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Regions for Health Network



Migrants and Health Care: Responses by European Regions (MIGHRER)

Complete reference material



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I. Introduction

“Migrants and Healthcare: Responses by European Regions” (MIGHRER) is a project of the Regions for Health Network (RHN) of the World Health Organization Regional Office for Europe (WHO-Euro).

The aim of the project is to describe, in a systematic way, strategies and actions adopted in particular at the regional level in the European Countries concerning the health of migrants and health services provided in order to improve it.

The basic rationale for the project is the assumption that there is a role for the regions - which should be studied and emphasized because of its relevance - in ensuring that national policies and strategies for migrants health are sensitively interpreted at local level and in promoting the actions needed for creating the proper conditions (health service organizations, coordination and integration of activities, resources for project, etc.).

The first phase of the project was dedicated to gathering data from participating regions of the RHN and the results are presented in two versions:

- this general report on the web - which includes the 11 regional reports with detailed information on the health systems, rules and initiatives relating to the migrants health and also an introductory chapter by Sandro Cattacin of the University of Geneva, and chapters on the work of PICUM (Platform For International Cooperation on Undocumented Migrants), the International Organization for Migration (IOM) and the Task Force on Migrant-Friendly and Culturally Competent Hospitals set up within the framework of the Health Promoting Hospital Network (HPH) of WHO Europe;
- a short publication - which includes a general overview of the project and short summaries of the regional chapter particularly focused on “promising actions” planned at a regional level in order to improve migrants health.

The health of migrants is a crucial and complex issue

Migration is radically modifying human geography of societies in the entire world. Migrants are part of the society and are also the most vulnerable group of it, presenting a greater difficulty in accessing adequate care. Therefore to address this challenge of social cohesion we have to face a problem of innovation and promote a process of development of the current structure. Particularly the healthcare systems have to consider differences in needs, beliefs and attitudes and make a step forward in the field of communication as one of the great barrier for migrants. They have to become, as stated in the Resolution of the World Health Assembly 61.17 on the Health of Migrant¹, “migrant sensitive” ensuring that health services are delivered in a culturally and linguistic appropriate way, in a comprehensive, coordinated and financially sustainable way,

¹ http://apps.who.int/gb/ebwha/pdf_files/A61/A61_R17-en.pdf (.pdf, 16 Kb)



and that the health and relevant non health workforce understand and address the health and social issues associated with migration.

In this project migrants have been considered as people from EU and non-EU countries which can be permanent, temporary and irregular. Health personnel mobility and Cross border health care were not taken into account.

Providing an overview of the demography of migration in Europe is complicated due to heterogeneity of data and definitions. Some statistics are based on nationality, others on place of birth and some others on legal status.

However, no matter how the data is reported, it is clear that the number of migrants in Europe is large and growing. Using International definitions, the UN estimates that in 2005, there were more than 190 million global migrants. This is an increase of approximately 50 million individuals since 1950. Of that total, just over 64 million or 34% of them resided in Europe.

The enlarged EU was home to 44.1 million international migrants- some 70% of the total in Europe. Migration in the EU has been strongly affected by geographic proximity. In fact, 30% of the migrants living in the EU are originally from other EU countries. Furthermore, net migration accounted for almost 85% of European total population growth.

It is observed a substantial variability in size and diversity of migrant groups across nations of the WHO European Region. The proportion of migrants in the European population was estimated to be 8.9% in 2005 while in 1960 was 3.4%. The percentages of migrants vary across European region with Western European nations reporting levels of 10-15% of the total population. In terms of numbers, the largest populations of migrants are found in 5 countries: Germany (10.1 million), France (6.5 million), the United Kingdom (5.4 million), Spain (4.8 million) and Italy (2.5 million).

In the '90s, the contemporaneous economical growth and population decrease has favoured the immigration also in Mediterranean Europe (Italy, Spain, Portugal, Greece), that previously had only been a transit area towards North Europe. It should be noted that also Ireland, a country symbolizing emigration, is now attracting foreign workers. In Italy, for example, traditionally an emigration country, during the '90s immigration of foreign citizens has highly increased: from about 500.000 people at the end of the '80s to about 4 millions in 2009 (6.5% of total population).

In Eastern Europe and Central Asia, Russia was the top country of destination in 2005, hosting 12 million migrants, followed by Ukraine (6.8 million migrants) and Kazakhstan (2.5 million migrants). Except for Russia with a 1.6% increase in the stock of migrants between 2001-2005, the region experienced a decrease in immigration over the period. Most migrants from Central and Eastern European countries move to Western Europe and the majority of migrants from Central Asia move to the wealthier Commonwealth of Independent States (CIS) countries.

Refugees and asylum seekers are an important component of migrant populations in Europe and might have specific and important health concerns. According to the UNHCR in 2006 refugee populations in Europe numbered 1,733,700 individuals. The number of refugees in Europe represented approximately 18% of the global refugee population of 9.9 million people.



Irregular migration is by definition difficult to measure, however, estimates show that irregular migration in the region accounts for an important part of total migration. In 2006, there were more than 3 million undocumented migrants in the EU and between 1.3 million and 1.5 million in Russia. Other estimated that the stock of irregular migrants in Europe varies between 2.6 million and 6.4 million with nearly 400,000 border apprehensions each year in the EU-25 zone.

In the introductory chapter Sandro Cattacin stated that the 1980s and, in particular, the 1990s completely changed the dynamics of migration and migration policy in Europe. The international reorganization of migration flows leads to differentiate migrants according to their knowledge and working skills, as well as according to their origins and legal status. In particular, the world of asylum seekers of the 1980s and earlier has been transformed from a marginal and cyclical phenomenon to one of continuous flow.

If the growing complexity, of the composition of the migrant population and their needs as well as the economic crisis (which highlights that the labour market was no longer a way to integrate migrants), has lead to inclusion policies, most European countries developed measures of migrants' inclusion orientated to health only since the middle of the 1980s or as late as the 1990s. With the arrival of HIV/Aids, previous defensive health policies regarding migrants have become obsolete.

At the same time, the awareness for the specific needs of migrants and the necessity to prevent a broad spread of the epidemic lead to specific measures sensitive to diversity. In this sense, HIV/Aids has been a motor just as important as both the transformation of migration flows and the political awareness for action in a context of increasing and differentiated migration. HIV/Aids prevention calls for innovative approaches, which include communitarian and street level measures. Some of the financed measures following a broad approach based on health promotion sometimes seemed to be far away from the original scope of HIV/Aids prevention.

Another aspect is suggestive of the fact that health was somehow used as a tool for migrants' inclusion. The interest in the health of migrant people comes at a time when the politics of admission have become progressively restrictive across the whole of Europe, which has caused to increase the number of people migrating illegally, or into uncertain legal situations. In this frame it has become apparent that health and illness have taken on special significance: The sick body, under certain circumstances, and when there is no possibility for the persons to be treated in their country of origin, allows the acquisition of an entry visa on humanitarian grounds. In other words, the essential significance of health permits to reconsider the stay of people whose presence and integration are not favoured by the state: in this case those who have entered the country without a valid work or residence permit, i.e. those whose presence in the country is perceived as provisional, or irregular, and by consequence precarious, be they asylum seekers or undocumented migrants.

The consequences of this change in Europe can be summed up as the awareness that migrants' health can no longer be an exclusion motif at the border and that the selection process ensuring healthy migrants was vein, as migrants' reproduction in the host society caused specific health issues. Addressing these health issues has been, since the 1990s, on the political agenda. While it is true to say that the healthy migrant still exists, he or she is no longer the



only kind of migrant. We increasingly see the appearance of the unhealthy migrant in the world of asylum or illegality, with which the health system has somehow do deal.

However identifying health determinants is complicated. They are strongly interrelated and difficulties have sometimes arisen in determining causality. What precisely causes persistent health variations and how they can be positively influenced is in fact not so easy to state and current debates about health care reforms illustrate this very clearly. This difficulty is even greater when one considers the case of migrants as their situation increases the number of variables related to duration of stay, history of migration (i.e. the difference between first, second and third generation), ethnic identity and legal situation of stay.

Access to healthcare, which includes health prevention and promotional services in addition to diagnostic and therapeutic care, is fundamental to maintain and improve the health of migrant populations. Those at greatest disadvantage continue to be irregular migrants. Depending on location, services may be limited by the migrants' status and right of residence.

There are additional important factors related to poverty and social exclusion some of which are shared with other poverty affected groups and some are specifically associated with the migratory process. Low levels of employment may be associated with limited sick leave, particularly poor people may not be able to access care during regular working hours. The availability of after hour's clinics or healthcare services varies across Europe.

The increasing diversity of modern migrants often overcomes the capacity of healthcare delivery systems. Also linguistic and cultural competencies affect the provision of health services particularly when migrants are not recognized as groups with different risks. Often there is a lack of awareness among migrant population of available services due to an absence of information provided by the host countries. At the same time lack of training of health workers on migrant health issues and lack of understanding of specific needs and expectations of migrant population are the major barriers in accessing health care services.

Delayed or deferred care is associated with the progression of disease and illness and the subsequent need for more extensive treatment and intervention. Additionally, limited access to preventive care increases the risks of degeneration of diseases that might result into illnesses or conditions that could have been successfully mitigated, often at reduced cost or complexity of service, if treated in advance. Particularly this can be very important in situations involving maternal and child health and the management and control of some communicable diseases of public health importance.

Migrants may be also subject to an increased risk of contracting infectious diseases upon arrival, particularly when living in situations of poor and overcrowded accommodation, and when limited or restricted access to health care delays recognition, diagnosis and treatment of conditions.

Migrants coming from less developed countries may not have been able to access preventive or therapeutic medical services. As a result, conditions that initially could have been easily managed may present a more advanced status or be less effectively treated in migrant population.



Due to genetic and biological factors migrants can be at higher risk of contracting chronic diseases and illnesses compared to the hosting country population.

It is difficult to identify a "community of migrants" as currently there are many different ethnic groups on our territories. However it is possible to identify groups of rich and poor people and notice that their social status is very different. The health issue is not only a problem of medical approach but involves also social and political matters.

Often migrant communities are weak and fragile and can have very different legal status. This problems compromise the possibility to work directly with migrants on a community base. However it can be possible to reach migrants just improving and helping the native local communities to manage their differences among themselves.

In order to establish a dialogue with migrant population it is important to identify a representative among them. However, sometimes people who have been chosen as leaders among migrants may not be accepted by the communities itself. In this case it is possible to reach migrants involving cultural mediators. These are an important resource also in preparing questionnaires about migrants' culture and social habits. Nonetheless cultural mediators can map meeting points making easier to reach migrants also helping to work directly with them.

In addition when possible is also important to work with already formed associations/ organizations of migrants.

Migration has radically modified human geography of societies in the entire world. Also in Europe in many situations multiethnic communities already exist, where groups of people with different experiences, languages and values live together. It is a structural phenomenon, but also constantly changing.

The health of migrants is an important problem for the European societies because of the complexity of the specific and technical issues carried, but even more because of the strong interrelationships with crucial economic, social, cultural and political aspects of the communities' life and for their perspectives. The diversities between migrant citizens represent one of the strongest challenges for health systems that have to confront with ethno-culturally different users. These people present particular vulnerabilities and have greater difficulty in accessing an adequate care because of their status as minority, their socio-economic condition, their difficulty in communicating in a foreign language and their little knowledge of the health system. The situation is even worse if illegal immigrants and people who are asking for residence permit are considered. The offer of healthcare has then to carefully consider differences in needs, beliefs and attitudes toward health and access to services, and should introduce organizational and communicative innovations.

Migrants encounter many difficulties in accessing health services: abilities and possibilities to access primary care, services for children and women, problems of linguistic and cultural mediation, health problems due to living and working conditions.

The problem is not new; new are the global dimensions and the characteristics of the local phenomena. The general rules for addressing these issues, particularly relating with citizenship and the connected rights, are defined at a national level with legislative actions and the definition of general policies. At a local level people has to face with the relationships in specific



contexts: in the working places, in the schools, in the houses, in the streets. There the implementation of the norms is put in practice, filtered through the personal capabilities of using good practices and the existing effective conditions.

The point is that it will not be enough considering only general laws and local practices in studying the health of migrants and practicing the ways for tackling problems and inequities. We need to consider an intermediate level responsible for influencing the conditions in which laws and practices are implemented. This level can be localized in the regions, which are defined as the administrative level immediately under the national one. This means usually an area more homogeneous than a country from many points of view, but in the same time large enough to permit the planning of policies and the efficient support of projects and actions.

Regions for Health Network

RHN was established in 1992 to strengthen the focus on health development in regions in view of their increasing role in Europe. Complementing work at the national level, RHN supports the development of policies and strategies to improve health at the level immediately below the national level. RHN promotes health equity, wide participation in decision-making, and a balance between health promotion, environment, and health care.

RHN is one of a number of networks organized through the WHO Regional Office for Europe. Networks are one of the main resources and strongest assets to promote and protect health and to reduce the increasing gap in health status both between and within countries. RHN members are from: Armenia (Sunik), Austria (Carinthia), Belgium (Flemish Community), Bulgaria (Varna), Czech Republic (Usti), Germany (Lower Saxony and North Rhine-Westphalia), Hungary (Győr Moson Sopron and Szabolcs-Szatmár), Israel (Northern District), Italy (Emilia-Romagna, Sicily, Tuscany and Veneto), Poland (Upper Silesia), Portugal (Madeira), Romania (Timisoara), Russia (Chuvash Republic and Vologda), Spain (Catalonia and Valencia), Sweden (Västra Götaland), Switzerland (Ticino) and United Kingdom (North West England and Wales).

Members of the RHN advocate through pan-European networks and observation; support regions in accession states; cooperate on regional health systems and information development; support existing members requesting help; and promote linkages between regions in areas of common programmatic interest. RHN members promote excellence and effectiveness in their regions by sharing resources and good practice. To this end, the aim is to exchange ideas and experiences concerning the structures, processes and skills essential for working across sectors to build new alliances for health, and to openly discuss some of the obstacles and threats to this approach. In a spirit of solidarity, appropriate members work together on specific projects to bring changes for health gain at the regional and local level. Progress is achieved by emphasizing:



- dynamic alliances - members work together at the regional / subnational and local level throughout Europe;
- knowledge transfer - we provide a forum for the discussion and sharing of ideas and experiences;
- intersectoral action - members are urged to involve other sectors in promoting health.

MIGHRER project

MIGHRER project was proposed by Emilia-Romagna Region during the network's Annual General Meeting in 2006.

The following 11 Regions participated in the study: Catalonia (Spain), Emilia-Romagna (Italy), North West England (United Kingdom), Sicily (Italy), Szabolcs-Szatmar (Hungary), Ticino (Switzerland), Tuscany (Italy), Varna Oblast (Bulgaria), Vastra Gotaland (Sweden), Veneto (Italy), Wales (United Kingdom).

The main questions to explore were:

- which data best describe the health situation of migrants, in the most complete way and considering the background of this population?
- which interventions best improve access to health services, healthcare appropriateness, and the state of health of migrant people?
- which approaches and interventions are the most efficacious to solve particular cases, such as services for children and women, access problems to primary care, problems of linguistic and cultural mediation, health problems due to living and working conditions?

After a kick-off meeting held in Bologna in July 2008, a feasibility study was held and a Preliminary Report was presented at the RHN Annual General Meeting in November 2008 in Dusseldorf (Germany).

Collection of regional detailed data was finalized during 2009 using a common report template (see Box).



Box. Report Template

Health system overview, national and regional situation

- a. Health system functions - Overview of the health system structure illustrating mission, responsibilities and powers of the main component.
- b. Structural organization at regional level - Organigram of the regional health institution responsible in the regional territory. Information on regulatory agencies, institutions and authorities that operate at regional level in the field of migrant health (including if applicable occupational health of migrants).
 - Intersectorial actions - With the purpose of showing a picture of the situation, information on actions and collaborations concerning migrant health between public or private health institutions and public or private institutions operating in different sectors.
- c. Health information system - National and regional framework of data collection on migrants. Reports, sources of basic health indicators, major migrant population health surveys, disease registries and reports produced by external agencies of national and regional relevance.
 - Laws on health information - Legislative framework for health information and related laws. Therefore the availability of information for migrants.
- d. Regulations and legal framework - Information about international conventions, charters, declarations and agreements ratified by the country concerning rights of migrants and health. Illustrate a list of health laws in force concerning migrants but also about their rights as patients.
- e. Service delivery - Institutions involved in the process of healthcare delivery to migrants, at national, subnational and local level. Cases where nongovernmental public health organizations have an active role in this sector. Brief outline of the institution in charge of providing health insurance coverage to migrants if applicable. How/whether insurance coverage for migrants is available.
 - Service availability to migrants - Overview of the types of services given at the level of primary, secondary, tertiary, long-term and social services for migrants. Available services in the field of pharmaceuticals, rehabilitation, dental health, emergency health, mental health and drug addiction and substance abuse. Level of centralization or decentralization of each service also informing when it is private, public or mix.
 - Shadow practices - Data about shadow practices in service delivery and explanation for their presence.

(continues)



The migration phenomenon

- a. General characteristics and extent of the migration phenomenon in the region - Measures, analysis and understand of the different types of mobility at national and regional level, internal and external, voluntary and forced. External factors and types of policies that have influenced migration.
- b. Composition of migrant flow - Gender, ethnicity, cultural background, skills, and status with attention to drivers to migration. In particular, inequality in human development, including health and income, demographics and governance factors.
- c. Migrant impact on social and economic standards – Analysis of the negative impacts on living standards and social tensions for host regions and evidence of positive aggregate economic and social impacts (e.g. migrants as new source of workforce).
- d. Migrant social determinants of health and healthcare needs - Analysis and descriptions of migrants' determinants of health at regional level in relation to age, sex and hereditary factors. Analysis and inclusion if possible of the following: whether there is lack of available information on health issues or lack of resources to reach the migrant population; existence of Mental health disorders in relation to migration; whether migrants are isolated/excluded from destination country societies (intentional on the part of the migrants or forced); whether education levels of migrants are lower/higher and access to education; linguistic barriers; exposure of migrants to occupational health hazards, access/understanding of information on rights of workers; workplace discrimination. Whether migrants have less access to healthcare services, lack of migrant-friendly services; whether living conditions lead to more health hazards.

Policy agenda

1. Current health system response to migrant health issues, at both National and Regional levels. Relevant policies and major government - or civil society -led activities. Eventually applying the health systems framework and referring to the four functions (i.e., stewardship, service delivery, financing, resource generation) for a system-wide analysis. The definition of "health system" and the functions are delineated in "The Tallinn Charter".
2. Stewardship - This include policies improving intelligence through the identification, verification and dissemination of best practices on migration and health issues. It entails the capacity of the health system to engage other sectors. Production of policies for social inclusion of vulnerable migrants and other poor and excluded groups particularly against discrimination and human rights violations. Collaboration for migrant health, in conjunction with civil society groups and social protection service providers. International cooperation between countries of destination, transit and origin on migration and health issues (e.g., to curb the prevalence of multi-drug resistance TB, as migrants may return to countries of origin for treatment and then not finish it before they go back to destination countries, or for the protection of seriously ill undocumented migrants from deportation when they do not have access to health care in their country of origin).

(continues)



3. Service delivery - This entails measures regarding cultural and linguistic competences and non-discrimination. Policies affecting the living and working conditions that migrants face, as well as the potential need for expertise regarding specific health conditions. The accessibility of services in terms of administrative procedures (including for undocumented workers) and location of health delivery structures. The increase in health system literacy among migrant populations, including about promotion and prevention services. Disease- and life-cycle-specific activities such as HIV/AIDS prevention, mental disorder prevention and child and maternal health programmes including targeted measures to monitor and address health inequities. Strengthening of information systems in term of disaggregation of data by foreign-born status, socioeconomic status and gender enhancement of Primary Health Care.
4. Financing - Policies mitigating the burden of out-of-pocket health. Measures that to incorporate migrants into national health insurance/social security schemes (including through bilateral/multilateral agreements). Measures improving prolonged/complicated procedures for reimbursing the costs of care or medicines that defer disadvantaged migrants from using medical services.
5. Resource generation - Measures about training and continuing medical education programmes for health workforce. Policies enhancing and formalizing the role of cultural mediators, community outreach workers and other staff from the migrant community involved in service delivery. Also awareness-raising activities for other health professionals about the services provided by cultural mediators.

Good practices and projects

Having covered activities in the Health System analysis in the previous paragraph, this part could look at "promising practices" that have been successful in meeting their objectives. Ideally, these profiled interventions would both have (a) increased health system access by migrant populations, while (b) also involved the health sector's liaising with other sectors (housing, labour, education) to act on key determinants of migrant health. If the project has been formally evaluated the methodology applied should be described, and findings discussed.

