systematic statistical monitoring” (Simon 2007: 47). Yet, across EU member states, discrepancies between data collection practices have increased, despite the passing of EU-wide anti-discrimination directives, in particular the Directive 2000/43/EC on “implementing the principle of equal treatment between persons irrespective of racial or ethnic origin” and Directive 2000/78/EC “establishing a general framework for equal treatment in employment and occupation” (Simon 2007). The types of variables related to ethnicity or migration collected in the member states of the Council of Europe are shown in Table 6.1.

Table 6.1 Information on national or ethnic origin, religion and language and their equivalents collected in official statistics in Council of Europe countries

	<i>Country of birth</i>	<i>Citizenship</i>	<i>Nationality or ethnicity</i>	<i>Religion</i>	<i>Language</i>	<i>Country of birth of parents</i>
Albania	X					
Armenia	X	X	X		X	
Austria	X	X		X	X	
Azerbaijan	X	X	X		X	
Belgium	X	X				
Bulgaria	X	X	X	X	X	
Croatia	X	X	X	X	X	
Cyprus	X	X	X	X	X	X
Czech Republic	X	X	X	X	X	X
Denmark	X	X				X
Estonia	X	X	X	X	X	X
Finland	X	X		X	X	
France	X	X				
Georgia	X	X	X	X	X	

Germany	X	X		X		
Greece	X	X				
Hungary	X	X	X	X	X	
Iceland	X	X		X		
Ireland	X	X	X	X	X	
Italy	X	X				
Latvia			X			X
Liechtenstein		X		X	X	
Lithuania	X	X	X	X	X	
Luxembourg	X	X				
Malta	X	X				X
Moldova		X	X	X	X	
Montenegro	X		X	X	X	
Netherlands	X	X				X
Norway	X	X				X
Poland	X	X	X		X	
Portugal	X	X		X		
Romania	X	X	X	X	X	
Russian Federation	X	X	X	X	X	
Serbia	X		X	X	X	
Slovakia	X	X	X	X	X	
Slovenia	X		X	X	X	
Spain	X	X				
Sweden	X	X				
Switzerland	X	X		X	X	X
The former Yugoslav Republic of Macedonia	X	X	X	X	X	
Turkey	X	X				
Ukraine	X	X	X		X	
United Kingdom	X		X	X		
Total (n = 43)	40	37	23	25	27	7

NOTE: The table contains information on data collected in censuses, but also population registers and statistical data systems combining administrative sources and population registers.

Source: adapted from Simon (2007)

The different categorizations and definitions of migrants, and whether it is deemed acceptable to collect “ethnic” data, mainly reflect different historical contexts, statistical traditions, administrative and political structures, welfare regimes and immigration histories (Kraler and Reichel 2010a). For some countries, ethnicity is a major criterion for describing the groups within a population, while others even refuse to use the concept (Simon 2007) (see Chapter 2 on “Trends in Europe’s international migration”).

In the United Kingdom, immigrant communities largely established through migration from former colonies after the Second World War are referred to as “black and minority ethnic” (BME) groups, rather than migrants, while asylum-seekers and refugees fall outside this category (Ingleby 2006). Migrants who have settled are not considered migrants any more. In the Netherlands, migrants and ethnic minorities are referred to collectively as “*allochtonen*”

(i.e. of foreign origin) (Ingleby 2006). Data are collected on where persons or their parents were born and those with at least one parent born outside the Netherlands are classified as “*allochtonen*”. In contrast to the United Kingdom, the third generation appear in the same category as “native” Dutch (Mladovsky 2009). These two examples illustrate that the categories used are shifting social constructions (Ingleby 2009).

Many countries are resistant to collecting “ethnic” data; this is sometimes due to ideological and ethical aspects and sometimes due to concerns over data protection (Simon 2007; Johnson 2008). In Sweden and many eastern European countries, a focus on “ethnicity” is currently regarded as both unnecessary and undesirable (Ingleby 2009), and in several countries, including Sweden, the collection of “ethnic” data is forbidden.

France has for a long time been disinclined to consider the idea of collecting “ethnic” data. In line with the republican ideology that “all citizens are equal”, routine data collection systems such as the national census only refer to nationality and country of birth and do not ask any questions about ethnicity or religion (Ingleby 2009). However, the debate has received new impetus through the introduction of anti-discrimination policies and measures to promote diversity in companies (Simon 2007).

In Germany, few analyses of routine data on the health of migrants have been conducted (Zeeb and Razum 2006), as information on the origin of migrants is lacking in most data sources, although some contain information on nationality (Mladovsky 2007). No “ethnic” data are collected officially. The country is still wary of collecting such data, as that would evoke memories of the categorization of individuals that preceded the Holocaust and give rise to concerns that such data might be misused to incite racism and discrimination. Furthermore, there are concerns about data protection; Germany’s Data Protection Act was one of the first to be enacted in Europe (Simon 2007).

Indeed, migrants themselves may be reluctant to reveal information on their migration status or related variables. They may – not without justification (European Union Agency for Fundamental Rights 2010) – fear discrimination, stigmatization, exclusion or, in the case of undocumented migrants, even denunciation and deportation (Ingleby 2009; Gushulak 2010; WHO 2010a). After all, much historical research on race and ethnicity in Europe and elsewhere has been racist and unethical (Bhopal 1997). Yet, without information on migration status it is very difficult to monitor and improve migrant health and to combat discrimination (Simon 2007).

Conceptual and methodological challenges of data collection

The need for better data on migrant health has been recognized for some time. As long ago as 1983, a consultation by the World Health Organization (WHO) on health and migration recommended more in-depth studies on differences in mortality and morbidity (Gushulak 2010). This was further underlined by the 2008 resolution on the health of migrants by the World Health Assembly, which called on WHO member states to establish health information systems in order to assess and analyse trends in migrants’ health, “disaggregating

health information by relevant categories” (World Health Assembly 2008: 2) and the subsequent WHO/IOM Global Consultation on Migrant Health (WHO 2010a). Within the EU, a consultation on “Migration Health – Better Health for All” in Lisbon in 2009 identified a number of areas for action, including the establishment of structures to support research and comparable data collection to better identify the health specificities of migrants (IOM 2009). The need for better health information systems on migrants has also been recognized in conclusions of the European Council (Council of the EU 2010) and declarations and recommendations of the Council of Europe (Committee of Ministers 2006; Council of Europe 2007).

Why have these calls for more accurate migrant health data failed to elicit improvements in health information systems in many European countries? Beyond the political issues discussed above, there are complex conceptual, methodological and technical challenges involved.

A fundamental conceptual problem is the lack of a universally agreed definition of what constitutes a migrant (Ingleby 2009). UN Recommendations on Statistics of International Migration (United Nations Department of Economic and Social Affairs 1998) and Regulation (EC) No. 862/2007 on Community Statistics on Migration and International Protection (European Parliament and Council of the EU 2007) aimed to establish a set of common definitions and classifications of migratory movement. However, data collection is still guided by national legislative, administrative and policy needs (IOM 2010), and follows national definitions and classifications (ECDC 2009; Ingleby 2009; Gushulak 2010), just as the determination of citizenship, residency and immigration in the EU remains to a large extent a national responsibility (see Chapter 3 on “Asylum, residency and citizenship and models of migrant incorporation”). As such, countries define migrants in many different ways, e.g. by country of birth, nationality, residency, and, less frequently, duration of stay (IOM 2010). This makes it very challenging to measure international migration, not to speak of monitoring migrant health or comparing migrant health across countries.

All the different definitions of migrant status have their limitations (Gushulak 2010). Nationality, ethnicity, citizenship and country of birth, for example, do not account for the time of arrival. Citizenship also fails to account for naturalized migrants, so that country of birth seems to be a better indicator of migration status (Juhasz et al. 2010). Country of birth can be used as an indicator for migrant origin or ethnicity, but, as is illustrated by groups such as Kurds coming from Turkey, it needs to be complemented with additional indicators (Stronks et al. 2009). In some countries, it is also complicated to account for children born to European parents in what were then colonies in Africa or Asia.