Conclusions

Comments about lessons learned from past and present experiences in health for migrants. Describe the main issues currently ongoing and the possible solutions. Future perspectives and reform challenges.

References

The aim was to include policies improving intelligence through the identification, verification and dissemination of best practices on migration and health issues. It entails, by the others, the capacity of the health system to engage other sectors. Production of policies for social inclusion



of vulnerable migrants and other poor and excluded groups particularly against discrimination and human rights violations. Collaboration for migrant health, in conjunction with civil society groups and social protection service providers. International cooperation between countries of destination, transit and origin on migration and health issues.

This entails also measures regarding cultural and linguistic competences and non-discrimination. Policies affecting the living and working conditions that migrants face, as well as the potential need for expertise regarding specific health conditions. The accessibility of services in terms of administrative procedures (including for undocumented workers) and location of health delivery structures. The increase in health system literacy among migrant populations, including about promotion and prevention services. Disease- and life-cycle-specific activities such as HIV/AIDS prevention, mental disorder prevention and child and maternal health programmes including targeted measures to monitor and address health inequities. Strengthening of information systems in term of disaggregation of data by foreign-born status, socioeconomic status and gender enhancement of primary health care.

And also measures about training and continuing medical education programmes for health workforce. Policies enhancing and formalizing the role of cultural mediators, community outreach workers and other staff from the migrant community involved in service delivery. Also awareness-raising activities for other health professionals about the services provided by cultural mediators.

And finally, probably the more significant effort was to look at "promising actions" (good practice and projects) that have been successful in meeting their objectives. Ideally, these profiled interventions would both have (a) increased health system access by migrant populations, while (b) also involved the health sector's liaising with other sectors (housing, labour, education) to act on key determinants of migrant health. If the project has been formally evaluated the methodology applied should be described, and findings discussed.

The described approach, which could be defined as "region centered", is the distinctive characteristic of the MIGHRER project. But it is also his principal limit, because if it was clear the objective of analyzing contexts, policies, projects, no methodological framework, or even similar experience, for this comparative exercise was feasible in the group involved. A common descriptive scheme was requested but able to explain, either with quantitative data and narrative tools, the complexity of the matter and the diversity of the different regions participating.

This work is preliminary and it should be considered for the moment more as a database on regional situations and an opportunity to share experiences and learn about good practices from regional perspectives.

From this point it could possible try to reach more specific objectives as defining common set of indicators for describing situations and studying, comparing and identifying solutions to help the decision making process in regions relating, eventually, with how to redesign and reshape healthcare systems to handle the issue of migration.

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**II. Migration and Health -
Ontological Security and Pluralist Inclusion**

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This chapter is an attempt to analyse the relationship between Migration and Health from the point of view of migrants and their environment, as well as that of the health care providers embedded in a political and institutional framework.² Three main arguments are developed. Firstly, we describe the change in post-World War II Europe from the “healthy migrant effect” to the “unhealthy migrant effect”, which secondly coincided with the change from homogenous to heterogeneous societies and in particular from the acculturation perspective to the perspective of difference sensitivity in the provision of health services. Thirdly, we want to give some insights into the differentiation of institutional and political answers to these challenges on health and migration in Europe.

1. From the “healthy migrant effect” to the “unhealthy migrant effect”³

The danger of spreading infectious diseases and the need to preserve the health of the local population were already recognized when maritime commerce commenced (Ewald 1986). Throughout the 20th century, regulations within European countries were unilateral, defensive and nation-state based. In this framework, the question of the health of migrants has only been tackled as a problem of border control, focusing at that time on screening Tuberculosis (TB) among migrants. Particularly after World War II, the main goal was the selection of healthy workers for the Fordist industrialization of Europe. Migrants were accepted as a workforce for a limited period. The “Guest workers” were healthy, and policies concerning migration assumed that their stay in the host countries was of limited duration.

The political and scientific consciousness of migration as a continuing phenomenon, something that is not particular or marginal in the host societies, only began in the 1970s. On the one hand, migrants settled and were joined by their relatives through family reunification; on the other hand, due to the economic crisis, migrants became an issue in developing unemployment policies. These changes shattered the image of migrants as young, healthy males, in work and present for just the short-term. Because most of the migrants of the 1960s through the 1980s were more threatened by unemployment and precariousness as they were low skilled and immigrants, host countries were led to formulate “integration policies” (Cattacin and Chimienti 2006). The field of “integration policies” began to be elaborated upon, and research was developed into settlement dynamics, consequences that migrants might have on the social security system and risks to harmony in a society with a high rate of immigration⁴.

The political and scientific description of migrants started to become more realistic, indicating in particular the change from a mobile to a settled existence. Despite this dawning of

² I would like to thank Milena Chimienti for her substantial contribution to this text and David Ingleby and Alison Ricketts for their constructive critics.

³ This introduction is partially based on Cattacin and Chimienti 2007.

⁴ This situation led to topics such as racism and discrimination on the political agenda see for the English case Schuster and Solomos (2004).



consciousness of migrants' settlement in the host country, the question of their inclusion was still regarded as a linear and one-way process. Popular concepts of assimilation or acculturation were more or less reduced to the idea that "time integrates" (Hoffmann-Nowotny 1985). First measures aimed at the inclusion of migrants did not include relevant elements concerning health, but instead were oriented towards schooling and professional training in most of European countries of destination (Mahnig 1998). In these fields, rapid inclusion was regarded as essential. Other aspects of everyday life - such as access to healthcare or quality of care - were not perceived to require specific policy measures. Indeed, it was assumed that these issues would be resolved automatically through the duration of stay.

The 1980s and, in particular, the 1990s completely changed the dynamics of migration and migration policy in Europe. The international re-organization of migration flows led to differentiating migrants according to their knowledge and working skills, as well as according to their origins and legal status (OECD 2005). In particular, the world of asylum seekers of the 1980s and earlier was transformed from a marginal and cyclical phenomenon to one of continuous flow (Efionayi-Mäder et al. 2001).

If the growing complexity, of the composition of the migrant population and their needs⁵ as well as the economic crisis (which highlights that the labour market was no longer a way to integrate migrants), led to inclusion policies, most European countries developed measures of migrants' inclusion oriented to health only since the middle of the 1980s or as late as the 1990s. With the arrival of HIV/AIDS, previous defensive health policies regarding migrants have become obsolete.

At the same time, awareness of the specific needs of migrants and the necessity to prevent a broad spread of the epidemic led to precise measures. From this perspective, HIV/AIDS has been as important a motor for the transformation of migration flows as has political awareness of the need for action in a context of increasing and differentiated migration. HIV/AIDS prevention calls for innovative approaches, which include communitarian and street level measures. Some of the measures funded as part of a broad approach based on health promotion may seem to be far away from the original scope of HIV/AIDS prevention⁶.

Another aspect is suggestive of the fact that health was in a way used as a tool for the inclusion of migrants. Interest in the health of migrants comes at a time when the politics of admission have become progressively more restrictive across the whole of Europe, which has caused an increase in the number of people migrating illegally, or into uncertain legal situations. In this frame it has become apparent that health and illness have taken on special significance: the sick person, under certain circumstances, including where there is no possibility for the persons to be treated in their country of origin, is allowed to acquire an entry visa on humanitarian

⁵ Diversity among migrants in terms of age, sex, origins, possibility of employment and duration of stay in the host society brought the same plurality of health needs than the one within the general population of the host society.

⁶ For instance: community interpreters as well as documentation on health access were financed on HIV/AIDS funds.



grounds (Fassin 2001). In other words, the importance of health allows the state to reconsider the stay of people whose presence and integration are not favoured: in this case those who have entered the country without a valid work or residence permit, i.e. those whose presence in the country is perceived as provisional, or irregular, and by precarious consequences.

2. Health, Migration and Ontological Security

The consequences of this change in Europe can be summed up as the awareness that migrants' health can no longer be an exclusion motif at the border and that the selection process ensuring healthy migrants was vain, as migrants' reproduction in the host society caused specific health issues (Lechner and Mielck 1998). Addressing these health issues has been, since the 1990s, on the political agenda. While it is true to say that the healthy migrant still exists, he or she is no longer the only kind of migrant. We increasingly see the appearance of the unhealthy migrant in the world of asylum or illegality, and the health system has somehow to deal with this.

However identifying health determinants is complicated. They are strongly interrelated and difficulties have sometimes arisen in determining causality. What precisely causes persistent health variations and how they can be positively influenced is in fact not so easy to ascertain and current debates about health care reforms illustrate this very clearly. This difficulty is even greater when one considers the case of migrants as their situation increases the number of variables (Ingleby et al. 2005) related to duration of stay, history of migration (i.e. the difference between first, second and third generation), ethnic identity (Nazroo 1998) and the legal situation relating to their stay.

Going back a step and thinking about migrant experiences as a challenge to their ontological security (in the sense of Giddens, i.e. as a destabilisation of identity, material conditions and projectuality) permits clarification of what the public health literature tells us⁷. Hence, the point of view of migrants can be discussed from their personal perspective, differentiating their (a) personal history (b) relational experiences and (c) the confrontation of migrants' environment with the institutional and political environment.

- (a) Migration leads to a contextual change that generates uncertainty and insecurity for migrants (Obrist et al. 2007). Practices vary based on context and a demand that migrants make an effort to learn the rules of the new society. This learning process cannot be done from one day to another and requires research for information, situational experimentation and reflexivity (Chimienti 2008). The everyday challenge of migrants in a new context is to transform insecurity that prevents security that creates the possibility of projection. In this confrontation between the "old" and the "new" world, Sayad and Bourdieu see a central psychological burden with which each migrant has to deal (Sayad and Bourdieu 2003). Even if Sayad and Bourdieu go too far indicating that suffering is a structural component of the migration experience, they give us a first key to understanding a psychological burden that can have consequences

⁷ See for instance the review of Weiss 2003, Bischoff 2006 and Maggi 2003.



on health. However, the personal experience of migration can also be made worse by the professional and social aspects of inclusion in the new society.

- (b) The relational dimension of the process of the inclusion of migrants relates to the production of "otherness" in the new society, as it confronts differences and struggles to understand such differences (in the sense of Honneth 1992). The search for understanding relates to specific life experiences, cultural habits and the inclusion in a system of equal rights. This relational perspective includes health-related risks, inasmuch as the understanding of these differences is distorted by prejudices, misunderstandings and partial or lack of recognition of the access to concrete health services (Domenig 2007; Coker 2001).

Migration is, in this logic, a major challenge for health care providers. Having tried to deal with pluralistic indigenous demand since the 1970s, the quest for inclusion of differences is also aggravated by the diversity of migrant background and status. The main answer resulting from years of research and practical work on healthcare and migrants in the 1990s was Cultural Competent Care (CCC) (Bischoff 2006).

This programme focused on two levels. First, it focused on the health care providers and ensuring that they are able to integrate competencies in dealing with migrants. Second, it focused on the individual level with the idea that migrants have to be better informed about their rights, but also that they have to be seen as partners in the development of healthcare responses. This empowerment perspective was particularly important in order to show that that a new relationship has to be developed.

This ambitious programme failed when confronted with a complexity of the provision of medicine in a health system set up to provide medicine for the "middle classes" (patients of high performance, and high health literacy). The fundamental ambivalence appeared in the confrontation of this high performing medicine with the quest for a medicine for people on the margins (Cattacin 2007).

Access barriers appeared across Europe due to the fragile legal status of many migrants (asylum seekers waiting to be sent home or illegal workers without access rights to social security), the quality of provision of healthcare, and the high levels of mobility - all problems adherent to migrants. A known problem was also the continuing change of physicians and the rare use of psychiatric or psychological services (Watters 2001).

- (c) Migrants repeat the same habits in a new setting as in their region of origin. These habits include religious practices, traditional forms of consumption and ways of dealing with health matters. In addition, there are some specific health issues related to different groups of migrants (diffusion of specific somatic figures, biological differences) that demand a varying range of responses from the health system. The challenge for a health system confronted with such specificities is to learn how to respond to such requirements from specific groups. For the migrants, the question is not only to understand how to communicate the differences, but also how the health system in a new setting differs from the known one. It is in some ways a necessity to develop health literacy from two sides: from the health system's and the migrants' ones.



Attempts were made to classify factors that explain the inequalities in health determinants, whether individual, social, economic or environmental factors that influence health outcome, as well as the way macro-political factors lead to inequalities in health. A long tradition of public health literature highlights the relationship between health risk factors and the socio-economic position at an individual level, lending itself in a straightforward way to empirical analysis. A more conceptual model focuses on underlying structural factors, the role of which has been more difficult to measure (Asthana and Halliday 2006: 45). Among the different models that were developed since the 1980s, some are referred to as social models (Black et al. 1980 and Acheson 1998). In Whitehead and Dahlgren (1991) the determinants of health are illustrated as layers of influence.⁸ Bartley (2004) and Asthana and Halliday (2006:28) mention different reasons for health inequalities that cannot be directly influenced by migrants or health care providers.⁹ Wilkinson and Marmot (2003) discuss such factors having an influence on the health outcome in terms of the health implications of economic and social policies, in particular those concerning the social gradient, early life, social exclusion, workplace and unemployment, social support, addiction, food and transport.

In comparison studies on health of the native-born and migrants, the differences in such studies are often explained by socio-economic factors (Nazroo 2001) or legal status (Chimienti and Achermann 2006; Wolf 2008). For example, we know that:

- migrants and ethnic minorities on average are more likely to experience poor health compared to the rest of the population;
- ill-health in ethnic minorities starts at a younger age than the rest of the population;
- there are increased rates of long-term illness or disability and worse health reported for several ethnic groups;
- they have higher rates of cardiovascular diseases than the rest of the population (Ingleby et al. 2005).

In such ethnic differences, genetics play only a small role. This means that personal factors play a smaller role in differences than social or structural factors. However, there are a number of diseases, which could be defined as ethnically specific (Pearce et al. 2004). For example, Tay Sachs disease is associated with people of Jewish descent; Glucose 6 Phosphate Dehydrogenase deficiency is associated with people from the Mediterranean; Cystic Fibrosis affects mostly white Europeans and some South Asians and Sickle Cell Diseases affect mostly

⁸ The layers include (from outside): the general socio-economic, cultural and environmental conditions influencing the living and working conditions; social and community networks as well as individual lifestyle factors; age, sex and constitutional factors of individuals.

⁹ Such as individual income, beliefs, norms and values influencing health behaviour, status, control, social support at work or at home and the balance between effort and reward, events and processes starting before birth and during childhood, political processes and distribution of power affecting the provision of services as well as the quality of physical environment and social relationships.



African, Caribbean and Asians (Pearce et al. 2004). With time (both over the duration of the stay and during the following generation) these differences, with change in lifestyles, may disappear.

The difficulty in isolating risk factors complicates prevention and even treatment, and so there is a need to act in a holistic and dynamic way. In concrete terms, health systems should be flexible enough to go beyond sectoral priorities (i.e. to find a *modus vivendi* between for instance migration and employment and health policies), to take into account both individual and structural factors, and to include the time perspective in relation to birth rates and ageing patterns of migrants and their duration of stay in the host society.

3. Difference as normal in the health system? Institutional answers¹⁰

Let us consider now how institutions really react to these challenges. For some years, many local, regional, national and international commissions have been searching for viable solutions for dealing with patterns of new migration. The response of the health systems differs from country to country across Europe but with a common framework - the first initiatives were adapted in the context of a competent health care system and not solely dictated by cultural differences. Policy answers regarding migration and health are related to the general logic of the health system, which combines a framework of values (the "referential") and an organizational structure, based on organizational traditions (the "path dependency" argument; see for instance Merrien 1990). This is especially true when new policies are developed. A first distinction can be made in relation to the insurance scheme in the health system, which can be divided into more universalistic systems (i.e. ones favouring universal access - access for all, with tax based financing and open access to health care services) or more 'categorical' systems (i.e. ones where individuals are allocated to a category or status, based around separate insurance schemes and a means-tested access to health). As Ferrera points out, the two systems are often mixed today, but the initial decision on how the system works is always influencing and structuring future developments (Ferrera 1993). The second distinction is related to the general value systems framing the management of diversity. We can distinguish systems that are based on a communitarian approach of diversity (sensitive towards diversity) and systems that are based on the republican approach ("blind" towards diversity). Table 1 indicates where the major immigration countries are placed in relation to this logic. This differentiation already permits an analysis of the major institutional responses in Europe relating to migration and health, which we call liberal universalism (a), liberal selectivity (b), socialist universalism (c) and socialist selectivity (d).

¹⁰ This chapter is partially based on Cattacin et al. 2007.



Table 1. Health structures and value system of differences

Health structure Value system regarding diversity	Tax-based (Universalistic approach)	Insurance-based ("Categorical" approach)
Sensitive towards diversity (Communitarian)	Liberal universalism	Liberal selectivity
"Blind" towards diversity (Republican)	Socialist universalism	Socialist selectivity

(a) What we call *liberal universalism* seems to be best prepared to include migrants in the health system, because of its openness and its structural sensitivity towards diversity. The United Kingdom (UK), as a former colonial power can be taken as an example of this logic: first because the UK is oriented towards diversity in the sense of liberal acceptance of black and minority ethnic differences (due to its past), nowadays demonstrated by the plurality in terms of origin and ethnicity of its population (about 8 % of the UK population in 2000 considered themselves as having origins outside the UK or as being of a foreign nationality and the majority of them are ex-colonials and labour migrants from Pakistan, Somalia, India and Nigeria (ONS 2004) and second because the UK has, in theory, egalitarian access to health care. However, this egalitarian approach is based on the logic of minimal appropriate services, corresponding to the liberal ideal of health for all, but only for basic services. In concrete terms, this universalistic health care system means that no-one will be denied life-saving, urgent care and most people are entitled to primary health care. This is helped by the fact that the UK National Health Service (NHS) is financed at 80% by taxes.

Nevertheless, since the neo-conservative political change in the 1980s, private health insurance services have grown. Most private health care providers are focused on treatment rather than primary care. In 1997, 11% of the population was already covered by a private supplementary health care insurance (Robinson and Dixon 1999).

Undocumented migrants do have the right to private (non-NHS) health insurance and service provision - but many will be unable to pay for it. They do not have entitlements to free secondary health care through the NHS (except for certain diseases and for life-saving treatment). They may be able to access free primary care through the general practitioner (GP) but it is the GP who has discretion as to whether they are registered¹¹. Before April 2004 they also had free access to specialists, which is no longer the case. However, some treatments are free for everybody (emergencies, some mental disease, STI but not HIV). Pregnancy and HIV treatment (except the test) are not taken into free care for undocumented migrants. The UK also offers, in exceptional cases, an authorisation for three years for acute medical troubles, authorisation that can theoretically be renewed.

¹¹ With general practitioners, it depends on the individual doctor whether he or she takes someone on as his or her patient.



There are two main types of protection:

- humanitarian protection for a maximum of three years if the person risks being killed or tortured in his or her country of origin;
- discretionary authorisation for acute medical troubles in exceptional cases for three years, which can be renewed. After 6 years it is possible to ask for a permanent permit of residence. It is interesting to note that seropositive people cannot get this authorisation.

The main actor in the field of migrants health access promotion is the Department of Equality and Human rights. It has a long history: started as a women's unit looking at employment, then an equality unit looking the employment, it then became an equality unit looking at employment and service delivery. Finally, the unit works on equality and human rights and looks at employment and service professions. The work of this unit with migrants and ethnic communities started in the 1980s on employment issues. First of all gender issues were addressed, because women were under-represented in several positions in the health services (only 25% of the executive directors were women and today that figure is 43%). The claim of ethnic recognition started from black and other ethnic groups.

The first actions focused on the right to have systematic information about employees, which was implemented by data collection (monitoring) in order to deal with the situation in a systematic way. A policy was then developed that tried to tackle these issues by creating a commitment of people working in the NHS. The Department of Equality and Human Rights today produces guidelines (responsibilities at both national and local level), guides and help for the 28 local authorities and co-ordinates them; monitors and publishes different information (disease, demographic, etc); develops an equality impact assessment on equality issues (age, gender, sexual orientation, race) and gives public health messages.

In the year 2000 a new legislation was decided upon with the new amendment "Race Relation" that set up an Action plan. As a result every service and organisation in the country that works in health has had to produce an action plan that identifies what they would do to tackle discrimination and inequalities. That is now a legal requirement but the local organisations can choose the way they wish to implement it.

The Race Relations (Amendment) Act provides new powers to tackle racism in public authorities in two major ways:

- Outlawing any discrimination (direct or indirect);
- Eliminating unlawful discrimination and promoting equality of opportunity and good relations between people of different racial groups (the "duty to promote race equality").

The new legislation will also empower Ministers to extend the list of public bodies that are covered by this Act (as amended) and to impose specific duties to ensure compliance and better performance. The Act gives to the Equality and Human Rights Commission (the



former Commission for Racial Equality) power to enforce specific duties to promote racial equality and to influence codes of practice to provide guidance to public authorities on how to fulfil their general and specific duties to promote racial equality.

The general duty means that, in performing their functions public authorities must have due regard to the need to promote racial equality. Public authorities will need, for example, to ensure that they consult ethnic minority representatives, take account of the potential impact of policies on ethnic minorities, monitor the actual impact of policies and services and take remedial action when necessary to address any unexpected or unwarranted disparities and monitor their workforce and employment practices to ensure that the procedures and practices are fair. As a result, the department of Equality and Human rights receives around 5.3 millions euros per year in order to implement this policy which covers 17 jobs, guidelines, and some innovative projects at national level.

Whereas the policy tried to improve the inclusion of UK residents whatever their gender, age, ethnicity or ability is, entitlements to free NHS services changed. They are based on length of (legal) residency, amongst other criteria, in England, and not the migrant status or ethnicity. As a result, undocumented migrants and asylum seekers failed since 2004 from accessing free secondary health services, such as treatment in hospitals for HIV, amid concerns about the spread of so-called 'health tourism'- people travelling to country to receive treatment. A case won in April 2008 by an undocumented migrant against the NHS changed once more the law until the NHS makes appeal, showing how much the current policy is versatile. This decision has actually been again revoked.

- (b) The second category, that we call *liberal selectivity* can be represented by Switzerland, by the Netherlands and in part by Germany. This group includes societal systems with a "categorical" background in the social security system (Cattacin and Tattini 2004) that are structurally and ideologically open to resident migrants and their needs, but have to devise special measures for people (like undocumented migrants) who are outside the regular insurance system (and not only the health system) because of the need to identify their social position (their categorical affiliation). These systems are obliged to create parallel structures for specific needs outside the normal insurance schemes. These structures are largely recognized as complementary to the system and generally subsidized by the State. To keep it brief, we will discuss in concrete terms only the Dutch case.

The Netherlands represents *par excellence* this type because of its particular openness related to its history of religious pluralism (the pillarized system; Kriesi 1990) and its colonial background and its fee-based insurance system for health. Recently (in January 2006), the Netherlands introduced obligatory insurance for residents. For the poorest a possibility to get reimbursement exists, but it involves an administrative process of registration and means testing. Since then, health care has been structured according to the type of insurance (it means that some treatments are no longer covered by the basic health insurance).



For asylum-seekers there is a gate-keeping model. In centres where they have to stay, a nurse is required to see them before they can have access to a medical doctor. Undocumented migrants are deprived of the right to health insurance since the "Koppelingswet" (Linkage Law), which entered into force on July 1 1998. This new law states that they are only entitled to collectively financed provisions in case of 'necessary medical care'. There is a fund of 5 millions euros per year for the reimbursement of these treatments. Undocumented migrants can nevertheless go to general practitioners (GP) or hospitals, and it is the GP responsible that decides if they can be treated. In the case of an acute illness their expulsion is delayed but there is no possible regularisation.

If we analyze the first initiatives, we see that the topic of health for migrants received hardly any attention in the multicultural policies introduced from the beginning of the 1980s. Many initiatives have been set up, mostly on a short-term, local, project basis. Most of these projects work with the community in deprived neighbourhoods with nurses and peer educators (Ingleby 2005).

The GP plays a central role in Dutch health care since he or she is the point of referral and provides access to other parts of the health care system. The mental health care system has been strongly influenced by American models of 'community care'. The provision of health care in the Netherlands is characterised by a high degree of professionalism. The counterpart of this is a much lower level of user involvement - in particular, from migrant groups - than, for example, in the UK.

At the present time, the consciousness that important problems exist in this area is fairly widespread. However, a small but highly active group of concerned professionals has been drawing attention to the problems of service provision for migrants and ethnic minorities since the late 1970s. This movement is particularly active in the field of mental health. It is only recently that these problems have begun to receive structural attention in the form of education, research and policy changes.

The Netherlands has a significant - though somewhat idiosyncratic - tradition of tolerance, which can be traced back as far as the 16th century. The Dutch government formally adopted "multiculturalist" policies during the early 1980s, though it is interesting for us to note that these policies scarcely made any reference to health issues. In the year 2000, the Council for Public Health and Health Care (RvZ) published two highly critical reports (RvZ 2000a, 2000b) highlighting the health problems of migrants and ethnic minorities, as well as the problems of accessibility and quality in service provision. In response to these criticisms, the Minister of Health set up a Project Group to work out a strategy for "interculturalising" health care. In these plans, emphasis was placed on mental health - the sector, which had campaigned most vigorously for improvements. A four-year Action Plan for intercultural mental health was approved, which was to be supervised by the co-ordinating agency for mental health services (GGZ Nederland). At the same time an 'inter-cultural mental health centre of expertise' called MIKADO was set up, with financing guaranteed until 2007.



However, opposition to cultural pluralism has been increasing. In the Netherlands this started in the early 1990s, although it did not become a major political theme until the end of that decade: "9/11" and the assassination of Pim Fortuyn in 2002 contributed to a hardening of public attitudes and a renunciation of multiculturalism by the government (Ingleby 2005).

- (c) The third category we call *socialist universalism*, here represented by Sweden, which works on the basis of openness to residents, but because of the high level of social security and the high homogeneity of the population (for Sweden in a comparative view: Lijphart 1984), socialist universalism distinguishes strongly between insiders and outsiders (Olsson 1993). In this context, inclusion of difference is organised by parallel systems outside state institutions (NGOs), lacking state legitimisation.

The Swedish health system is based on a universally-oriented provision, and financing of health services is a public sector responsibility. Responsibility rests primarily with the County Councils (in 21 geographic areas). Patient fees range from 10 to 30 Euros. Personal expense has a high-cost ceiling (of 90 Euros) and entitlement to free medical care for the rest of a twelve-month period. Medical and dental treatment for children and young people under 20 is free of charge. Migrants with a permanent residence permit (PUT) are entitled to health care.

Asylum-seekers are not included in health and dental care social insurance but have a special entitlement on the level of County Councils. They have access only to emergency treatment and care that cannot wait according to responsible experts. Children are treated free of charge. The County Councils (Regional Authorities) are funded by the Board of Migration and some of them have developed specific projects of care for traumatized asylum-seekers. This system is under revision.

Undocumented migrants are not included in the general health care insurance but are eligible for emergency and immediate health and dental care. In the case of non-emergency (such as births) fee-for-service (without public subsidy) is supposed to be applied. There is a great inconsistency within the health care system and different interpretations apply in different regions. Consequently practitioners are forced to act as gatekeepers. Undocumented migrants are in general dependent on civil society associations and individual health care professionals engaged in their deprived access to care. In the 2006 Social Report from the Board of Health and Welfare these circumstances are acknowledged and discussed.

The first developments in the field of migration and health took place in the 1960s. Migrants were identified as a welfare target group and officially acknowledged in an 'Survey of Immigrants' in 1968 in general socio-economic terms as "getting satisfactory social and cultural services" and equality with the majority of the population in terms of living conditions and health care, education and social services. The responsibility lay explicitly



with the general authorities and institutions within the welfare system, not with special provision. This process can be understood as a result of a trade union movement standpoint since the mid-1950s against the guest worker model as a political strategy.

In 1975 a new Immigrant Policy was brought into effect expressing a 'multicultural' strategy regarding immigrants and minorities. The focus was on equality in terms of access to cultural goods (language, education, culture) aimed at maintaining linguistic and cultural identity linked to inclusion in the overall society. Issues of health were not explicitly addressed but were implied in general welfare solutions.

- (d) The fourth case, which we call *socialist selectivity*, indicates a combination of a 'categorical' system - with all the difficulties that hinder entry into an affiliation scheme without a resident permit - and difference-blindness. Migrants - or people with a migrant background - also experience, in these cases, difficulties in finding appropriate care - difference-sensitive care. The pressure on migrants and minorities to assimilate to a model of normality creates not only structural barriers, but also moral barriers for a system change in the direction of more sensitivity for differences. In these systems, parallel initiatives of the State are the general answer to its lacking the capacity to read and intervene in a pluralistic society. Adaptations in these systems challenge not only the logic of the health system, but also the general model of welfare provision. They are highly controversial. France, with its republican tradition, is a good example to use in describing this situation.

The French social security system for all regular residents covers 70% of their needs. In fact, as a categorical system, employed people get insurance ("mutuelle") in order to be insured. Today, this system has also integrated universalistic elements. In fact, unemployed people enter into an insurance scheme through a complementary financing system (the "couverture médicale universelle complémentaire" - CMU), which covers 30% of the costs of the regular insurance scheme). Asylum-seekers can get the CMU as soon as they apply for asylum.

Undocumented migrants have had access, since the year 2000, to the "assistance médicale d'Etat (AME)", which provides 100% insurance cover, but two reforms in 2002 and 2003 limited access to those who were in France for less than 3 months. Health care professionals do not have a duty to report an undocumented migrant to the authorities because the law stipulates that they have the right to health care regardless of their residence status in France. They can also get a provisional permit to stay if their illness is acute and they cannot be treated in their country of origin.

Responsibility for the development of a strategy in the field of migration and health lies with the Department for the Direction of Population and Migrations, which deals with the interface between the General Directorate of Public Health and the Directorate of Public Liberties and Judiciary Affairs (in the Ministry of Internal Affairs) on questions relating to health. Some initiatives of outreach work are also taken at the regional level (Departments), but under the auspices of acting in the field of marginalized people.



In contrast to the selective model, France has taken the question of migration and health seriously, following a policy of inclusion in the general schemes of the health systems (through subsidizing insurance fees or through the minimal guaranteed health services). The working group created by the Ministry of Health in 1993 formulated, for instance, an action plan, which was partially implemented. On the legal level and based on the recommendation of the working group, the policy of admission and stay since 1998 has taken into account for the first time the question of health with the possibility of getting a provisional permit of stay and work for people with acute illnesses and without the possibility of being cared for in their country of origin. This "republican" model adopts a policy of blindness towards difference as a strategy of inclusion.

4. Conclusions

This rather simple typology - combining structure and referential¹² - nevertheless permits one to understand why the measures taken in different countries to act in the field of migration and health are so different. It also allows recognition of the different measures taken in the light of similar challenges coming from migrant health issues.

The analysis indicates that the existence of difference-sensitivity in a universalistic system and the development of a policy based on the "fact of pluralism" (Rawls 1993) -difference-sensitivity as a result of an equity-oriented modernization - are fertile conditions for introducing measures in the field of "health and migration", as the case of the UK has illustrated. It is nevertheless a risky model because it is based on the premise that ideas can be implemented hierarchically and that the inclusion of difference is also a solution for the "dis-enclosure" of communities. The openness of universalistic systems is certainly a good basis against discrimination, but in reality overlooks the highly dynamic nature of migration and ethnic communitarianisation processes. The (Marshallian) static view of society interpreted as a continuous inclusion towards a middle class society for all disadvantaged groups, contrasts with the normality of an extreme mobile society, less determined by class than by the world of everyday life. In practical terms that means that the measures of inclusion on the one hand should be promoted as soon as migrants enter the host country, while on the other hand they should be more flexible as migrants' stay in the host country might be short term.

This short discussion indicates already that the search for an ideal model in the field of health and migration cannot be based on a static reality, but has to cope with different histories and values.

A "new model", if we nevertheless want to try to describe it, would be necessarily based on a combination of the UK and Dutch experiences. It certainly has to put forward what we can call *difference sensitivity* (or "migration mainstreaming"), introducing a systematic - structural -

¹² From the analysis of welfare State's point of view, we have simply tried to combine a structural logic à la Flora or Ferrera (Flora 1985; Ferrera 1996) with a political process analysis à la Esping-Andersen (Esping-Andersen 1990); see also: Cattacin 1996.



empathy for differences in systems (as described in the Migrant Friendly Hospitals-project¹³). This means shifting the focus of the health system from the management (including difference sensitivity in the decision-making process through the incorporation of "advocacy" positions) to quality control, giving power to differences and through this, changing from paternalistic inclusion to active participation and projectuality. This also means normalising difference sensitivity in the training of health care providers - and migrants, to introduce "trans-nationalists" in organisations with a concrete employment policy based on the analysis of the social and human capital of candidates. In this context, we can learn from the gender mainstreaming measures; we would even say that we have to radicalize this approach transforming it into a more open logic of difference mainstreaming. This is the strength of the universalistic model.

However, the new model of "difference sensitivity" also has to work in a multidimensional way against exclusion tendencies, so that there is no privileging only of the universalistic approach, with the risk of forgetting differences, migrant dynamics and communitarian acceptance of the chosen inclusion tactic. This relativization of universalism can be done by introducing elements of pragmatism, judging as useful having partial rights, for instance, for the undocumented migrants. Pragmatism means also putting forward group and situation related projects, based on the idea that only a specific adaptation of a measure permits entry into contact with a complex reality.

Migration and ethnic difference represents normality in Europe. We have arrived at the end of the assimilative policy model, but also of the communitarian policy model. Our argument, we hope, indicates ways to think pragmatically about how to combine measures with the grain of multidimensional changes to the health system.

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¹³ For detailed information about research instruments and outcomes see the final project report by Krajic et al. 2005.
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Migrants and Health Care: Responses by European Regions (MIGHRER)

Complete reference material

III. Regional report Catalonia

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Summary

In Catalonia² 14% of total population are migrants - 53% of them are men. Migrants seek health support less than Spanish, have less alcohol and tobacco addiction and less prevalence of chronic illness, but immigrant women consider their health status worse than women born in Spanish. Women's death rate related to gender violence is far higher among women born abroad than among local women. The rate of fatal occupational injuries is very high for immigrants (58.58 vs. 13.20/100.000).

Under Article 12 of the Immigration law (Law 4/2000) on the right to the healthcare, all non-Spanish people in Spain have the right to services from the public health system if they suffer from a serious illness or an injury, regardless of the reason, until the moment of the medical discharge.

An Immigration Master Plan for Health (IMPH) has been adopted to set objectives and actions to improve services to the foreign immigrant population for a three-year period. These actions will be determined by the strategies relating to reception, mediation and training. The Master Plan, under the principles of the Secretariat for Immigration, will conform to the principle of interdepartmental action. The initial strategic planning recommends the implementation of a community-based model of territorial organisation.

The Programme for Migrants' Health was established to cope with the existing situation and has the following objectives: to ascertain the health status of migrant populations and healthcare services utilization; to improve access to healthcare by migrants and the quality of the services provided; to define the territorial organization and management of the immigration and Health Plan; and to implement the mediation service by a project in 2008-2009 to train and certificate 50 new cultural mediators.

² <http://www10.gencat.net/catsalut/eng/>



1. Health system overview, national and regional situation

1.1. Health system functions

History of the model

The Catalan health care model, which follows guidelines from the WHO for the 21st century, is currently being consolidated from the point of view of a national health care service which is comprehensive and based on the community.

From the transfer of authority to Catalonia to the Health Care Organization in Catalonia Act (LOSC)

- 1981. The Generalitat was given authority over health care.
 - Health care centres and services (Insalud) and social centres and services (Inserso)
 - Beds: 30% SS, 70% others
- 1981-1983. The beginning of health management.
 - Drawing-up of the health map of Catalonia, a proposal that brought together the desire to make use of all existing resources
 - Accreditation of centres
 - Main agreements
- 1983-1989. Bases for the model were established.
 - Creation of the Institut Català de la Salut (ICS), Catalan Health Institute, the organization that manages the health services and provisions of the Department of Social Security
 - Creation of the public hospital network (PHN)
 - Beginning of the primary health care reform (PHCR)
 - Hospital organization plan
 - Decentralization and management control
- 1989-1990. Transition.
 - Beginning of the separation between funding and provision with the creation of the Directorate General of Economic Resources at the Department of Social Security (DGRESS)
 - New role of the ICS: service producer
 - Beginning of a new organizational culture
- 1990. Approval of the LOSC (Health Care Organization in Catalonia Act); formalizing the Catalan health care model.



From the LOSC to CatSalut as the public provider of coverage

- January 1991. The Catalan Health Service (CHS) was created. The CHS began its task of becoming the public provider of coverage.
- 1995-1999. 1995 modification to the LOSC.
 - Further diversification of service providers in the field of primary health care
 - Plan for health and social services in Catalonia
 - New model of health care funding 1998-2001
- 2001. 10 years after it was created, the CHS effectively separated the functions of funding and service provision.
- 2001. The Catalan Health Service, CHS, changed its abbreviated name to CatSalut. CatSalut strengthened its function of providing coverage, including the purchase of services as well as other functions. The funding function was removed from its brief and given to the health authorities within the sphere of Parliament.

Principles of the LOSC

- Health is a public service and should be publicly funded.
- Comprehensive health care.
- Integrated health care system: emphasis on promoting healthy lifestyles and preventive health.
- Addressing and overcoming territorial and social inequalities in the provision of health care services.
- Rationalization, efficacy, simplification and efficiency.

The LOSC defines the Catalan health care model

- Separation of the functions of funding and purchasing health care services.
- Diversification of service providers.
- Mixed market of planned and regulated authority.
- Diversity in forms of management.
- Decentralization of services.
- Decentralization of organization: health regions and sectors.
- Community participation: management councils, health councils, participating organizations for government of health institutions.



The bases

The bases of the Catalan health care model follow guidelines from the WHO for the 21st century.

- Programmes are aimed at results in health and investments to develop health and health care.
- Primary health care is aimed at the community and families, supported by a flexible and receptive hospital system.
- A process of participation involving relevant parties in the development of health (at home, school, work and in the local and regional community), promoting joint decision-making, implementation and openness.
- Multi-sector strategies for tackling health issues, taking into account the physical, economic, social and cultural environments and sex and ensuring the assessment of their impact on health.

Priorities

- CatSalut is working towards a model based on personalised and humane services for all citizens.
- To develop its health care role, CatSalut has established a number of priorities based on the health care model established under the LOSC and which follow guidelines periodically established by the Catalan Health Plan.
- We are directing our health care role towards more efficient, quality management.
- Counting on the professionals we work with also being responsible.
- Guaranteeing citizens' access.
- Working to ensure the sustainability of the health care system.

Citizen access

Making use of information and communication technologies to overcome limits of space and free up procedures, helping to improve access for citizens.

Accessibility brings us closer to citizens so they can be more involved and more aware of the whole system (free choice of professionals, responsible consumption of services and provisions, looking after their own health).



Counting on the professionals' responsibility.

The quality of the services and health care treatment for users are particularly important and closely focused on citizens.

The continual search for quality requires greater responsibility from professionals, who become involved both in management and overall results at the centres.

Towards a more efficient, better quality management

Over the years in which we have been consolidating CatSalut as the public health provider in Catalonia, we have strengthened the diversity of management formulas used by our health care providers. This diversity has involved formulas such as public companies, consortiums, professional bodies and management concessions. At the same time, we have introduced a more business-focused management, without losing sight of CatSalut public service function, which is essential for citizens' wellbeing.

Ensuring the sustainability of the health care system

In a system of comprehensive coverage like ours, where everyone has access to health services, efficiency is essential to be able to ensure sustainability. This involves providing health services or offering provisions in an accessible and professional manner and providing the most suitable level of care.

Human and personalised service

CatSalut is tackling problems comprehensively and putting multidisciplinary activities into action, where different types of professionals are involved: doctors, nurses, social service assistants, psychologists and other support personnel.

New realities

New situations and social realities require new health care needs. CatSalut has the answers.

New situations

- Demographic change
- Increased life expectancy
- Ageing and the very elderly
- Changes in relationships of dependency
- Changes in family roles
- The flood of migration



The new epidemiology

- Chronic illnesses and multi-illnesses
- Overemphasis on acute illnesses
- Imported illnesses
- Towards new models of illnesses

Technological evolution

- Continual innovation
- Information and communication technologies (ICTs)
- New indications, new technologies
- R&D applied research

Economic evolution

- Macro economy and micro economy
- Public deficit (-)
- Public debt (+)
- Efficiency in spending
- Prioritizing and rationalizing service provision
- The logic behind coverage
- Democratic legitimacy

The new answers

New situations and social realities have led to new health care requirements. CatSalut aims to meet these new needs.

- Making new headway in primary health care, considering it not only the entry to the health care system but also the guarantee of ongoing health care services.
- With regard to hospitals, we would like to highlight the relationship with other health care levels, in a model that is more open to the community and gives increasing importance to alternatives to hospital admissions (same-day surgery, home care).



Responsibilities

The Central Government keep responsibilities on international health, general co-ordination of health and drugs legislation.