Another problem is that the commonly used definitions of migrant status do not distinguish between the many sub-categories of migrants, such as asylum-seekers, undocumented migrants, trafficked persons, regular migrants, and students. In migrant health research this poses a problem because these groups have specific health needs (Loue and Bunce 1999) and may face particular legal or other barriers in accessing health services (Watson 2009). Furthermore, even within distinct categories of migrants, there is bound to be great variation in the problems faced (Gushulak 2010).

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The changing dynamics of modern migration (see Chapter 2 on “Trends in Europe’s international migration”) pose another challenge, with an increase in temporary, return or circular migration. Terminologies or classifications modelled on “traditional”, unidirectional migration fail to account for these new types of migration (Gushulak 2010). In addition, the health effects of migration often extend beyond the first generation, with second and third generations facing particular health issues making it desirable to collect data in such a way that can capture this variation (Gushulak 2010).

Migrant health data are also limited by the fact that, until recently, the focus has typically been on specific diseases or conditions, particularly communicable disease (Gushulak 2010). In many of the traditional countries of immigration, health assessments are a routine element of immigration procedures (Gushulak 2010). However, they are frequently limited to specific diseases viewed as a public health threat to the host population, such as tuberculosis (Gushulak 2010). Research on social determinants of health, entitlements to health care, and accessibility and quality of care is still rare (Ingleby 2009).

Another common problem in migrant health research is that the denominator, i.e. the size of the underlying population, is unknown (WHO 2010b). Even where information is available, data may be misleading if not adjusted for age, sex and socioeconomic and migrant status. This also raises the question of which groups migrants should be compared to: is it to the host population, other groups of migrants, or the population in the country of origin? The latter comparison has hardly been addressed by research so far, but may yield particularly valuable information on how migration has affected those who have moved from one country to another.

The heterogeneity and relatively small size of some migrant communities is also a factor. As over-sampling is often required in surveys or clinical studies in order to yield statistically relevant information on smaller sub-groups of the population, and as researchers tend to be from the ethnically dominant, “native” population, mainstream medical research has for a long time favoured homogenous samples, excluding migrants and ethnic minorities from clinical trials (Ingleby 2006), although there are exceptions such as the ethnic boost in the 2004 Health Survey for England (Sproston and Mindell 2004).

Access to some populations, such as undocumented migrants, is another obstacle to research on migrant health. Finally, much research on migrant health is confined to the grey literature, not translated into English and is not used to inform future research or policy-making in countries other than where it was undertaken (Ingleby 2009).

Background data

In most countries, general background information on the number and sociodemographic characteristics of migrants is routinely collected by national authorities, typically in censuses. Although census data on citizenship or place of birth have considerable limitations, they can be used to provide rough estimates of the size and demography of migrant populations and to plan health policies (Gushulak 2010).

Regulation (EC) No. 763/2008 of the European Parliament and of the Council of the European Union (9 July 2008) on Community Statistics on Population and Housing Censuses (European Parliament and Council of the EU 2008) obliges member states to submit to the Commission (i.e. Eurostat) data on a range of indicators, including the following which can be related to migration:

- place of usual residence;
- country/place of birth;
- country of citizenship;
- ever resided abroad and year of arrival in the country (from 1980);
- previous place of usual residence and date of arrival in the current place; or place of usual residence one year prior to the census.

It can be hoped that the implementation of this regulation at the national level of EU member states will increase the comparability of statistics on migrants.

Data on mortality and morbidity

Health information systems in most European countries are not designed to identify people by migration status and the information collected in medical files rarely includes information on migration origin or status (Juhasz et al. 2010). However, an exception is the death registers maintained in many countries, which include indicators of migration or ethnicity. A study on the availability of large-scale epidemiological data on cardiovascular diseases and diabetes among migrants and ethnic minorities in the EU found that national death registers that allowed for disaggregation according to ethnicity or migrant status were available in 24 countries. Country of birth was used as an indicator in 15 countries, citizenship in 8 countries, and nationality in 7 countries (some countries used more than one indicator) (Rafnsson and Bhopal 2009). Yet, a complicating factor affecting analysis of mortality data is that migrants often return home when they become old or sick (Ingleby 2009), so that register-based studies may underestimate migrant mortality (Mladovsky 2007). The above-mentioned study on the availability of large-scale epidemiological data on cardiovascular diseases and diabetes found that disease-specific, population-based registers with data on ethnicity or migrant status were available only in Germany, England, Scotland and Sweden (Rafnsson and Bhopal 2009), although, as noted above, Germany and Sweden do not register data on ethnicity, but only on country of birth.