The parties involved in the Catalan public health care system have a number of particular responsibilities aimed at providing better coverage.

The responsibilities of the Catalan health care system

The Department of Health and Social Security (DHSS) is responsible for determining health policies, ensuring the sustainability of the system and verifying the levels of quality.

CatSalut is responsible for establishing service policies in accordance with the health policies of the DHSS, determining the system of provisions, purchases and assessing results.

The service providers are the organisations CatSalut contracts to provide services that have to guarantee the people they cover in accordance with the DHSS's health policy. The service providers are responsible for the quality of the services they provide.

The citizens of Catalonia, who are covered by CatSalut and make up the service providers' customers, are also the owners of the public health care system. In a comprehensive health care system like ours, the citizens are also considered to be responsible for their health.

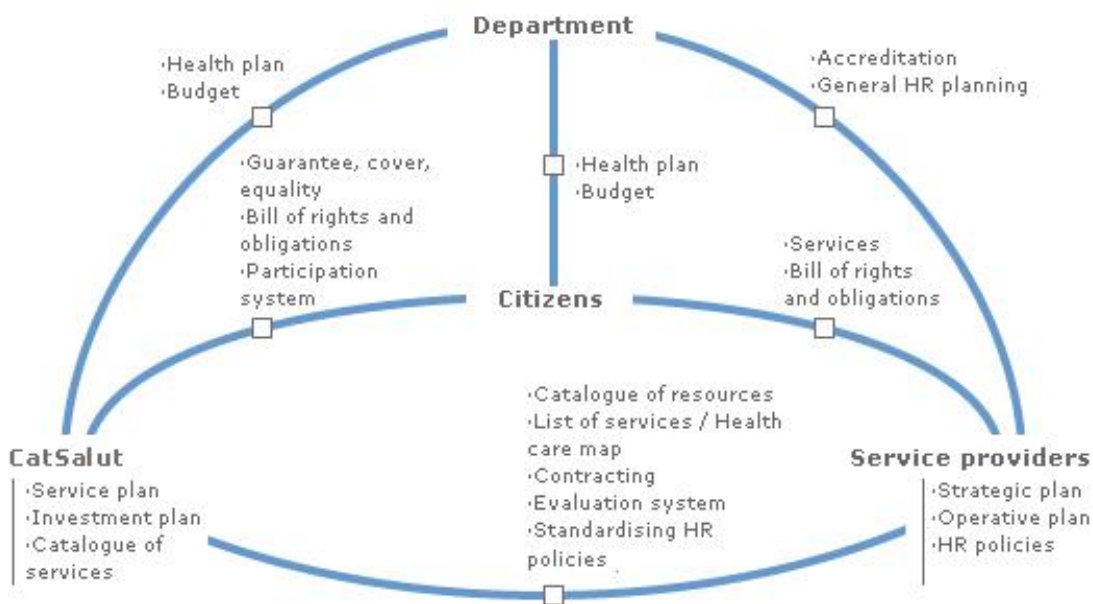
They should fulfil their responsibilities

In order to fulfil their responsibilities, the parties involved in the system use different tools.

- The DHSS prepares the Health Plan, is responsible for the health care budget and the accreditation of providers.
- CatSalut works with different tools such as the services plan, investment plan, the list of provisions (service portfolio/health map), the list of resources, contracting and the system of assessment.
- The service providers follow the strategic and operating plans in order to meet their commitments to CatSalut and the DHSS and to offer quality services to their clients.
- Citizens have systems of participation developed to make the public system work for them and also have a bill of rights and obligations.



Figure 1. Parties involved in the Catalan health care model



1.2. Structural organization at regional level

Since 2004, the Catalan health system has approved new measures in order to decentralize the organization and the model of financing. The creation of 37 new territorial governments is expected to integrate national and local responsibilities in order to improve the governance of the health system and the co-ordination of the increasing number of organisations that provide health services. This new model encompasses a policy of proximity to the territories and of approximation to the citizens, which allows the initiatives promoted by the administration to adequately meet the needs of population. Thus, it enables a more adequate offer of services of improved quality, the reduction of bureaucracy and a better knowledge of local costs.

The process of decentralisation has begun with the creation of the health pacts, specific agreements between the government and the local administrations, and the constitution of the Regional Health Authorities (GTS).

Each GTS is made up of a Governing Council, a Health Council and a Commission for Service Provider Co-ordination.

The Governing Council is a transversal body in which the professionals in charge of the Ministry of Social Welfare and Family Affairs of the Government of Catalonia and the representatives of the Secretariat for Immigration can take part. Citizens and associations are also represented in the Health Council, so that they may be consulted while designing policies and monitoring or evaluating activities in the territory.

All citizens of Catalonia are covered by CatSalut. CatSalut is the abbreviation we use to refer to the Catalan Health Service. The Catalan Health Service is defined by its commitment to guaranteeing comprehensive health care. All the citizens of Catalonia are or can be covered by CatSalut.



However, in today's world people move around a great deal. Whenever people travel, should be sure they are informed of what they need to do to continue to be guaranteed health coverage.

The right to health care is a basic human right. The citizens of Catalonia covered by CatSalut have a number of Rights and Obligations in terms of health care which they should know about.

1.3. Health information system

The Catalan Health Department has a number of registries including:

- Hospital discharges
- Primary Health care registry
- Central register of covered people (with a Health Card)
- Drugs delivered
- Waiting list
- Mortality
- Authorizations and accreditation of centres
- Inspections and penalties of the Public Health Department
- Patients Health information
- Specific diseases and health activities follow up
- Human Resources
- Occupational Health
- Health planning
- Disability management and medical evaluations
- Complementary services delivery
- Finance

We also have a Catalan Health Survey.

1.4. Regulations and legal framework

According to Article 12 of the Immigration Law (Law 4/2000) on the right to healthcare and as stipulated in the Decree that develops the law in Catalonia, all non-Spanish people who are registered as citizens of the municipality in which they live have the same rights concerning healthcare as Spanish citizens.

All non-Spanish people that are in Spain have the right to services from the public health system if they suffer from a serious illness or an injury, regardless of the reason, until the moment of the medical discharge.



Foreigners under eighteen years old who are in Spain have the same right to healthcare as Spanish citizens, without the need to be registered in a municipality or any other additional requirements.

Similarly, non-Spanish pregnant women who are in Spain have the right to healthcare during pregnancy, delivery and the post-partum period, without the necessity of being registered in a municipality or any other additional requirements.

Who is covered by CatSalut?

All citizens of Catalonia have the right to make use of the public healthcare services. The Catalan healthcare system is defined by its commitment to guarantee universal healthcare.

In Catalonia, CatSalut is responsible for acknowledging the right of all citizens, that is, all people who are registered residents of any town in Catalonia, to receive healthcare assistance.

This right corresponds to all citizens, with specific coverage levels established in accordance with specific personal circumstances and guaranteed cover which is confirmed by CatSalut by means of the issue of an individual public healthcare card or TSI.

Citizens can apply for the card at the primary healthcare centre (CAP) that corresponds to them based on their home address. They will need the following documents:

- an identity document (Spanish Identity Card-DNI, Foreigner's Identity Card-NIE, passport, etc.)
- a certificate proving they are registered with their municipality, dated no more than three months prior to the application date. (A collaboration project has been started up to provide for online consultations of citizens registered with town halls that will make the need for this document unnecessary in the future)
- a photocopy of a document indicating they are registered with the Social Security system, MUFACE, MUGEJU or ISFAS.

Anyone who does not have a document of this kind (or people without coverage) may request the right to healthcare assistance through one of the following ways.

Access for people without sufficient financial resources

People without sufficient financial resources have the right to receive healthcare assistance, provided they meet the following requirements.

- They must be registered with a town hall in Catalonia.
- They must have annual income from any source that is less than or equal to the minimum inter professional salary or, if they exceed this limit, the result of dividing their annual income by the number of minors or disabled persons they are responsible for must be lower than or equal to half the minimum inter professional salary.
- They must not have access to public healthcare protection in any other way.



How to apply

They will have to submit the following documents to the primary healthcare centre (CAP) that corresponds to them based on their home address.

- A certificate proving you are registered with your municipality
- For applicants over the age of 14, a photocopy of a Spanish Identity Card (DNI), photocopy of a tax identification number (NIE) or passport
- For minors, a photocopy of the family register (llibre de família)
- A document from the Social Security if they have a Social Security number or are registered with the Social Security system
- A tax return from the previous fiscal year
- To claim a disability of more than 33%, they must submit a certificate from the competent organization (Institut Català d'Assistència i Serveis Socials, ICASS) stating that they have such a disability

Individuals apply at the CAP to have their right to public healthcare assistance acknowledged.

The CAP personnel will check to make sure they have fulfilled all the requirements to receive healthcare assistance and will process their application with CatSalut, which will issue the corresponding individual public healthcare card, as applicable.

Access for people with financial resources

People with financial resources who are excluded from or not covered by the public healthcare system may also have access to the public healthcare system.

These people must fulfil the following requirements:

- They must be registered with any town hall in Catalonia and be able to provide proof of their residence by means of the registration certificate issued by the town hall
- They must not be legally obliged to pay contributions to the Social Security system or any other public healthcare system
- They must be unable to legally access a public healthcare protection system
- They must not be a beneficiary of a public healthcare assistance system
- They must make a regular financial contribution to gain access to public healthcare assistance



Beneficiaries

The following people may access the public healthcare system as beneficiaries of the main cardholder: the spouse, descendants, adoptive children, brothers and sisters and ascendants, provided these family members live with the cardholder, do not have remunerated employment and do not receive income or a pension for an amount that is twice that of the minimum inter professional salary.

How to apply

Applicants must submit the original and a photocopy of the following documents to the citizen service unit in their healthcare region:

- For applicants over the age of 14, an identity document (Spanish Identity Card DNI, Foreigner's Identity Card, NIE, passport, etc.)
- The identity documents or passports of the beneficiaries
- The family register (llibre de família) in the case of minors
- A residency permit in the case of foreigners
- The individual tax return of the last financial year (when applying for healthcare assistance for beneficiaries)
- A certificate from the town hall where the applicant lives certifying that the applicant and his/her beneficiaries are registered with the town hall's census rolls. To claim a disability, a certificate is required from the competent authorities stating that the applicant has the indicated level of disability

Applicants must also fill in the application forms for access to public healthcare assistance at the citizen service units and the forms for direct debit of the financial contribution required to access public healthcare assistance.

Once access has been approved, the individual healthcare card (TSI) will be sent to the applicant's home. The card is valid for one year from the date of issue.

Cost: The amount of the financial contribution to be paid by the cardholder is equivalent to the amount established for medical and pharmaceutical care for common illnesses paid by groups that do not belong to the Social Security system. The monthly amount established for 2009 is €87.34.

The financial contribution may be paid monthly, quarterly or annually by direct bank debit.

New citizens

- Newborns - People born in Catalonia may make use of public healthcare system as beneficiaries of the holder of the public healthcare card by means of a certificate from the town hall that states that the applicant and his/her beneficiaries are registered on



the town hall census rolls. The newborn will have the same coverage as the holder of the public healthcare card.

- Recent arrivals to Catalonia - Recent arrivals who establish their residence in Catalonia. After registering with their town hall, they may apply for the public healthcare card like any other citizen.

Travellers

Travellers are considered to be any user of the public healthcare system who is away from his/her normal place of residence and needs healthcare assistance. When travelling they can continue to have guaranteed health services.

There are a number of ways that EU citizens residing permanently in Catalonia can register with the health service. The methods have to be explained by the relevant authorities in their country of origin.



People with the correct documents should report to:

- the Department of International Agreements of the National Social Security Institute (NSSI) in order to have their right to the health care system accredited.
- the regional offices of the National Social Security Institute in Tarragona, Lleida and Girona.

The National Social Security Institute will explain how to obtain health care. This involves all the services they will require and will be granted immediately for the length of their stay in Catalonia. Foreigners have the right to the same public health care as any Catalan citizen with regard to normal and emergency services and hospital stays. In the event of pharmaceutical provision for emergency care, prescriptions or the provision of pharmaceutical products and materials, the same regulations will apply as for users covered by CatSalut.

In the event that they do not have the documents needed, they should report to the nearest regional offices of the NSSI so they can be registered. They will need the accrediting documents from their country of origin.

Patients who require urgent attention and do not have their accrediting documents must be seen to in the emergency rooms of public health centres. In these cases, the hospital administration will require payment for the services rendered.



If admission is necessary, the patient or the family member responsible must sign the promise of payment so that if the accrediting documents have not been received when the patient is released from the hospital, the bill shall be paid in full.

Citizens who come to Catalonia to receive a particular (scheduled) treatment within the public health service must previously have received the E 112 form entitled "Certificate concerning the retention of the right to sickness or maternity benefits". The E112 form states the specific treatment, the address of the health centre or service to provide the treatment and the period during which it will be provided. This form must be issued by the relevant authorities in your country of origin. Before leaving home, they must make a reservation in the relevant hospital in Catalonia

Those people newly arrived in Catalonia who have come to live here on a temporary basis from non-Community countries must meet a series of administrative requirements to be able to access the public health service:



- Be registered on the census
- Pay Social Security
- Have a low income
- Opt for a comprehensive service through the payment of 82.33 euros per month.

For all options, the person making the request must fill out the "Request for Access to the Public Health Service" form available at the Customer Services Centre of their regional health care offices.

If they have not had their right to the health care service recognised, they should report to an emergency centre in the case of an emergency, for monitoring a pregnancy, to give birth or receive post-natal care and for all types of health care for children under the age of 18.

1.5. Service delivery

We already have described the institutions that are involved in the process of healthcare delivery to migrants, at national, sub national and local level. The national level (Spain) is not involved in delivering health services as those are a responsibility of the regional (Catalonia) and local level (Health Regions).



Our service providers

CatSalut works with different health service providers, of which the Catalan Health Institute is the main one.

CatSalut plans and acts as a guarantor of health care through the service purchase contracts it makes with its providers.

The best professionals and health services at the service of those we cover, ie, the citizens of Catalonia.

Below we will introduce our service providers, the organisations that provide the care that CatSalut's clients require. We have classified our service providers according to the type of service they provide: they can be organisations that supply primary health care services or specialised and other services.

Providers of primary health care services

Primary health care is citizens' first level of access to the health care system. This type of care mainly refers to the primary health care centres (CAP), or municipal surgeries in smaller towns.

Organisations that provide specialised and other services

Specialist health care is citizens' second level of access to the health care system. It includes hospital admissions, social health, psychiatric and mental health care, drug dependency and pharmaceutical care.

Public companies and consortiums

CatSalut introduces a number of business criteria into the management of the public health care system, aimed in all cases at guaranteeing quality health care services.

CatSalut chooses to employ different forms of management, e.g. direct, indirect or joint management to manage and administer services and provisions of the public health care system. This diversity allows us to make headway in incorporating business management mechanisms suitable to the service-provision nature of the health authorities.

Different forms of management also allow us to start up new organizational structures aimed at guaranteeing the quality of our services and ensuring greater efficacy and efficiency of the health care system.

The public companies and consortiums assigned to or partly controlled by CatSalut, the Catalan Health Service, are one of its spheres of corporate structure and show that it is possible to introduce business criteria into public health care management.



Public companies essentially make autonomous and flexible health care management possible. They are owned by Generalitat de Catalunya, Catalonia's regional government.

The creation of health consortiums basically makes it possible to meet particular needs involving the organisation and optimisation of resources through the Generalitat's purchase of services and provision of human resources and experience in managing associated companies.

The public companies and consortiums have been created in accordance with article 7, section 2 of the LOSC, which allows CatSalut to create or have holdings in entities to manage and execute services and provisions in the public health care system.

We will also pay some non-profit institutions to deliver community services for the migrant population such as for:

- Prevention of genital female mutilation
- Psychological support for migrants mothers
- DOT for migrants TBC patients
- Intercultural mediation services
- Period health check up for prostitutes
- Other

Service availability to migrants.

They have the rights to the healthcare and as stipulated in the Decree that develops the law in Catalonia, all foreigners who are registered as citizens of the municipality in which they live have the same rights concerning healthcare as Spanish citizens. Once they are registered at their municipality they are entitled to a health card (regardless of whether they are documented or undocumented migrants), except if they are from the EU and have insurance in their own EC country or have the European health card. People from high income countries have also to prove that they do not have insurance in their country.

This card gives them the right to access all the health services that are covered for the health system.

All foreign people, that do not have this health card, have the right to services from the public health system if they suffer from a serious illness or an injury, regardless of the reason, until the moment of medical discharge

In our webpage we explain to the population what the health card is:

The TSI card, your personal health care card

Your personal health care card (TSI) identifies and accredits you as a person covered by the Catalan Health Service. Your TSI is the key to accessing the centres and services of the public health care system.



The personal health care card (TSI) is the document that provides citizens with access to the centres, services and provisions of the public health care system. Your TSI is also an easy and reliable way of identifying you, using a personal identification code (PIC) which is printed on the first line.



Everyone has to have a TSI. It is a personal and non-transferable card for each member of the family, whatever their age.

If you have not yet received your health care card you should report to your primary health care centre (CAP), phone the Sanitat Respon helpline on 902 111 444 or contact the Customer Services Centre of your regional health care offices. They will provide you with information and indicate the steps you need to take to request the card.

When children travel (separated parents, school excursions, etc.) it is important to remember to provide them or the adult responsible for them with their TSI.

CatSalut provides free health care cards to citizens.

The TSI can also be used for pharmaceutical services.

The health care card provides access to all services provided under the public health system. These services include drugs subsidised by CatSalut. The card of the person in whose name the prescription is made out must be presented when buying medicine. Drugs cannot be given to another person if they are not carrying the TSI.

2. The migration phenomenon

2.1. Composition of migrant flow

Spain's good economic performance for the last 8 years has been a factor that attracted migrant populations. That is why we increased the Catalan migrant population to more than a million during this period.

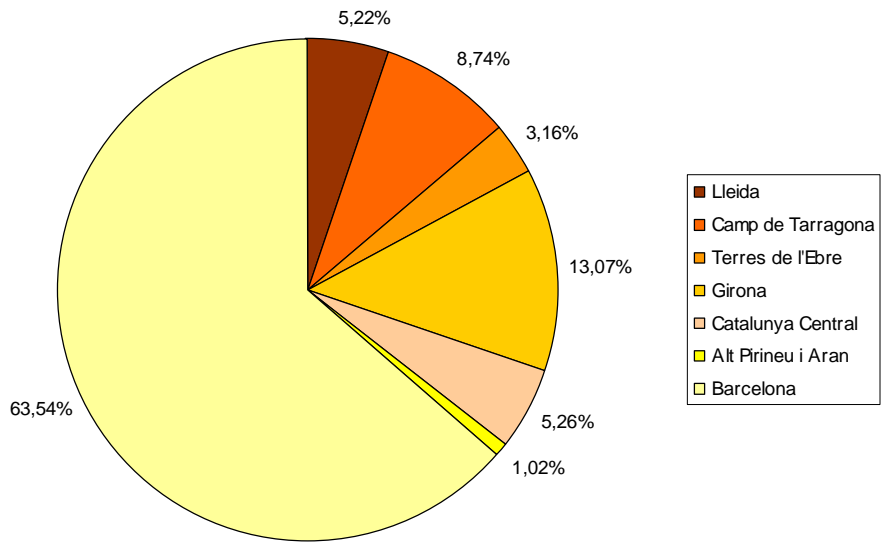
In the year 2008 and according to our Health Card Registry, we had the following migrant population by sex and age.



Age	HEALTH CARD REGISTRY 2008					
	number of people			% over total population		
	Total	Men	Women	Total	Men	Women
0-14	167,206	86,106	81,100	14.35%	14.37%	14.34%
15-44	714,656	392,445	322,211	21.54%	22.89%	20.10%
45-64	135,994	70,278	65,716	7.59%	7.98%	7.21%
65-74	16,245	6,913	9,332	2.71%	2.50%	2.90%
75-84	6,274	2,469	3,805	1.34%	1.32%	1.36%
85 i més	1,561	517	1,044	0.96%	1.06%	0.91%
Total	1,041,936	558,728	483,208	13.89%	15.07%	12.73%

The distribution by Health Region was the following.