Health care utilization data

Health care utilization data can be an important source of information on migrant health. However, utilization levels cannot be equated with health needs, as migrants may face barriers in accessing care. In addition, the utilization of health services may not always be properly monitored and recorded, in particular where there are multiple providers spanning the private and public sectors and social enterprise organizations (Mindell et al. 2008; Gushulak 2010).

In 2008–09, registry data on health care utilization that allowed for some identification of migrants at national or regional levels were available in only 11 of the 27 EU member states: Austria, Belgium, Denmark, Finland, Greece, Italy, Luxembourg, the Netherlands, Poland, Slovenia and Sweden (Nielsen et al. 2009). In all 11 countries, utilization data were available for hospital care (although with varying detail), while only a few countries collected data on care in outpatient settings.

In England, the collection of data on ethnicity is compulsory in secondary care, except in outpatient care, accident and emergency care, and community settings (Mladovsky 2009). In 2007–08, there was an 86% coverage of ethnicity in hospital episode statistics (Jayaweera 2010).

The different categorizations of migrants in EU countries also affect the information collected in registry data on health care utilization: five of the 11 countries mentioned above collected data on both citizenship and country of birth, one on country of birth only, and five collected data only on citizenship (Nielsen et al. 2009).

Survey data

In addition to data routinely collected on the whole population, many governments commission surveys on representative samples of the population, some of which contain information on migrant status or ethnicity. They include health surveys (including health interview surveys and health examination surveys), as well as surveys concerned with broader issues that also contain some information on health, such as living standard surveys. In Sweden, for example, an annual survey on living conditions also collects information on self-assessed health and country of birth, although it does not ask about ethnicity (Mladovsky 2009). Sometimes, more general surveys are supplemented by targeted surveys aimed at hard-to-reach groups and qualitative investigations (WHO 2010a).

Although incomplete, Tables 6.2 and 6.3 present a heterogeneous patchwork of indicators of migrant health included (in many cases only recently) in national or European surveys. The migrant data collected from the surveys typically have serious limitations, such as low response rates and low sample sizes; combined with the definitional weaknesses discussed above this makes it difficult to use these data to measure the health of migrants compared to the “native” population. Exceptions include the Netherlands, Sweden and the United Kingdom, which have undertaken extensive surveys on the health of migrants (Mladovsky 2007; Ingleby 2009). For example, in England, survey data on health disaggregated by ethnic origin and country of birth (including parental country of birth) are collected annually in the Health Survey for England. In 1999 and 2004, as noted above, the survey had a special focus on minority ethnic groups, boosting their numbers in order to draw statistically relevant conclusions (Mladovsky 2009).

The above-mentioned study on the availability of large-scale epidemiological data on cardiovascular diseases and diabetes among migrants and ethnic minorities in Europe could identify relevant health survey data in only six of 27 EU countries; data from nationally representative health examination surveys were available in England, France and Scotland. Nationally representative health

Table 6.2 Examples of health and migration indicators collected through surveys in selected European countries

<i>Country</i>	<i>Measurement tools</i>	<i>Migration indicators</i>
Belgium	1. National Health Survey , organized by the Scientific Institute of Public Health	<ul style="list-style-type: none"> • place of birth • present nationality
Denmark	1. National Survey on Health and Morbidity , published by the National Institute of Public Health in 1987, 1994, 2000 and 2005	<p>Since 2005:</p> <ul style="list-style-type: none"> • country of birth • parents' country of birth
Germany	<p>1. Children and adolescent health survey, Robert-Koch-Institute, conducted between 2003–06 citizenship of respondent and of his/her parents</p> <p>2. Telephonic Federal Health Survey, conducted since 2002 onwards in several consecutive waves by the Robert-Koch-Institute. The surveys have different foci each year</p> <p>3. Sexually Transmitted Diseases Sentinel, conducted by the Robert-Koch-Institute, 2003–05</p> <p>4. Microcensus (Federal Office of Statistics)</p> <p>5. Socioeconomic panel</p>	<ul style="list-style-type: none"> • country of birth (respondent/parents) • duration of residency • migrant status <ul style="list-style-type: none"> • country of birth of respondent (not parents) • citizenship (not parents) • year of naturalization • age at migration • duration of stay/residency <ul style="list-style-type: none"> • country of origin • citizenship • migrant group • age of migration • duration of stay/residency • self-estimated level of command of German <p>New legislation was introduced in January 2005 allowing more precise sampling of data related to migration. Before 2005, only nationality (German vs non-German) was included. Current variables include:</p> <ul style="list-style-type: none"> • nationality of the respondent • previous nationality (if applicable) • nationality of parents • year of entry <ul style="list-style-type: none"> • citizenship • country of birth • nationality • residence status • reason for migration • relatives living abroad

Continued overleaf

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Table 6.2 *Continued*

<i>Country</i>	<i>Measurement tools</i>	<i>Migration indicators</i>
Finland	There are no national or regional surveys measuring both health and immigration variables, although occasional health surveys focusing on immigrants only have been commissioned by the government	
France	<ol style="list-style-type: none"> INSEE (the National Institute of Statistics) population census surveys Survey on Health and Social Protection, conducted by the National Research Institute, the National Statistics Office and the Institut de Recherche et de Documentation en Économie de la Santé biennially since 1988 	<ul style="list-style-type: none"> • country of origin • nationality • parental place of birth (only in 1999) <p>2002/03:</p> <ul style="list-style-type: none"> • country of origin • nationality
Ireland	<ol style="list-style-type: none"> Survey of Lifestyles, Attitudes, and Nutrition (SLAN) Cross-sectional survey repeated at 4-yearly intervals Quarterly National Household Survey 	<p>Since 2006:</p> <ul style="list-style-type: none"> • place of birth • start of residence in Ireland • ethnic or cultural background • nationality • citizenship
Italy	Occasional surveys conducted by the Italian Institute of Statistics	<ul style="list-style-type: none"> • citizenship
Netherlands	<ol style="list-style-type: none"> POLS (Permanent Research Life Situation) Administered every year; it is a general survey including topics such as health, but also safety, leisure time, and living and working conditions of birth The Local and National Health Monitor consists of three different monitors: one that monitors <i>child and youth health</i>; one that monitors <i>public health</i>; and one that monitors <i>elderly health</i> 	<ul style="list-style-type: none"> • country • country of birth mother • country of birth father <p>• country of birth</p> <ul style="list-style-type: none"> • country of birth mother • country of birth father • self-assessed ethnic identity

3. The **Second Dutch National Survey of General Practice** was organized by the Netherlands Institute for Health Services Research (NIVEL). The last survey was held in 2000–02 (but data are still used) and was combined with registration data of 104 GPs
- country of birth
 - country of birth mother
 - country of birth father
- Spain
1. **National Health Survey 2003**
- Citizenship (since 2003), with the following options:
- Spanish citizens
 - foreign citizens coming from: the EU; other European country; Canada or the USA; other American country; an African country; an Asian country; a country in Oceania
2. **Regional/municipal health surveys**
- Some of the latest waves of the regional health surveys include a question on the citizenship of the interviewed.
- e.g. **Catalan Health Survey 2006**
- The Catalan Health Survey 2006 contains more detailed information:
- place of birth with four options:
 1. municipality of residence
 2. Catalonia
 3. Spain
 4. Foreign-born
 - citizenship: Spanish; North Africa; sub-Saharan Africa; South America and Caribbean Islands; East Asia and the Pacific; South Asia; Middle East; Central and eastern Europe; EU; Other developed countries
 - year of arrival in Spain
- Sweden
1. **Annual surveys on living conditions (ULF)**, conducted by Statistics Sweden.
- Respondents are categorized as:
- born outside the country (first-generation migrant)
 - born in the country, but with both parents born outside the country (second generation)
 - born in the country, but with one parent born outside the country (second generation)
 - born in the country with both parents also born in the country (not migrant)