HEALTH REGION	HEALTH CARD REGISTRY 2008			Distribution		
	Total	Men	Women	Total	Men	Women
Lleida	54,373	31,176	23,197	5.22%	2.99%	2.23%
Camp de Tarragona	91,022	49,089	41,933	8.74%	4.71%	4.02%
Terres de l'Ebre	32,944	19,006	13,938	3.16%	1.82%	1.34%
Girona	136,155	74,291	61,864	13.07%	7.13%	5.94%
Catalunya Central	54,826	30,416	24,410	5.26%	2.92%	2.34%
Alt Pirineu i Aran	10,598	5,466	5,132	1.02%	0.52%	0.49%
Barcelona	662,007	349,276	312,731	63.54%	33.52%	30.01%
Non specified	11	8	3	0.00%	0.00%	0.00%
<i>Catalunya</i>	<i>1,041,936</i>	<i>558,728</i>	<i>483,208</i>	<i>100.00%</i>	<i>53.62%</i>	<i>46.38%</i>

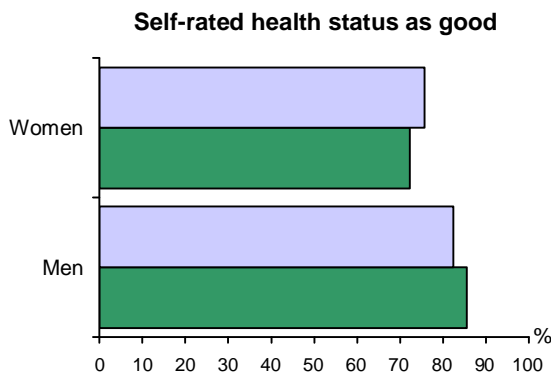


Source: Own elaboration. Data from Spanish Ministry of Work, Institute for National Statistics (INE), Secretary for Immigration and CatSalut (RCA, TSI Bureau).

Although it is well known that not all foreign citizens have real access to the public health system because of their ignorance of the system and because of fear due to their irregular situation, the data in the figure above show that the immigrant people who have been registered at their council and are listed in the municipal census, have the personal health card (TSI) which allow them to access to the Catalan public health services.

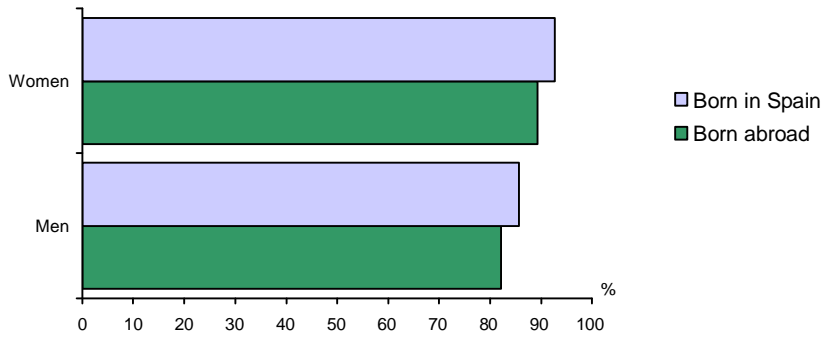
Differences in health according to place of birth by sex

According to the data of Catalonia gathered by the Health Survey of the Ministry of Health in 2006 (ESCA 2006), we can infer that, though men and women born abroad have fewer medical visits than Spanish citizens, have less alcohol and tobacco addiction and less prevalence of chronic illnesses, women born abroad consider their health status worse than women born in Spain.

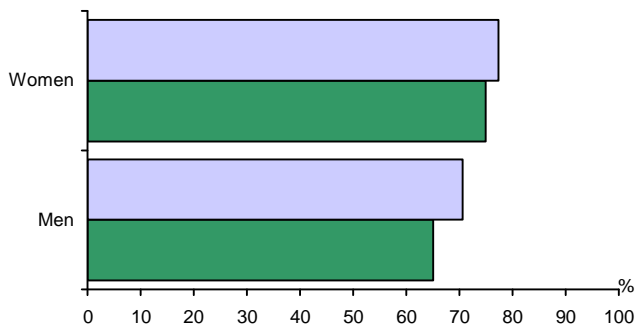




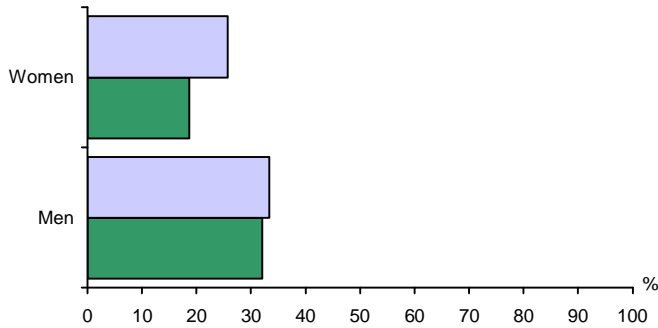
Medical visits during the last 12 months



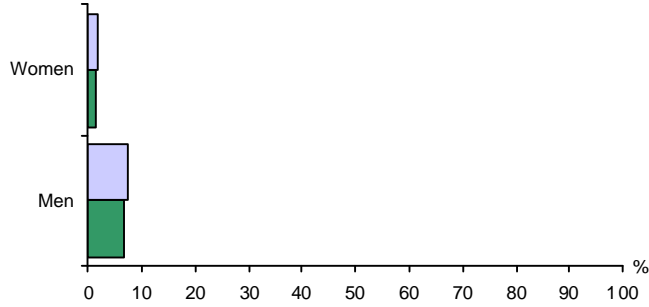
Prevalence of chronic illnesses



Prevalence of smoking status



At-risk alcohol consumption



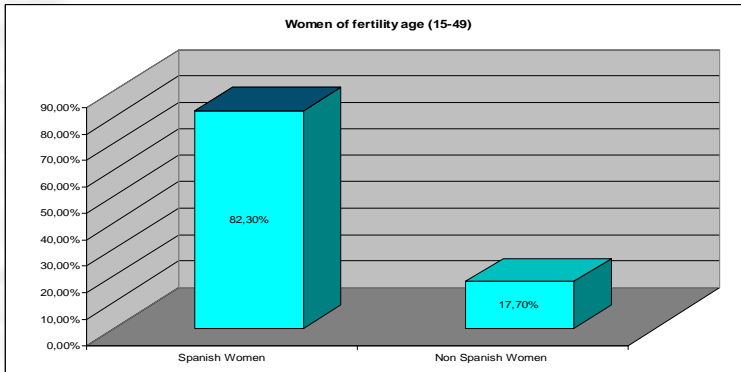


From 1998 to 2008 there is an increased number of newborns with one or both parents having a foreign origin, reaching 29% of the total newborns in 2008. Currently one in three newborns has one or both parents foreign-born.

If we look at women of reproductive age (15-49), we find that non-Spanish women represent 17.7% of the total women of reproductive age, and looking at the % of births among adolescent mothers, this is 53% from non-Spanish adolescents.

ANALYSIS OF THE SITUATION: FOREIGN POPULATION

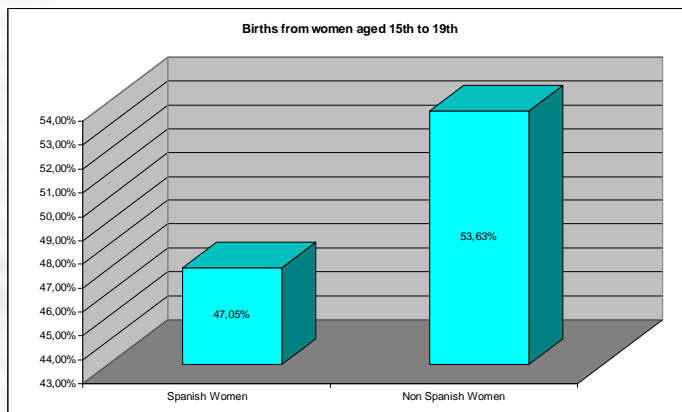
“WOMEN OF REPRODUCTIVE AGE (15-49)”



Departament de Salut

ANALYSIS OF THE SITUATION

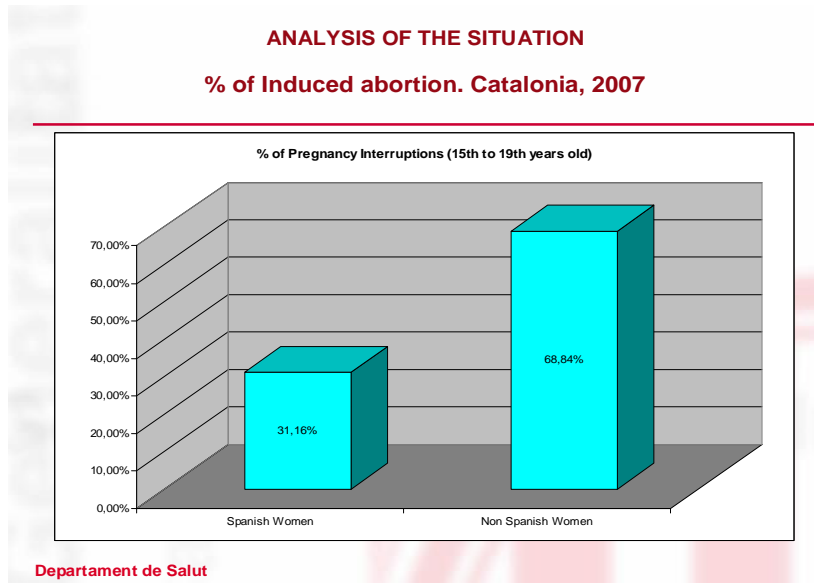
Births from mothers between 15 and 19 years old. Catalonia 2007



Departament de Salut



The 68.84% of the induced abortions among adolescents are for non-Spanish women.



Data from Women’s Institute of the Spanish Ministry for Work and Social Affairs emphasize that the women’s death rate related to gender violence is much higher among women born abroad (13.18‰) than among local women dead from this cause (2.5‰).

Weight of non Spanish population in relation with gender violence

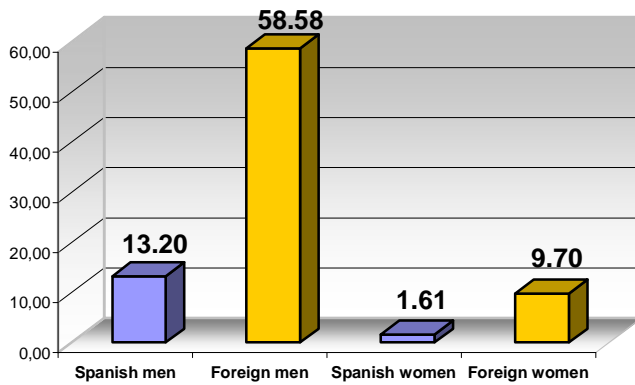
Women’s death rate per 1 million (in Spain)

	2005	2006	2007
Nons Spanish women	9,78	10,37	13,18
Spanish women	1,80	2,32	2,5

Source: Women’s Institute. Spanish Ministry for Work and Social Affairs

Departament de Salut

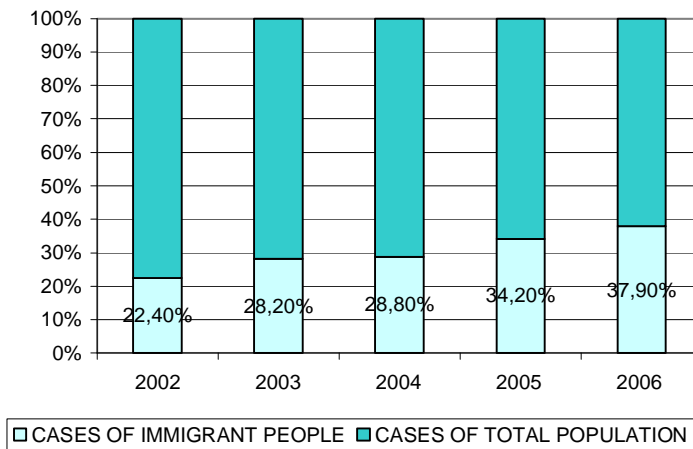
Occupational injuries, which are a serious problem in Catalan society, are also higher in the immigrant population than among local people: whereas the rate of fatal occupational injuries per 100,000 workers in 2003 was 58.58/100,000 among foreign men, it was 13.20/100,000 among native men. Although women do not suffer so many occupational fatal injuries as men, statistics of 2003 support the same tendency: 9.70/100,000 among foreigners and 1.61/100,000 among native women.



Source: Study by the Occupational Health Research Unit of the University Pompeu Fabra (UPF), 2007

In 2006 37.9% of cases of tuberculosis were for foreign citizens. The tuberculosis rate among foreigners (58.4 per 100,000 inhabitants) is fourfold that among those born in Spain (15.6 per 100,000 inhabitants). In recent years the proportion of cases of foreign people has been significantly increased: jumping from 6% of the cases in 1996 to 37.9% in 2006.

**TUBERCULOSIS: % IMMIGRANT CASES
2002-2006**

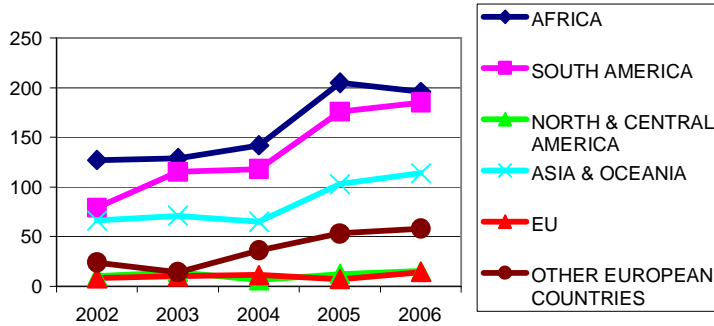


Within the foreign population, Moroccans were the most affected (19.6% of the foreign citizens who suffered from tuberculosis) followed by the people from Bolivia (13.7%), Pakistan (10.6%), Ecuador (8.4%), Romania (6.2%), Peru (5%) and Senegal (3.6%).

As it is shown in the following graphic, the people born in the African continent constituted in 2006 33% of the cases detected among the foreign population. Next were people from South America (32%) and Asia & Oceania (20%).

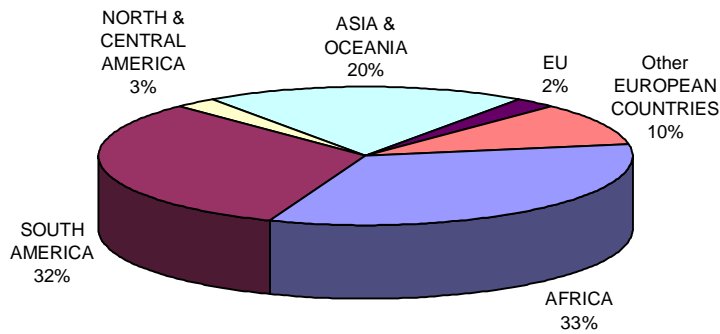


**PROCEDEENCE OF CASES
TUBERCULOSIS**



Although the African population is the largest affected group among the foreign citizens, the proportion of the affected Africans in the foreign group has decreased from 44% in 2001 to 33% in 2006. On the other side, the proportion of people from South America has increased from 25% in 2001 to 32% in 2006.

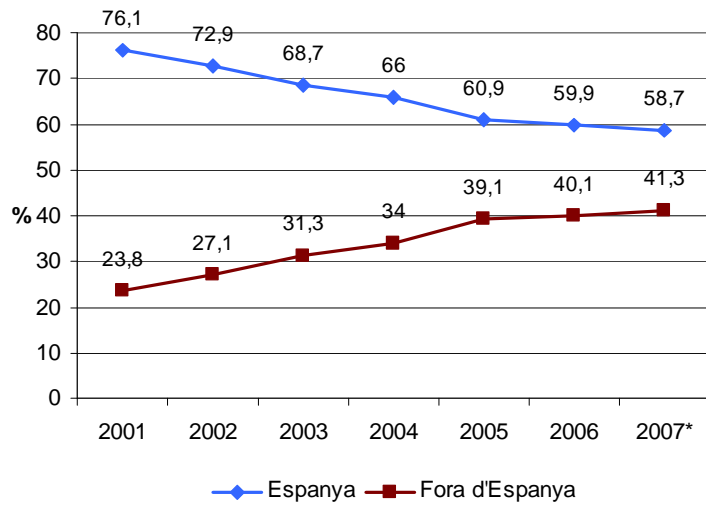
TUBERCULOSIS: % IMMIGRANT CASES according to the country of birth (2006)



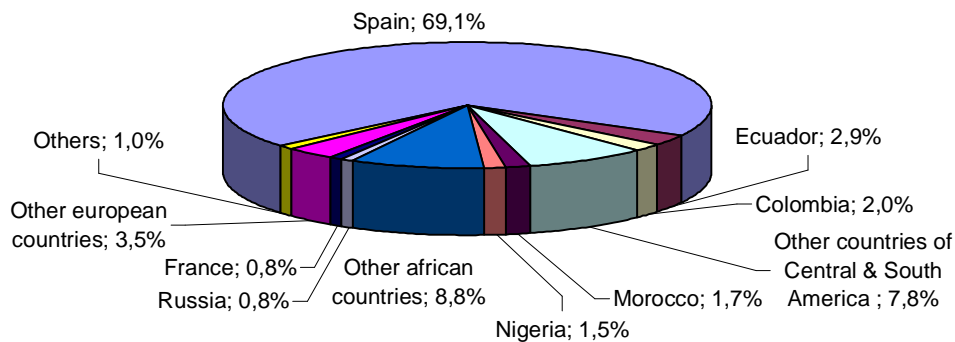
For HIV infection also the situation has been changing.



Distribution of the new diagnosed cases of HIV infection according to the country of birth. Period 2001-2007 (Espanya - Spain; Fora d'Espanya - outside Spain)



Country of birth of the new diagnosed cases of HIV infection (2001-2006)



Studies on immigration and health funded by the Immigration Master Plan for Health (IMPH)

We have carried out a number of research studies to assess the health status of the non-Spanish population and their access to the health services:

- Health needs and health service utilization by immigrant population in Catalonia.
- Costs in relation to emergency services attendance.
- Perceptions and needs of health professionals in relation to care of the foreign population.
- Health policies for foreign immigration at national and international levels.



Outcomes of the study on health needs and health service utilization by the immigrant population in Catalonia (2004).

The study's objective was to analyse the Spanish and Catalan bibliography in order to identify the health needs and health service utilization of immigrant population.

Some conclusions of the eighty-five studies reviewed were:

- The immigrant population is in general younger than the Spanish or Catalan.
- Job insecurity and poor living conditions may have a negative influence on their health.
- Immigrants' health self-perception may be worse than that of the Spanish population (in a research carried out by Sanz B and col in 1997 in Madrid, 63% of 300 immigrants expressed a worse health self-perception and 33,4% considered that their health had worsened after their arrival in Spain.
- In 2001, the most commonly perceived morbidities were related to physical jobs, such as muscular or articular pain (53,2%) or work injuries (37,1%)
- While somatisation diseases and unspecific symptoms are more common in the immigrant population as an expression of mental health conditions, psychotic diseases seem to be less frequent among immigrants.
- Particular immigrant communities are more likely to be infected from certain diseases before their arrival in Spain.
- While particular immigrant communities have a stable or rising prevalence of tuberculosis, Catalan population TB prevalence is falling.
- HIV immigrant patients who suffer from AIDS may live shorter lives than Spaniards.
- Immigrant children have worse dental health than autochthonous children.
- The foreign population has difficulty in accessing particular health services because of ignorance about the system and fear due to their irregular situation.
- The most common reasons for consultation and admission were obstetrics and gynaecology for women and digestive pathologies for men.
- There is a lower participation in preventive programmes.
- There is a lower compliance with therapeutic regimes in the immigrant population.

Some of the studies' recommendations were:

- Some indicators on foreign people should be introduced to the information system enabling the collection, without stigmatization, of more information about immigrants and development of better planning and resource allocation.
- It is necessary to improve working and housing conditions to reduce the gap between autochthonous and immigrant population.
- Some measures to improve surveillance and control of particular transmissible diseases, such as tuberculosis, in the most affected communities should be improved.



- Although the profile of health mediators is not clear, their introduction in the health system seems to be an appropriate intervention to improve the health services' efficiency and immigrants' access to health services.
A network of health providers and institutions that offer their services to the immigrant population are needed to co-ordinate the resources in health mediation.
- Courses about multiculturalism for health professionals should be established. They should be mainly focused on preventive activities particularly Maternal and Child Health, Childhood Vaccination and Dental Health.
- Social Support networks should be strengthened in order to improve the immigrant population's mental health.
- Guides and protocols for the new-arrived immigrant's health care should take into account the more prevalent infectious diseases in the countries of origin in the initial screening for their early diagnosis.
- Some suggestions for new research are:
 - All different immigrants' communities should be included in studies of the general population. Samples should be randomly selected and a size sufficient to ensure that the sample is representative of the frame and to have statistical significance.
 - It is important to include in the research:
 - All possible determinants of health inequalities
 - Eating habits of the different cultures
 - The health professional's perspective
 - The immigrant's perception of health and illness.
 - The physician-patient relationship.
 - The preventive and curative activities' efficiency.
 - A mixture of specific variables related to cultures and migration histories. They should be defined as possible determinants of immigrants' health; therefore, they should be included as useful variables for the analysis of the morbidity and mortality of immigrant communities in Catalonia.