Continued overleaf

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Table 6.2 *Continued*

<i>Country</i>	<i>Measurement tools</i>	<i>Migration indicators</i>
United Kingdom	2. Survey on public health (Folkhälsoenkäten) , conducted by the Swedish National Institute of Public Health	Respondents are categorized by country of birth: Sweden; other Nordic country; other European country; non-European country
	1. General Household Survey , an annual cross-sectional survey conducted by the National Statistics Office	<ul style="list-style-type: none"> • how many years have you /has(...) lived at this address? • in what country were you/was (...) born? ... • in what year did you (...) first arrive in the United Kingdom? • in what country was your/(...)'s father born? • in what country was your/(...)'s mother born? • what do you consider your national identity to be? • to which of these ethnic groups do you consider you belong?
	2. British Household Panel Survey , conducted annually since 1991 by the National Statistics Office	<ul style="list-style-type: none"> • ethnic group • nationality/country of birth • year of arrival in the United Kingdom
	3. English Longitudinal Survey of Ageing , conducted biannually since 1998 by University College London, the Institute of Fiscal Studies and the National Centre for Social Research	<ul style="list-style-type: none"> • ethnic group • cultural background • country of birth • year of arrival
	4. 1970 British Cohort Study , conducted by the Centre for Longitudinal Studies. Surveys have been conducted at birth (1970), then again after 10, 16, 26, 29 and 34 years	<ul style="list-style-type: none"> • ethnicity (based on 2001 census question)
	5. Millennium Cohort Study , conducted so far at the age of 9 months, 3, 5 and 7 years	<ul style="list-style-type: none"> • ethnic group
6. Health Surveys for England and Scotland (annual)	<ul style="list-style-type: none"> • ethnic origin • country of birth 	

Source: adapted from Mladovsky (2007)

Table 6.3 Selected European surveys collecting information on health and migration

<i>Survey</i>	<i>Migration indicators</i>
<p>European Community Household Panel (ECHP)</p> <p>This is an annual panel survey based on a representative panel of households and individuals in each country (in the EU15), covering a wide range of topics: income, health, education, housing, demographics and employment characteristics. The survey was running from 1994 to 2001.</p>	<ul style="list-style-type: none"> • last foreign country of residence before coming to present country • foreign country of birth • citizenship
<p>European Union Statistics on Income and Living Conditions (EU-SILC)</p> <p>This survey aims at collecting timely and comparable cross-sectional and longitudinal multidimensional microdata on income, poverty, social exclusion and living conditions. The survey contains the Minimum European Health Module of the European Health Survey System, an EU initiative to improve the comparability of health survey data in the EU.</p>	<ul style="list-style-type: none"> • country of birth • citizenship
<p>Survey of Health, Ageing and Retirement in Europe (SHARE)</p> <p>This is a multidisciplinary and cross-national survey on health, socioeconomic status and social and family networks of individuals aged 50 or over.</p>	<ul style="list-style-type: none"> • country of birth • year came to live in country • citizenship
<p>European Health Interview Survey (ECHS)</p> <p>This survey aims to monitor the health status and health care utilization in EU member states. Its basic survey, the European Core Health Interview Survey, is performed Europe-wide under the responsibility of Eurostat and covers about 130 questions. The first wave of surveys was conducted in 2007–09.</p>	<ul style="list-style-type: none"> • nationality • country of birth

Source: adapted from Mladovsky (2007) and Juhasz et al. (2010)

interview surveys were conducted in Belgium, Denmark, England, France, Italy, Northern Ireland, Portugal and Wales (Rafnsson and Bhopal 2009).

In the Netherlands, the Permanent Research Life Situation (POLS) survey collects data on the general population that are disaggregated by migrant status; there are also regular surveys on child and adolescent health, public health and the health of older people (Mladovsky 2009). In contrast, countries such as Belgium, France, Germany and Spain have only recently begun to include questions on migration status in health surveys (Table 6.2).

The variation in migration-related indicators used makes it almost impossible to use the national surveys for cross-country comparisons. More comparable

data across the EU can be derived from European surveys using the same indicators across countries (Table 6.3).