Costs in relation to emergency services attendance (2006)

The aim of the study was to determine the workload generated by emergency department visits by immigrants according to country of origin.

A total of 165,267 emergency visits to Hospital del Mar between 2002 and 2003 were included in the analysis.



The results of the study were:

- From 2002-2003 there were 165,257 emergency visits, of which 15.5% were made by ILIC (immigrants from low-income countries).
- While for Spanish-born residents 38% of visits were made by persons aged more than 50 years old, this percentage did not exceed 13.7% in IHIC (immigrants from high-income countries) and 8% in ILIC.
In contrast, 78% of visits by immigrants were made by individuals aged 16-50 compared with 44% of those by Spanish-born residents.
- Males predominated among immigrants from Asia and northern Africa, while females predominated among those from Latin America and sub-Saharan Africa.
- Differences in specialty were found in greater relative utilisation of gynaecology and obstetrics services and lower utilisation of medicine and orthopaedics among ILIC compared with Spanish-born residents and IHIC.
- Both IHIC and ILIC showed lower costs than did Spanish-born residents. Emergency variable cost was 9 to 17% lower for all immigrant groups.
- The average cost per emergency visit was 11.66€ for Spanish-born residents and IHIC, and was 7.21€ for ILIC.
- Variable cost was significantly lower for ILIC among the specialties of medicine (37%), orthopaedics (22%) and surgery (12%). All reductions in variable costs exceeded 10%.
- No differences were found between obstetrics and gynaecology and paediatrics.

Some of the conclusions of the study were:

- Results supported the view that the immigrant population tends to access the health service through the emergency department even more than the Spanish-born population.

The most probable hypothesis is that immigrants overcome certain barriers by using the emergency department as the route of access to health services in preference to other routes.

The finding that both ILIC and IHIC showed greater emergency services utilisation department use suggests that the cause lies in overcoming barriers to access rather than in the immigrants' socioeconomic position.

The most coherent explanation seems to be the short length of residence among immigrants and their consequent lack of knowledge of the normal routes of access to health services.

- The substantial increase in both IHIC and ILIC in using the health system intensifies the imbalance that an increase in demand for emergency services represents for a hospital. The increase in pressure on the emergency services is probably related to lower levels of efficiency, since it involves the use of expensive high-intensity resources to respond to non-urgent conditions that could be managed in the primary care setting.



- The finding that gynaecological emergencies in adult immigrant women of reproductive age represented a greater workload than those by their Spanish-born counterparts can be explained by the difficulties of pregnancy follow-up in ILIC in primary care. Participation in primary care pregnancy follow-up programmes is substituted by sporadic contact with the emergency services that perform the pertinent procedures, with the variable cost that this represents.

The same occurs at delivery, increasing the cost of hospital care of the neonate in the early postpartum period.

Because of the relatively high volume of obstetric and gynaecological emergency visits, as well as their level of complexity, greater efforts should be made to reach immigrant women of reproductive age and include them in antenatal care programs.

- This study shows a variable costs' analysis that provides a certain level of evidence that is useful for the planning of health services and interventions to improve the healthcare of the distinct emerging groups in the Spanish health system.

Perceptions by health professionals in relation to immigrant population (2006)

The objective of this study, carried out in 5 Catalan regions during 2007, was to make a qualitative analysis of the health professionals' perceived needs in regard to the immigrants' health care. 49 health professionals and providers were personally interviewed and three discussion groups were conducted.

The main results of the study were:

- There is a work overload as a result of the increase of the general population and particularly of immigrant people whose socio-demographic characteristics rapidly change.
- Health professionals perceive the linguistic and cultural communication problems as a cause of overload work.
- These two factors lead to the general feeling of worry and frustration among health professionals although, in general, they have a positive approach to the phenomenon and feel satisfied with the good outcomes from their interventions.
- Access to the health system is easy, however, health professionals identify administrative barriers in the application of the health card because of difficulties with the previous register at the council.

Other institutional aspects, both at the local and central level, contribute to worsen the quality of their health care. Health professionals identify many negative factors such as overlapping schedules with their working timetable, lack of economic and human resources, insufficient time for visiting patients, hospitals not attuned to immigrant community's needs, and inadequate co-ordination inside and between providers.



- The inadequate utilization of the health services, particularly the emergency services, is considered as a result of ignorance with regard to the health system organisation. This fact, in addition to their economic and social problems, leads to common unjustified demands and lack of compliance with the visits scheduled.
- Health professionals are aware of their lack of cultural competencies.

Support needs of health professionals in relation with immigrant population (2007)

Different recommendations from the above mentioned study were:

- To provide the IMPH with enough resources in order to assure the implementation of its planned contents throughout all Catalan territory.
- To develop a diffusion and communication plan to give details of the available services among professionals whose work is addressed to foreign citizens, both from health system and from other sectors, and immigrant communities.
- To strengthen the supporting communication strategies:
 - In translation:
 - by making the telephone access to translation services easier, and
 - by incorporating new computerized translated materials.
 - In intercultural mediation:
 - by distributing translators/health cultural mediators through all Catalonia according to the characteristics of immigrant settlements existing in the different territories.
- To promote the co-ordination between the health system, the councils and other local or central organisms in order to:
 - Establish the reception and cultural mediation plan
 - Improve both the citizen's information and education about the phenomenon of immigration and the immigrant knowledge about the available social services as well as their duties and rights concerning with them.
- To take specific measures to resolve the structural problems at the local and central health system:
 - To adapt service provisions and personal resources to local realities taking into account the socio-demographic characteristics of their population, the number of immigrant citizens with their social, idiomatic or health needs, and so forth.
 - To adapt the reception and mediation plan to the specific needs of all kind of health professionals, and to the profile of the major immigrant communities.



- To promote the update training of health professionals in cultural competencies:
 - by dedicating enough resources and
 - by guarantying that professionals can do the courses during their working hours.
- To take specific measures addressed to health professionals:
 - by offering update courses mainly focused on acquiring practical skills and on attitudes towards multicultural diversity.
 - Including specific training during the pre- and post-graduation courses.
- To take specific measures addressed to both immigrant and general population:
 - By offering adequate and continuing training programmes in health education in partnership with local immigrant communities from design through to completion of the programmes.
 - By implementing educational programmes intended for a better utilization of the health services in partnership with Catalan citizens and immigrants from design through to completion of the programmes.
- To promote operational research, which might promote knowledge about:
 - immigrant population health needs
 - health services utilization
 - the barriers of immigrants to access to health services
 - the health professional and health system needs concerning services for immigrant communities
- To improve the data registers of information related to immigrants. The analysis of health needs and demands, of services utilization and of the supporting needs of health professionals, could benefit from the improvement of data recollection.

Health policy analysis for immigrant population care at a national level (Madrid, Andalusia, the Basque Country and Valencia) and international level (United Kingdom, Italy, and Canada) levels

The results of an analysis of scientific and grey literature on health policies for immigrant population in the United Kingdom, Italy and Spain conducted in 2007, showed that:

- General actions relate to: immigrants' specific health problems; access to and adaptation in healthcare services - the available resources and organization; professional training; communication; analysis of health needs; and institutional collaboration.



- While in the UK policies are oriented towards reducing inequalities in health, including among ethnic minorities, Spain and Italy have developed specific policies addressing immigrants' needs for health care and specifically access to the health system.
- Evaluation of health policies is in general scarce. Only in the UK are some results of their implementation available.

2.2. Migrant impact on social and economic standards

Obviously the arrival of a new population as a cheap source of workforce generates social tensions. Mainly because the local population feels that there is a competition for public services. Subsequently to the economical crisis, most of this workforce became unemployed and now competes for the unemployment benefits. And many of them became poorer and have worse living standards.

2.3. Migrant social determinants of health and healthcare needs

With regard to mental health in the migrant population, Joseba Achotegui, a psychiatrist from the University of Barcelona and the author of "The Ulysses Syndrome", has sent us a description of what this Syndrome is: "But the days found him sitting on the rocks or sands, torturing himself with tears, groans and heartache, and looking out with streaming eyes across the watery wilderness ..." (Odyssey, Song V, 150,). "You ask me my name. I shall tell you. My name is nobody and nobody is what everyone calls me". (Odyssey, Song IX, 360)

Human migrations have been a frequent phenomena throughout history; however, each migration usually presents its own specific characteristics. Today, the circumstances in which many immigrants come to Spain and Europe are characterised by their extreme conditions. For millions of individuals, emigration presents stress levels of such intensity that they exceed the human capacity for adaptation. These persons are, therefore, highly vulnerable to Immigrant Syndrome with Chronic and Multiple Stress, known as the Ulysses Syndrome (in reference to the Greek hero who suffered countless adversities and dangers in lands far from his loved ones). This Syndrome is an emerging health problem in our societies, making itself manifest in the current context of globalisation, in which the living conditions of a large majority of immigrants have deteriorated dramatically.

Stressors

Immigrant Syndrome with Chronic and Multiple Stress is characterised, on the one hand, by the fact that the individual suffers certain stressors or afflictions and, on the other, by the fact that he presents a series of symptoms from several areas of psychopathology. The most important stressors are:

- loneliness and the enforced separation, especially in the case when an immigrant leaves behind his or her spouse or young children;



- the sense of despair and failure that is felt when the immigrant, despite having invested enormously in the emigration (economically, emotionally, etc), does not even manage to muster together the very minimum conditions to make a go of it;
- in addition to these difficulties, the immigrant has to fight merely to survive: to feed himself, to find a roof to sleep under;
- the fear, the afflictions caused by the physical dangers of the journey undertaken (sailing on the *pateras* - light, precarious boats, hiding away in lorries, etc), and the typical coercive acts associated with journeys that are "organised" by the mafia and other groups that extort and threaten the immigrants. It is known that physical fear has a much greater de-structuring effect at the psychopathological level than psychological fear, because there are fewer ways of escaping it. It is also known that chronic stress increases the conditioning power of this fear, sensorial as well as conceptual (Reeve 2002). Furthermore, in all cases, the immigrant lives in fear of detention and deportation.

This combination of loneliness, the failure to achieve one's objectives, the experiencing of extreme hardships and terror forms the psychological and psychosocial basis of Immigrant Syndrome with Chronic and Multiple Stress (the Ulysses Syndrome).

Yet, the harmful effects caused by the adversities and dangers that the immigrant must face are increased enormously by a whole series of unfavourable characteristics associated with stressful situations, the fact that the stressors are:

- multiple - the greater the number of adversities and dangers, the greater is the risk to the mental health
- chronic - these situations of extreme hardship can affect immigrants for months on end, even years
- the feeling that whatever the individual does he will not be able to change his situation (learnt defencelessness, Seligman 1975)
- the enormous intensity of the stressors - quite unlike the stress associated with being stuck in a traffic jam or sitting an examination
- the marked absence of any network of social support, absence of social capital (Coleman 1984)
- the symptoms themselves (sadness, weariness, insomnia, etc.) become an additional handicap that hinders the immigrant in his attempts to survive.
- to all this, we have to add the classic shocks the immigrant must come through (coming to terms with a new language, culture, environment...the acculturative stress - and, to these shocks, we must now add the severity of the present extreme stressors.
- what's more, the health system often does not provide adequately for these patients: either because this problem is dismissed as being trivial (out of ignorance, a lack of sensitivity, prejudice and, even, racism, etc.) or because this condition is not adequately diagnosed and immigrants are treated as being depressive or psychotic, thereby giving



the immigrant even more stressors to face - neither are their somatic symptoms seen as being psychological problems, and so they are subjected to a series of tests (such as colonoscopies, biopsies, etc.) and given inadequate, costly treatment. The health system is a new stressor

So seven forms of grief can be identified as a result of migration (Achotegui, 1999):

1. grief for the family and loved ones
2. grief due to languages: how the change of language is experienced by the immigrant
3. grief for the culture: customs, sense of time, religion, values
4. grief for the homeland: landscape, the light, the temperature, the colours, smells, humidity
5. grief in relation to social status: legality, working conditions, housing, etc.
6. grief in relationship to the peer group: prejudices, xenophobia, racism
7. grief due to risk regarding physical integrity: dangers in the migratory journey, dangerous jobs (accidents, professional illness, etc), changes in diet, etc.

These seven forms of grief can be lived in a simple, complicated or extreme way (Achotegui, 2002):

- Simple grief - grief which occurs in good conditions and which may be worked through satisfactorily
- Complicated grief - when serious difficulties exist for working through the grief, but it is possible to do something
- Extreme grief - when the situation is so problematic, so difficult that the grief cannot be worked through. This is the case of The Ulysses Syndrome

Symptomatology

The clinical expression of Immigrant Syndrome with Chronic and Multiple Stress is a specific combination of symptoms:

- symptoms related to depression include, fundamentally, sadness and crying, but do not include other basic symptoms such as apathy, low self-esteem, guilt, thoughts of death, so that we are not dealing with a depressive disorder;
- it also includes symptoms of the area of anxiety-related disorders, such as tension, insomnia, recurrent and intrusive thoughts, irritability;
- somatic symptoms, above all migraines, fatigue, osteoarticular complaints, etc.;
- symptoms of confusion (tempo-spatial disorientation, depersonalisation, derealisation etc.);



- to this symptomatology is often added an interpretation made from the perspective of the subject's own culture. Thus, it is typical to hear: it's not possible that things can have turned out so badly for me, I'm suffering such bad luck, I must be cursed, I'm the victim of witchcraft, etc. It should be borne in mind that this symptomatology occurs in relation with the culture of the immigrant, since it is his culture that channels the expression of the symptoms and we find differences in the clinical conditions of migraines, tiredness, etc., as Gailly (1991), Bennegadi (2005), Obiols (2005), Wintrop (2006), Varma (2006) have pointed out.

3. Policy agenda, good practices and projects

3.1. Policy agenda

The Immigration Master Plan for Health (IMPH) has been prepared to set the objectives for improvement in services to the foreign immigrant population for a three-year period and also to establish the actions to achieve the objectives. These actions will be determined by the strategies defined in the areas of reception, mediation and training.

The co-ordination of actions throughout the territory and the appropriate responses to all petitions and appeals will be managed by the Department of Health, through the Health Regions and the future Territorial Health Governments (THGs).

At the same time that the decentralisation model is being implemented, the IMPH is also been taken forward.

The Master Plan, under the principles of the Secretariat for Immigration, will be governed by the principle of interdepartmental action.

The Plan includes, as a fundamental element of its implementation and consolidation, a territorial organisation that reflects both the principle of decentralisation of the Department of Health and the policies of participative accommodation of the Citizenship and Immigration Plan of the Secretariat for Immigration.

In order to effect decentralization throughout the territory, the Plan strengthens and consolidates the participative work in networks that already exist in some parts of the territory. The initial strategic planning recommends the implementation of a community-based model of territorial organisation. This model involves the creation of central and regional Committees for health and immigration.

Firstly, the central level Health and Immigration Committee (Department of Health) and the Regional Health and Immigration Committee will be created. Secondly, as the THGs are established, and to the degree that the region judges necessary their creation, their Health and Immigration Committees will be formed



Organization Chart of Health and Immigration Committees

In meeting the Objectives of the Committees, the following series of actions are critical to the efficiency of the Immigration Master Plan, for both public health care centres and hospitals:

- to promote community activities;
- to involve communities in assessing needs;
- to develop suitable databases for the health information systems;
- to promote joint reception actions with other actors involved in immigration plans;
- to prepare personnel, in terms of quantity and quality, to meet the needs created by the phenomenon of immigration among professionals who provide services to the immigrant population;
- to strengthen user services with personnel from immigrant communities and promote the hiring of health professionals and support staff from abroad;
- to diversify the models of mediation amongst the different options. To enable the coexistence of different models according to the needs of a particular area.

The main parts of the IMPH are: the Reception Plan, the Mediation Plan and the Training Plan, together with the document for reorganisation of the International Health Units.

The Reception Plan

The Reception Plan will establish a series of programmes and actions in the health sector that improve the reception and consequently the integration of the immigrant population, recognising that a good reception is beneficial to the whole of society because it aids in the integration of immigrants and is beneficial to social cohesion.

The Reception Plan must improve, coordinate and optimise the informing of the immigrant population and the access it has to health and health services through the following steps:

- Performance of needs analysis for co-ordinated reception.
- Preparation of audiovisual materials to support reception, on DVD, CD-ROM.
- Creation of a web page "Health and immigration".
- Improved registers and information. Information for the public suitably adapted.
- Provision of the TSI (personal health care card) to all new arrivals or those who are currently excluded from the system.
- Identification of the most vulnerable people or groups.
- Provision of information on the Health Reception Plan to all institutions/bodies throughout the community who have contact with new arrivals.
- Creation of a network that works to co-ordinate access to health services.
- Monitoring and evaluation of the projects developed in this line.



Under the Reception Plan various actions have been taken in the following areas:

- in 10 languages: Catalan, Spanish, Web page for professionals and immigrants, which can be found at <http://www.gencat.cat/salut/immigracio.htm>
- Audiovisual material English, French, Russian, Romanian, Arabic, Darija (Moroccan Arabic), Chinese and Urdu. There are 8 short video segments that provide information about the following health topics: The personal health care card and health care services in Catalonia, What to do in case of illness, The primary health care centre teams, Hospitals, Prescriptions, Pregnancy, Infant health care, and Sexual and reproductive health. New content is currently being developed. These materials can be found on the web page given above in both audiovisual and written form.

The Mediation Plan

In the overall context of reception, equality and accommodation policies and in accordance with that proposed in the Citizenship and Immigration Plan, it will be necessary to introduce the role of mediation professionals in the field of health.

The incorporation of mediators into the health system will enable the provision of better services to meet health needs, as well as improve accessibility of and autonomous use of health resources.

In recent years, some informal initiatives have been developed in the area that is known as MEDIATION. These have generally been directed voluntarily by sensitive and motivated professionals, in response to the phenomenon of immigration, especially in those areas where the immigrant population began arriving many years ago. The models for mediation have been and continue to be diverse, even if all of them have come about in response to a need and with the objective of facilitating communication between the immigrant population and professionals.

The general objectives of the Mediation Plan are as follows:

- To reduce disadvantages experienced by the immigrant population in access to health services.
- To adapt the health system to the new reality, to meet the new needs arising.
- To inform about the different perceptions, attitudes, and knowledge resulting from cultural, social or linguistic differences between professionals and the immigrant population, as well as aiding their interpretation.

The Mediation Plan must be considered in the context of and in relation to the directives of the Health Plan. The proposal for the organisation of mediation in health services of Catalonia has to take into account the following key areas of the framework established in the Citizenship and Immigration Plan, 2005-2007 of the Government of Catalonia.

- Interdepartmental action and coordination, to create coherence.
- Consensus and participation of local councils, professionals and all civil organisations.



- Standardisation, since immigrants need to be served with existing services, without creating parallel structures, but while still respecting the specific situation of new arrivals.

The mediation model of the Master Plan must be aimed at overcoming the situations of inequality in which various groups find themselves in relation to the health system.

The role of intercultural mediator arose to facilitate intercultural relations, above all during an initial contact period. The knowledge mediators have of the language of origin, both cultures, and the language of the country of reception are the key to enable improved knowledge and communication between professionals and the immigrant population.

Mediation should be considered a provisional and temporary mechanism to get around great cultural-linguistic difficulties in the case of new arrivals and during the time necessary for them to adapt to and undergo a process of progressive integration and it is desirable as a model at which detailed policies should be directed (teaching of Catalan, etc.).

We need to approach as closely as possible the definition of intercultural mediation in the profile, role and competences of mediators.

Definition of profiles and actions taken by the IMPH

Translator³ - a person who makes a literal translation of a message, without necessarily intervening on a cultural level. The translator does not have to be present; on many occasions translation could be done over the telephone or in written form. This is most commonly required type of mediation because obviously, language is the primary communication barrier.

The Department of Health has a permanent telephone helpline called "Sanitat Respon", serving all of Catalonia. Calls from mobile phones as well as landlines are accepted. Sanitat Respon offers telephone translation service for professionals of health centres or organisations who work in health reception and are attending a foreigner whose language is unknown where this hinders the medical response. This service can be accessed by phoning, requesting it and giving the name of the centre and the contact person. An easy-to-access telephone line must be available which is not a switchboard and with which the immigrant and the health professional can both talk. There is no cost to the centre for the service, which is a three-way call made by Sanitat Respon. The translation service is available in 102 languages.

The following table shows the use of "Sanitat Respon" (translation on line service) by health professionals over the years. Over the period 2002-2007, there has been an increase of 258% in the use of "Sanitat Respon".

Years	2002	2003	2004	2005	2006	2007
N. of professionals who used it	567	886	1,453	1,731	1,689	2,018

³ Definition of the Immigration and Cooperation Master Plan, 2005.



Intercultural mediators - bridging resources that improve communication and promote constructive change in relations between people from different cultures. They are professionals that collaborate in attending to the social needs of immigrant communities and their action aims to prevent and resolve individual, family or group conflicts that occur in the area of health, education, social well-being or community life.

They assess and enable communication between health care professionals and users, and ease their access to services provided. The tasks of mediation and escorting, assigned to the local areas, should logically be complete, interdepartmental, and designed as personal services.

The multivalent profile of mediators is one that in the majority of cases has to make compatible similar functions in different fields (education, law, employment, etc.) that are especially convergent in the local sphere, and under the control of local and provincial councils. Furthermore, since 2005 specific funds designated for integration have existed, particularly for the tasks and functions described in the mediation model (escorting and translation for services). For these reasons it would seem best in the first place to optimise these resources and so use the route of local funding to provide the proposed resources that have to come from a local level, or in certain cases with the approval of the RHAs.

It is recommended that mediators be assigned to municipal institutions. It is proposed that the hiring of mediators should take place at a local level to provide support to health centres and hospitals.

In the following table it is shown the approximate preliminary estimate of intercultural mediators/translators needs, based on the resources of the Immigration Plan of Girona Health Region.

NUMBER OF HEALTH CULTURAL MEDIATORS BY HEALTH REGION				
HEALTH REGION	EXISTING MEDIATORS			NEEDED MEDIATORS
	Existing MEDIATORS*	MEDIATORS Hours / week	Existing MEDIATORS (30 h / week)	
Lleida	19	156	5	11
Tarragona	15	30	1	11
Terres de l'Ebre	0	0	0	4
Girona	21	576	19	23
Catalunya Central	4	52	2	6
Alt Pirineu & Aran	0	0	0	3
Barcelona	40	415	14	32
<i>TOTAL</i>	<i>99</i>	<i>1,229</i>	<i>41</i>	<i>90</i>

During the period 2008-2009, the IMPH, with the Institute of Health Studies (IES) and the Department of Psychiatry or the Vall d'Hebron University Hospital collaboration, has organized a training course for 80 existing and new health mediators.



The course's objective is to offer a continuing training for 50 available health mediators and to train 30 new health mediators who will be distributed throughout all the THGs in order to satisfy all territorial needs of mediation.

The THGs are currently identifying 20 new candidates for the next course which will be organized for the period 2009-2010.

The training course is, at present, being simultaneously developed in the Girona and Barcelona Health Regions.

The course for the 50 existing mediators includes a 200 hours programme, with 120 hours of theory and 20 hours for their supervision.

The total learning time for the 30 new health mediators is 345 hours composed of 240 hours of theoretical sessions and 105 hours of supervised practice at the health centres where they have been assigned for their work during the 2009 period. For this purpose, they signed a training contract at the beginning of the practical work which will be in force by next year.

The training modules are:

- Immigration and multiculturalism in Spain.
- Medical anthropology: immigration, culture and health.
- The Spanish Health System.
- Health in Western Countries.
- Cultural competency.
- The intercultural patient-health professional/health mediator relation.
- Translation.
- Intercultural mediation and professional identity.
- Community health planning.
- Roles of Health Mediation and health aspects of cultural mediation.
- Patients' Rights and Duties. Ethics in Health Mediation.
- Intercultural Mediation with the main ethnic groups in Spain

Community health worker - a professional who is part of a community health team and whose objective is to create a bridge between health services and the community or group to whom programmes, especially preventative programmes, are addressed, in order to improve the circulation of information, initiatives and resources in both directions. They also contribute to health promotions carried out by either side.

Summarizing, they are informants, community mobilizers, inter cultural mediators, analyzers of needs and promoters of health activities. These are community health figures who will carry out functions in the local sphere, specifically in the area community health teams provided for by



the Public Health Agency of Catalonia, and which will obviously be tied to the Regional Health Authorities.

In the community environment, the health services need to prioritise and define technically the training for and contents of health promotion and prevention campaigns. And more specifically and tied to the roll-out of the Public Health Agency at a local level, it will be the local public health environment, tied also to the RHAs, which will decide the community health programmes to be developed, based on the particular immigrant communities and cultures present in the area.

They become agents capable of carrying out specific tasks such as promotion and prevention, in relation to AIDS, TB, STDs, etc.

Foreign health professional - allows communication between health care professionals and users, promote access to services and equality in health care provision.

34% of the doctors who were enrolled in professional associations in 2006 (11% of medical professionals in Catalonia in 2007) were foreigners.

The Training Plan for professionals

The Immigration Master Plan, in accordance with its mission and in order to achieve its objectives, and to carry out the functions described in the decree of its creation, explicitly describes the need to prepare a Training Plan to aid health professionals in attaining the knowledge and abilities needed to reach the grade of cultural competence needed to guarantee quality while providing services, both from the point of view of the service provided and from that of the relationship between the parties and in the information provided.

The general lines for training actions are drawn and implemented on the basis of needs detected in the area of communication and knowledge in order to improve the relationship between immigrant, organisation and professional and improve the actions taken as part of the service that immigrants receive.

This training will be offered through the Institute of Health Studies (IES) throughout the whole of Catalonia in a co-ordinated manner with the territorial services, health committees and organisations.

The requirement for decentralized and prioritized activities in conjunction with the Immigration Master Plan, the territorial services and the IES can be totally or partially funded by the Department of Health.

In order to facilitate planning, the contents of activities addressed to health professionals are presented grouped in modular form by areas of interest, so they can be adapted to the objectives and needs of the Institution and the professionals to whom they are directed and the context in which they are undertaken.



Some of these training modules include:

- Reception, cultural competence and immigration, designed for user services professionals in health centres.
- Health topics for mediators.
- Adolescence and immigration, designed for health professionals in the Health and Schools programme.
- Parasitological diagnostic techniques for microbiology laboratory professionals.
- Cultural competence and health topics specifically related to the immigrant population, aimed at pharmacy office professionals.
- Cultural competence; Inequalities in health and the immigrant facing the pathologies of the receiving country; International Medicine; Migration and Mental Health; Paediatrics; Sexual and Reproductive Health; Immigrant Alimentary and Nutritional Adaptation, designed for attendant health professionals.

Since 2004, 113 courses have been developed with 2,532 professionals trained:

SUMMARY OF THE LAST YEARS	YEAR 2004	YEAR 2005	YEAR 2006	YEAR 2007
Number of courses	18	38	34	23
Number of professionals	437	836	733	526

Elaboration of protocols, guides and support materials

The Immigration Master Plan for Health has also promoted or supported the preparation of documents directed at professionals to improve services to the immigrant population. Some examples are those in the following areas:

- Maternal/infant health
 - Services protocol for diversity in pregnancy
 - Services protocol for birth and puerperium diversity
 - Services protocol for immigrant children
 - Protocol for prevention of female genital mutilation
- Infectious diseases:
 - Audiovisual material for health education on tuberculosis: video in 9 languages, culturally adapted
 - Protocol on action for tuberculosis control and prevention in immigrants and imported cases.



- Parasite diseases:
 - Protocol for the prevention, diagnosis and treatment of imported parasite diseases designed for Primary Health Care professionals
- Mental health:
 - Guides on mental health in immigrants, in coordination with the Master Plan on Mental Health
- Oral and dental health:
 - Translation of health education materials into different languages
- Nutrition:
 - Document designed for professionals to improve alimentary advice provided to the immigrant population
 - Guide to improve dietary counselling in immigrant population
- Translation of information and health education brochures
 - Dental health
 - Maternity
 - Infant health

Model for the functioning of mediation through the regional immigration and health committees and the RHAs

In accordance with the proposed organisation described in the Immigration Master Plan for the territory, which meets the criteria of decentralization and participation of the Department of Health and follows the policies of participative accommodation of the Citizenship and Immigration Plan of the Secretariat for Immigration, the RHAs and regional committees will be responsible for adjusting mediation requirements according to the observed situation. At the same time they will identify the models and profiles of mediators - ASC, as well as establishing the functions, timetables and objectives of the interventions for the mediators/ASC and their work plans.

It is proposed that the mediation requirements should be determined jointly amongst the municipalities (or councils), those responsible for health (the Ministry, Primary Health Care Centres, hospitals) and the other actors involved (NGOs, associations, mediators, etc.) through the "health and immigration committees".

It will be important to have leaders to provide support for the implementation of the plan throughout the territory. For this reason the hiring or contracting of new specialists is proposed (2 for all Catalonia).



Action Plan for the period 2008-2010

Progressive closing of the strategic stage. Boost to operational stage.

Objectives:

- To complete the creation of the immigration and health committees at the regional and territorial level.
- To implement the project "Cultural Mediation 2008-2009": training 50 cultural mediators already working for the system and certificate their training as well as to train and contract 50 new cultural mediators over 2 years.
- To collaborate in the definition and development of the Health Community Care Model.
- To evaluate the impact of action plans.

Future Goals

- Keep working to achieve a humanised health system without inequalities between population groups or territories, open to all communities and facilitating coexistence, tolerance and respect.

3.2. Good practices and projects

Background

In Catalonia, the immigrant population has increased rapidly from 2.9% in 2000 to 15.4% in 2008. This percentage contrasts with the 9.1% of foreigners in Spain.

Foreign population according to the municipal census records published by the Spanish National Statistics Institute (Instituto Nacional de Estadística) on 1 January 2008:

Spanish population	45,200,737	Foreigner citizens in Spain	4,519,554
Catalan population	7,390,083	Foreigner citizens in Catalonia	1,138,427

The percentage of immigrants has increased in the majority of Catalan provinces in less than a year. In the provinces of L'Alt Empordà in the north and La Segarra in the centre of the territory, immigrants make up more than 18% of the population.

According to the Department of Statistics of Barcelona City Council, the capital of Catalonia, Barcelona, houses 17.3% of the total foreign population in the Catalan territory (280,817 immigrant citizens).

Moreover, just in Catalonia, immigrant citizens in Barcelona are not evenly spread through the different districts, but concentrated in the oldest districts of the city, located downtown, the areas in which the majority of them live being: the neighbourhoods of the Raval and Ciutat Vella, where 47.7% (22,967 immigrant citizens) and 39.7% (41,572) of the city's foreigners live, respectively.



Even though the health problems of immigrants are essentially comparable with those of the non-immigrant population, it is necessary to consider some issues that generate inequalities and require particular care in the services immigrants receive.

The differentiating characteristics of the people arriving: their culture, traditions, religion, their manner of interpreting health and illness, language difficulties, different lifestyles, etc., can lead to a series of internal and external factors that act as barriers and hinder access to health services.

This has a negative impact on health, on the quality of assistance and on the use of health resources and, therefore, requires an adaptation of the system to address the situation in the most appropriate way possible.

Main and specific objectives

The health system must be adapted to the population changes and for that reason the Catalan Health Department created the Programme for Migrants' Health. The programme was established to cope with the existing situation and has the following objectives:

- To ascertain the health status of migrant populations and healthcare services utilization
- To improve access to healthcare of migrants and the quality of the services provided
- To define the territorial organization and management of the immigration and Health Plan

The Immigration Master Plan (PDI) for health has been prepared in order to set the objectives for improving medical services for the immigrant population and also to establish the actions to achieve the objectives. These actions will be determined by the strategies defined in the areas of reception, mediation and training.

The co-ordination of actions throughout the territory and the appropriate responses to all petitions and appeals will be managed by the Ministry of Health, through the Health Regions and the future Governes Territorials de Salut or GTSs [Territorial Health Authorities].

While the decentralisation model is being implanted, the PDI is also being disseminated.

The Immigration Master Plan, under the principles of the Secretariat for Immigration, will be governed by the principle of interdepartmental action.

The Plan includes, as a fundamental element of its implementation and consolidation, a territorial organisation that responds to the criteria of decentralising the Ministry of Health and also to the policies of participative accommodation defined in the Citizenship and Immigration Plan of the Secretariat for Immigration.

In order to effect decentralisation throughout the territory, the Plan strengthens and consolidates the participative work in networks that already exist in some parts of the territory. The initial strategic planning recommends the implementation of a community-based model of territorial organisation. This model involves the creation of central and regional committees for health and immigration.



Firstly, the central level Health and Immigration Committee (Ministry of Health) and the Regional Health and Immigration Committee will be created. Secondly, when the Regional Health Authorities (GTS) are established, and to the degree that the region judges their creation necessary, the GTS Health and Immigration Committees will be formed.

Implementation

In accordance with the proposed organisation described in the Immigration Master Plan for the territory, which meets the criteria of the decentralisation and participation of the Ministry of Health and follows the policies of participative accommodation from the Citizenship and Immigration Plan of the Secretariat for Immigration, the Territorial Health Governments and regional committees will be responsible for adjusting mediation requirements according to the observed situation. At the same time, they will identify the models and profiles of mediators: ASC, as well as establishing the functions, timetables and objectives of the interventions for the mediators/ASC and their work plans.

It is proposed that the mediation requirements should be determined jointly among the municipalities (or councils), those responsible for health (the Ministry, primary healthcare centres, hospitals) and the other actors involved (NGOs, associations, mediators, etc.) through the health and immigration committees.

It will be important to have leaders to provide support for the implementation of the plan throughout the territory. For this reason the Catalan Health Department created a logistic centre to control all the health centres where health cultural mediators are working in order to assure that these professionals are well optimized by the centres and their uses their skills properly.

Innovation features

Once we had a better knowledge of the situation we designed the policies to address the needs identified, improving the access of the migrant population to the Health services, and to solve the main migrant health problems. This policies include: a reception program, an intercultural mediation program and a training program.

For intercultural mediation, the program has:

- A translating phone helpline that works 24 hours a day and translates into 102 languages. The utilization of the translation services for health professionals has increased 258% from 2002 to 2007. The predominant language is Chinese (40-50%) followed by Arab (10-40%), Russian and Romanian.
- Intercultural mediators that facilitates communication between migrants and health professionals. They also work as community health workers with multiple tasks (information, awareness raiser) At the end of the year 2009 our health system will have 102 mediators trained to work for Health Centres and at the community.



- Health professionals of non-Spanish origin. In 2006, 34% of the new registered medical doctors are foreigners.

With regard to the cultural mediators we have a project for the years 2008 and 2009 to train and certificate, through the Catalan Health Studies Institute, 50 new cultural mediators who did not have any experience in working for the Health System and 53 cultural mediators already working for the health System. This project has been funded by the "Obra Social Fundació La Caixa", the Social Foundation of a private bank called La Caixa. The training includes a theoretical part and a practical part. They attend to the school two days a month and the rest of the time they are working at the Health Centres.

We have created an IT system to register their activity and have evaluated the year 2008 with a very good results.

Results

Table 1. Mediations per month 2008-2009 (till 30th June)

Month	2008	2009	
January		800	
February		1.196	
March		1.357	
April	2	2.386	
May	229	2.312	
June	490	2.902	
July	713		
August	413		
September	622		
October	855		
November	674		
December	714		
Total	4.712	10.953	15.665

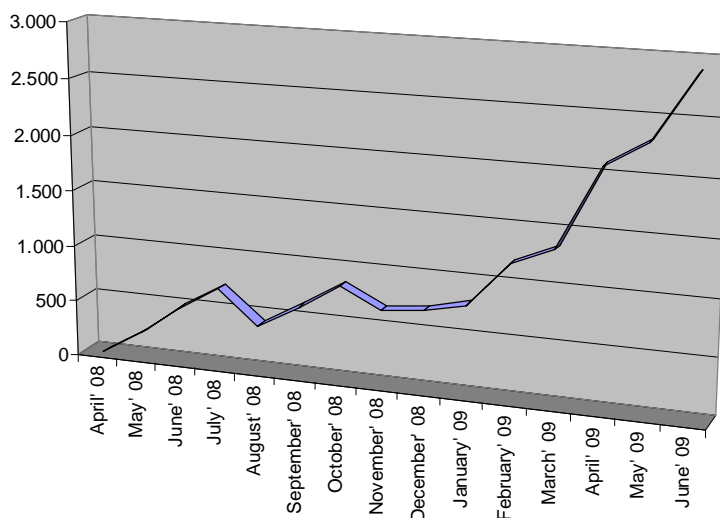




Table 2. Mediations per age and gender 2008 - 2009 (till 30th June)

Age groups	Women		Men		Unknown		Total	
	N	%	N	%	N	%	N	%
0 - 12	1.322	8%	1.427	9%	61	0,39%	2.810	18%
13 - 24	1.468	9%	461	3%	0		1.929	12%
25 - 64	7.322	47%	3.274	21%	2	0,01%	10.598	68%
65 & +	174	1%	154	1%	0		328	2%
Total	10.286	66%	5.316	34%	63	0,40%	15.665	100%

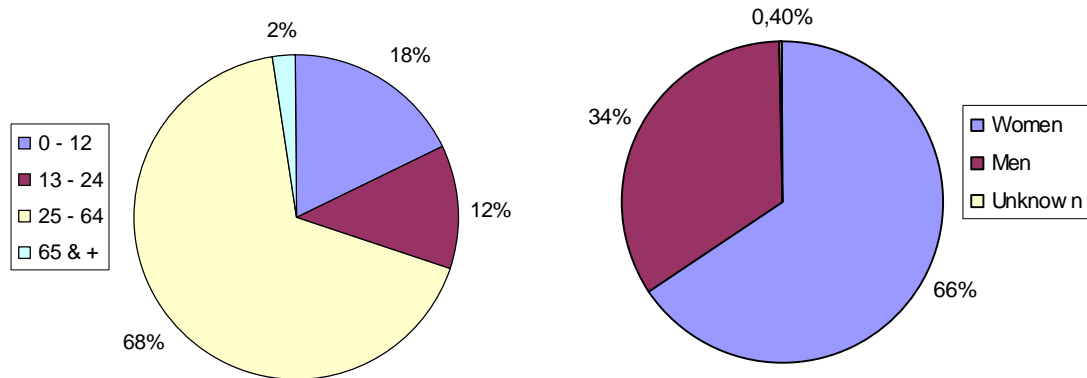


Table 3. Mediations per nationality 2008 - 2009 (till 30th June)

Nationality	N	%
Africa - Magrib	9.572	61%
Asia	2.359	15%
Africa - exc. Magrib	1.453	9%
EU	851	5%
Spain	217	1%
Non-EU European	104	1%
Latin America	44	0,28%
North America	8	0,05%
Oceania	4	0,03%
Unknown	1.053	7%
Total	15.665	100%

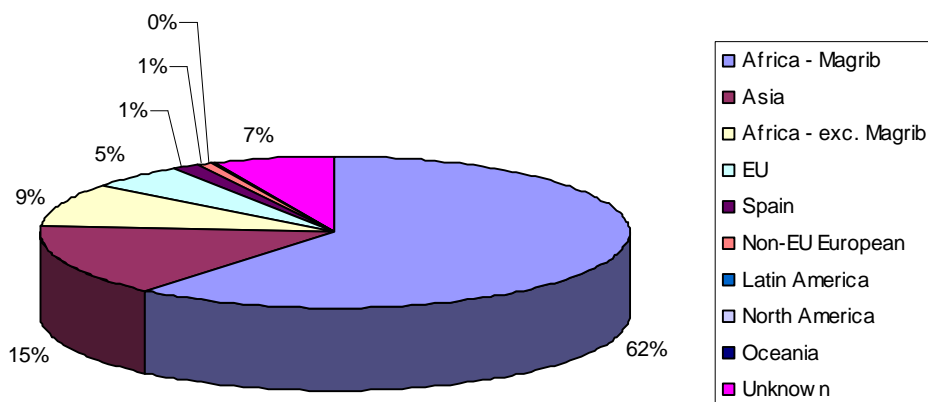




Table 4. Mediations per language 2008 - 2009 (till 30th June)

Language	N	%
Arab	9.261	59%
Chinese	1.732	11%
Amazigh	830	5,3%
Wolof	749	4,8%
Romanian	663	4,2%
French	412	2,6%
Punjabi	362	2,3%
English	282	1,8%
Spanish	130	0,8%
Mandinga	124	0,8%
Urdu	116	0,7%
Russian	77	0,5%
Hindi	76	0,5%
Lithuanian	54	0,3%
Fula	26	0,2%
Catalan	25	0,2%
Bambara	17	0,1%
German	10	0,06%
Sarahule	6	0,04%
Akan	4	0,03%
Hungarian	4	0,03%
Armenian	3	0,02%
Mende	2	0,01%
Hausa	1	0,01%
Paixtu	1	0,01%
Macedonian	1	0,01%
Unknown	697	4,45%
TOTAL	15.665	100%