Of the European surveys, SHARE has the richest information on health, but is confined to the population over 50 years of age and has smaller samples from each country, leading to a limited applicability in migration issues. EU-SILC and ECHP have larger samples and cover all age groups, but contain more subjective indicators on health, based on self-reporting (Juhasz et al. 2010). While survey data in general have the advantage of containing a large number of indicators and not being restricted to specific health outcomes, such as mortality (Juhasz et al. 2010), one of the major challenges with population-based surveys is that, as with health interview surveys, they are often confined to subjective measures of health, such as self-reported health, with major question marks over cross-cultural validity (Ingleby 2009). However, this can be addressed to some extent by the use of anchoring vignettes, in which respondents are asked to indicate the health status they would attribute to a hypothetical person (Salomon and Murray 2004). Another problem is low response rates among migrants (Mladovsky 2009; Juhasz et al. 2010), although response rates improve when participatory research approaches are used (Fenton et al. 2002).

Another source of information comprises clinical studies and disease registers that contain information on migration status or ethnicity. However, these are confronted with the challenge that migrants often face barriers in accessing care and that the overall size of the migrant population is often unknown, making it difficult to interpret prevalence or incidence rates (Ingleby 2009). In 2009, epidemiological studies on cardiovascular disease that allowed for the identification of ethnicity or migrant status, were available in England, Germany, the Netherlands, Sweden and Wales, but only the Dutch National Survey on Morbidity Interventions in General Practice was nationally representative (Rafnsson and Bhopal 2009).

European research projects

A number of projects related to migrant health have been funded by the European Commission in the 2000s, including two specifically aimed at improving the evidence base on migrants and their health status (Samuilova et al. 2010):

- Monitoring the Health Status of Migrants within Europe: Development of Indicators. Migration and Ethnic Health Observatory (MEHO) (led by Erasmus University, Netherlands);
- Promoting Comparative Quantitative Research in the Field of Migration and Integration in Europe (Prominstat) (led by Bristol University, United Kingdom).

Several of the studies quoted in this chapter have been the result of these research initiatives. Yet, while the EU has supported some work and research on migrant health, overall cohesion and direction was sometimes missing, as efforts were fragmented between different agencies of the European Commission, as well as between the research projects it funded and those initiated by International Organization for Migration (IOM), WHO or others

(Ingleby 2009). In addition, findings and results from surveys coordinated by the European Commission are not always easily accessible to the public (Mladovsky et al. 2008; Kraler and Reichel 2010b).

Conclusion

This chapter has reviewed the availability of migrant health data in the EU and some of the challenges involved in data collection. At present, most EU countries do not collect routine data on morbidity and health care utilization by migrants, and those that do use different categorizations and definitions, so that data are not comparable across countries.

Furthermore, available data often refer to health status only. It is imperative to move beyond this disease-based monitoring of migrant health and also collect data on age, sex and social determinants of health, as well as on health-seeking behaviours of migrants, entitlements, provider attitudes, and how health systems perform with regard to health services to migrants (WHO 2010a). It is also important to define better those indicators of health directly related to the migration process and to conduct cost–benefit analyses of interventions to improve migrant health.

Many countries need to step up efforts to monitor migrant health if the current lack of data on migrant health is to be overcome. There is a clear need for standardized definitions, and the inclusion of relevant questions on migration and health in existing data collection activities, such as censuses, national statistics and health surveys, as well as in the collection of routine health information (Bischoff and Wanner 2004; Juhasz et al. 2010; WHO 2010a). Ideally, this should put minimal additional requirements onto existing data collection systems; allow duration of stay to be assessed; include the descendants of migrants; and be uniform across Europe (Razum 2006). At the same time, these efforts must ensure respect for the principles of confidentiality, informed consent and voluntary self-identification.

However, this chapter has shown that this will not be an easy task, as categorizations and definitions are often related to dominant perceptions of national identity and specific immigration contexts and histories. Apart from stepping up European-wide surveys, the development and implementation of EU guidance or legislation on data collection on migrant health might be one option to improve the standardization of data collection and the comparability of data, in line with the 2008 regulation on community statistics. The EU has funded several projects for improving data collection on migrant health, but there is substantial scope for developing migrant health research further, including through increased collaboration at the European level. An overall European vision on the collection of migrant health data, agreed with other major stakeholders such as the IOM and WHO, would help to ensure a more coherent approach to improving the monitoring of migrant health in Europe.

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