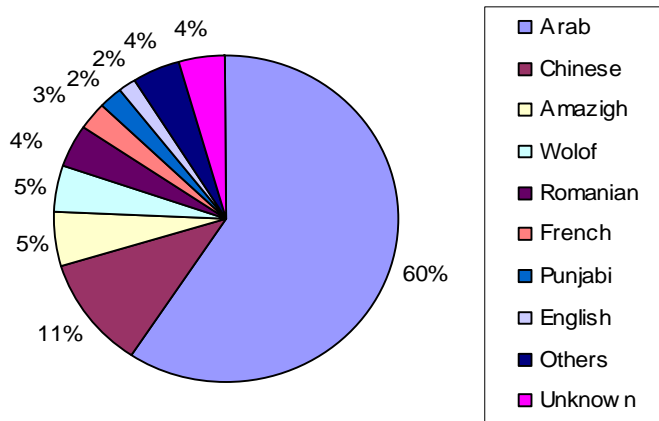




Table 5. Mediations per service 2008 - 2009 (till 30th June)

Type of service	N	%
Outpatient services	5.624	36%
Hospital stay	3.920	25%
Customer service	1.785	11%
Urgency	922	5,9%
Sexual and reproductive health	692	4,4%
Diagnostic services	330	2,1%
Hospital day	246	1,6%
Phone Call	212	1,4%
Delivery room	129	0,8%
Home service	20	0,1%
Unknown	1.785	11%
Total	15.665	100%

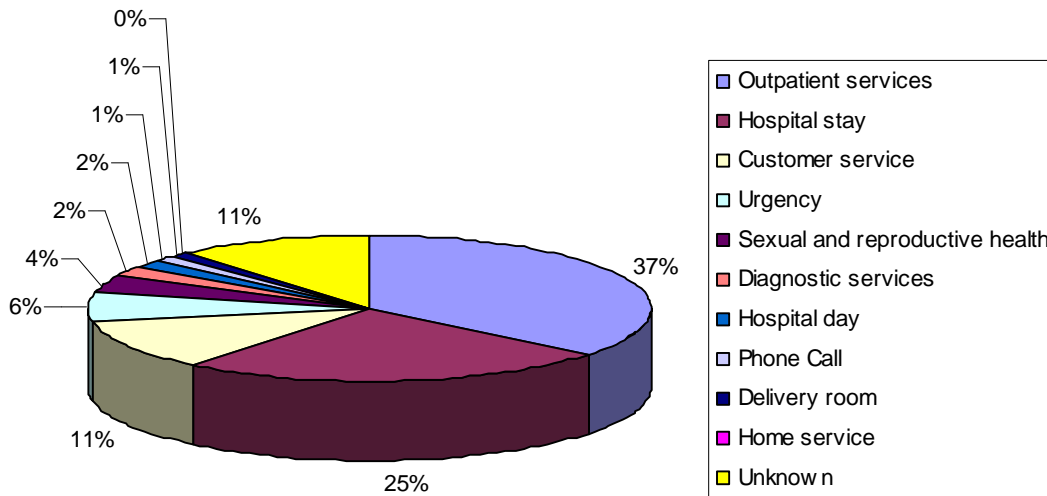


Table 6. Mediations per medical specialty 2008 - 2009 (till 30th June)

Medical Specialty	N	%
Gynecology - Sexual & reproductive health	3.546	22,64%
Family medicine	3.053	19,49%
Pediatrics	2.495	15,93%
Customer service	938	5,99%
Tocology - Obstetrics	759	4,85%
Internal medicine	588	3,75%
General surgery	402	2,57%
Traumatology	312	1,99%
Hematology	299	1,91%
Psiquiatrics	252	1,61%
Oncology	237	1,51%
Odontology	235	1,50%
Cardiology	223	1,42%
Endocrinology	217	1,39%
Digestive health	135	0,86%
Neurology	129	0,82%
Pneumology & respiratory medicine	127	0,81%

Especialitat	N	%
Nephrology	119	0,76%
Ophtalmology	93	0,59%
Radiology	91	0,58%
Infectious diseases	70	0,45%
Dermatology	66	0,42%
Otorinolaringology	64	0,41%
Urology	51	0,33%
Anesthesiology	25	0,16%
Rheumatology	19	0,12%
Angiology & vascular surgery	13	0,08%
Nuclear medicine	10	0,06%
Maxilofacial surgery	11	0,07%
Logopedy	6	0,04%
Allergology	6	0,04%
Physical medicine and rehabilitation	3	0,02%
Unknown	1.071	6,84%
Total	15.665	100%

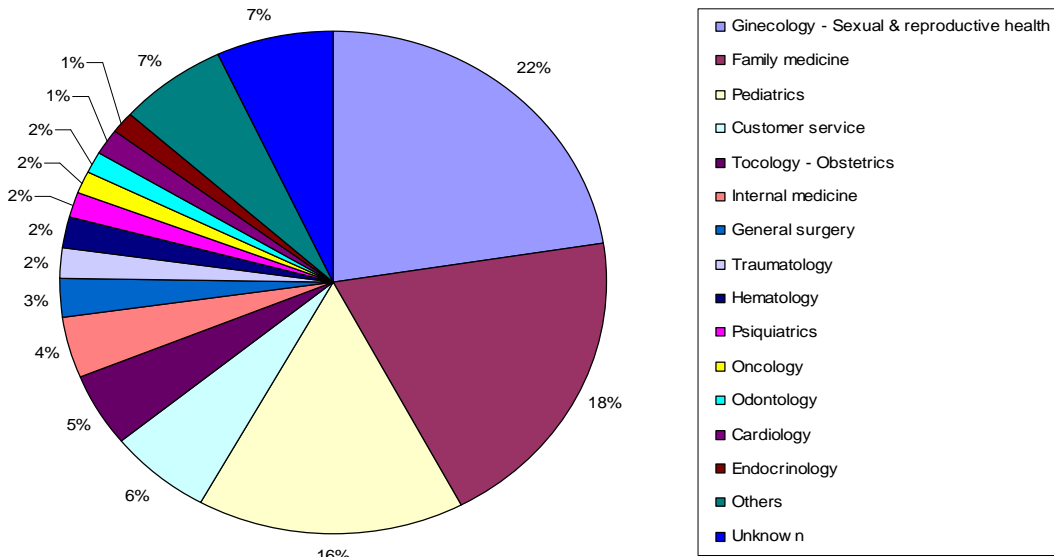
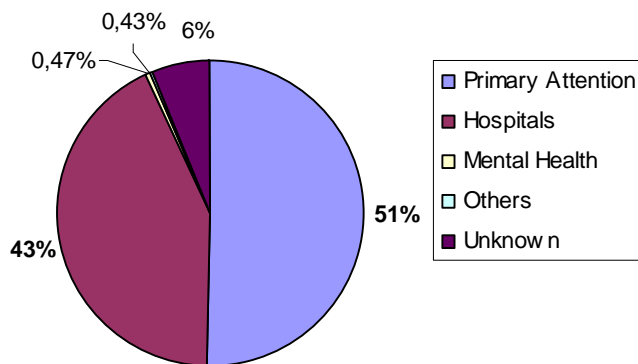


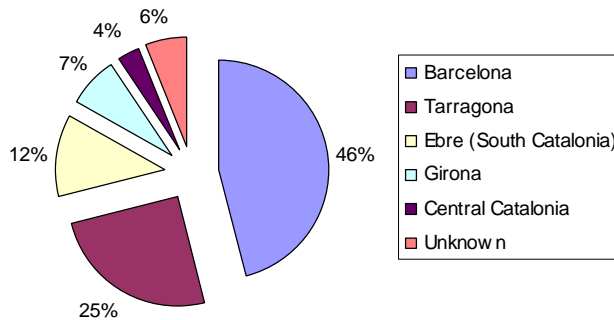
Table 7. Mediations per type of center & sanitary region 2008 - 2009 (till 30th June)

Type of Center	Sanitary Region	N
Primary Attention	Barcelona	3.146
	Central Catalonia	515
	Girona	620
	Tarragona	2.187
	Ebre (South Catalonia)	1.418
	Subtotal Primary Attention	7.886
Hospitals	Barcelona	4.018
	Central Catalonia	33
	Girona	514
	Tarragona	1.643
	Ebre (South Catalonia)	484
	Subtotal Hospitals	6.692
Mental Health	Central Catalonia	6
	Tarragona	65
	Ebre (South Catalonia)	3
	Subtotal Mental health	74
Others	Barcelona	67
	Subtotal Others	67
	Unknown	946
TOTAL		15.665





Sanitary Region	N	%
Barcelona	7.231	46%
Tarragona	3.895	25%
Ebre (South Catalonia)	1.905	12%
Girona	1.134	7%
Central Catalonia	554	4%
Unknown	946	6%
TOTAL	15.665	100%



We have counted more than 15,000 interventions during 2008 and 2009. These interventions are mainly language and cultural translations among north African women between 25 and 64 ages. They are generally based at hospital centres and requested by doctors (gynaecologists, GPs and paediatricians).

We have intercultural mediators in more than 97 health centres (Hospitals, Primary Health Care Centres, Mental Health Centres, etc.). We try to reinforce the role of the intercultural mediators as community health workers (CHW) as they can serve as a means of improving outcomes for underserved populations for some health conditions.

CHW interventions can result in greater improvements in participant behaviour and health outcomes when compared with various alternatives. CHW interventions had the greatest effectiveness relative to alternatives for some disease prevention as STDs, drug addictions, cervical cancer screening, and mammography screening outcomes in migrant population. As well as to treat successfully TBC patients.

In our country, as in others where the impact of intercultural mediation on health outcomes has already been published, the professionals' satisfaction with this service is very well known. To be able to prove it we are undertaking a qualitative study during the year 2009.

We finally should not forget that the intercultural mediation services avoid the use of children as translators. In many cases children are taken to the health centres to help their families which means that they do not attend to school and it also can affect their psychological development as they have to assume a responsibility that exceeds their degree of psycho-emotional development. The intercultural mediation can also avoid that other relatives or friends intervene between professionals and patients which damage the confidentiality of the interview and the patient's dignity.

World Health Organization
Regional Office for Europe
Regions for Health Network



Migrants and Health Care: Responses by European Regions (MIGHRER)

Complete reference material

IV. Regional report Emilia-Romagna

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Summary

In 2009, there were approximately 421,500 foreign residents in Emilia-Romagna, which is equivalent to about 9.7% of the total population, while the national average is 6.5%. This has been the pattern in Emilia-Romagna for many years, which can be explained by the availability of work as the reason for immigration. Also immigrant women are entering occupational world, in particular for the increasing request of caregivers. The immigration phenomenon is, therefore, becoming structural and now more stable, both for reunions, mixed marriages and second generation youths.

Emilia-Romagna was the first Italian Region to adopt a law on policies for the integration of migrants.

The Regional Law n. 5/2004 "Norms for social integration of migrant citizens" addresses immigration from all points of view (education, health, employment, housing, etc.) in a universal approach in order to guarantee rights. The previous approach that focused mainly on emergency situations was abandoned, replaced by policies for migrants now oriented towards regular structured planning.

One particular programme namely, "Programme of foreign citizens for social integration" favour universal access to regional welfare services, without any barriers focusing on the specific juridical condition of foreign citizens. The Programme also promotes the institution of a Regional Observatory on Migration, the implementation of a Regional Centre against Racial Discriminations, and a Monitoring Report on the three-year activities.

In recent years, many projects at the local level were developed and expertise gained on the subject matter. In Reggio Emilia, the Local Health Trust established a network collaboration system to spread and share experiences at trust and provincial level, to increase knowledge of health professionals and end users, to monitor needs, to guarantee a fair use of resources, to homogenize the organization, to diversify choice and to assure quality standards. SOKOS Association in Bologna is aimed at people who for social, cultural or personal conditions, cannot or are not able to use public health services. The Association offers these people care and health protection. The Salem Project was developed in Cesena in order to guarantee access to health services for the excluded population groups (irregular, Roma, outcasts): the key factor is that this project uses the existing outpatient structure of family doctors.

1. Health system overview, national and regional situation

1.1. Health system functions

The Italian National Health Service (SSN) was created in 1978 based on the principles of universalism, equity and solidarity with two fundamental aims:

- to provide quality assistance with appropriate, timely and adequate services to guarantee health protection, care and recovery, while respecting citizens' needs;
- to promote health by contrasting environmental, social and work conditions that hinder it, and by encouraging the diffusion of health-respecting behaviours and lifestyles.



The reform defined an integrated, centralized system in which a few specific administrative responsibilities were allocated to the regional and local levels. The central and regional governments had clashed since 1978 about financing and jurisdiction. Following a process of informal expansion of regional power, during the '90s an explicit, formal process of devolving political power and fiscal authority to Regions started and local planning, organisation and management were progressively transferred to local health organizations.

The SSN is funded mainly by general tax revenue; national Government allocates funds to Regions on the basis of shared criteria. The actual strategy of administrative devolution guarantees however a list of health care services to all citizens and gives to every regional Government the responsibility of organizing and managing healthcare services. The so-called Essential Levels of Healthcare (LEA), introduced in November 2001, are provided and guaranteed to all citizens, free-of-charge or with only shared cost through resources collected by the general system of taxation. LEA were revised in April 2008 and they now amount to more than 5,700 rehabilitation, treatment and healthcare procedures. LEAs are structured in three main areas:

- public health - community prevention in work and life environments, food safety, injury prevention, etc. are also listed;
- primary healthcare - general practitioner, pharmaceutical care, specialist medicine to out-patient diagnostics, prostheses supply to disable people, domiciliary services provision to elderly and seriously ill citizens, territorial counselling services (parents counselling, mental health services, rehabilitation services for disabled persons, etc.), semi-residential and residential facilities (residential facilities for elderly and disabled persons, day treatment facilities, therapeutic communities);
- hospital care - given through emergency care, ordinary hospitalization, day hospital, day surgery, long-term care and rehabilitation facilities, etc.

Regionalisation of health care provision, together with fiscal and political devolution (in a country characterized by market economic and social interregional diversities, like Italy) is at the some time the answer to people's expectations and a source of concern about the integrity of the egalitarian nature of the SSN. It might indeed, lead to widely different regional health care systems in terms of both quality and quantity of care provided and in terms of availability of resources.

Additional services or inefficiencies are paid by the Regions through local tax revenues or other forms of cost-sharing or tickets. Thanks to an economic and financial balanced situation and to a well organized health system, Emilia-Romagna is between the Regions that are able to provide resources and funds to realize these aims without further burdens on citizens.



1.2. Structural organization at regional level

The 2001 Constitutional reform attributed larger competencies to Regions also in the healthcare sector. The Region issued a law³ in which the role of the Region in the Regional Health Service (SSR) is reinforced, the collaboration with communities and Municipalities is strengthened; a larger contribution of health professionals in clinical governance is promoted; education, research and organization and technological innovation are considered important functions of the health system.

The main planning tool of services and health goals at regional level is the Regional Health Plan. The new 2008-2010 Regional Plan became a Social and Health Plan which identifies social and health integration as a political priority of the Region. The well functioning of the system requires the collaboration and involvement of all stakeholders interested in health and social care, starting with local governments, who play an important role in programming and controlling health services and in running social services.

The Regional Government rules the Regional Health Service with the Department for Health Policies which is the seat for planning, qualification and address of resources and activities. Since 2005, it also deals with planning and managing policies for non self-sufficiency and with coordinating social-and-health services. It is supported by some regional Commissions and Committees on planning, coordination and control of specific activities, and by the Regional Agency for Health and Social Care, which has a function of technical-scientific support for the health system.

Health Trusts represent the local articulation of the SSR, that can count on 11 Local Health Trusts (AUSL), 4 University Hospital Trusts (AOU), 1 Hospital Trust (AO) and 1 Research Hospital (IRCCS - Istituti Ortopedici Rizzoli in Bologna) (Figure 1).

Local Health Trusts are geographically organized in Health Districts to guarantee access to first level health and social services and assistance, and are structured in Departments that offer services; at territorial level, there are the Primary Care Department, the Department of Mental Health and the Department of Public Health. The small and medium size hospitals belong to the Local Health Trust.

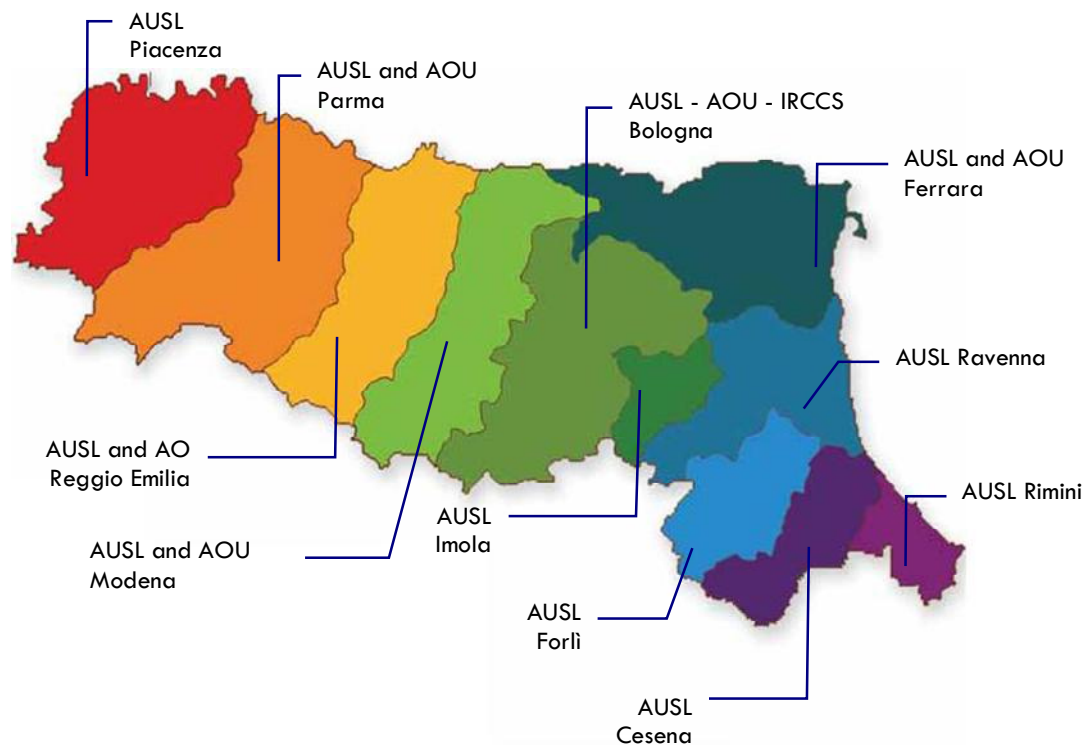
The Regional Health Service can also count on accredited (authorized by the public service) for profit or no profit private hospital, residential and outpatient structures, where citizens can refer for free on the basis of specific agreements with the RHS.

Social and integrated services are provided by Public Trusts for Personal Services (APS) and the private also plays an important role, for example for elderly and non self-sufficient people.

³ Regional Law n. 29/2004 "General norms on the organization and activities of the Regional Health Service".



Figure 1. The Emilia-Romagna Regional Health Service



1.3. Health information system

In Italy, demographic and health data are collected and managed by different institutions. The main sources of these data are the Italian National Institute of Statistics (ISTAT), the Regional Health Information Systems, the Italian Ministry of Health, the Ministry of Labour and Social Policies, and the Italian Workers' Compensation Authority (INAIL). These sources allow to describe population from a demographic point of view, participation in labour world, health demand and access to health services through indicators for hospitalizations, mother-child health, occupational accidents, infectious diseases, mortality (Table 1). The indicators can be measured both at national and at regional level. It is possible to consider historical data (since 1992) and with a minimum territorial detail that can correspond to municipality or province area. A general overview of the possible information available is presented in Table 1.



Table 1. Areas of information available for describing migrant's health

<p>Population</p> <ul style="list-style-type: none"> - Demographic outline - Labour <p>Health demand and utilization of services</p> <ul style="list-style-type: none"> - Hospitalizations - Mother-child health - obstetrical events <ul style="list-style-type: none"> o Pregnancy o Voluntary abortion o Spontaneous abortion - Occupational accidents - Infectious diseases - Mortality
--

Many reports describe specifically migrant population's aspects, but none of them is exhaustive. ISTAT publishes data on demographic balances of foreign citizens taken from municipality registry offices and data from sample surveys as from the "Health and utilization of health services" carried out every five years. Caritas⁴ produces yearly reports on migration flows and occupational and health conditions, including also estimated presences. In the last years attention focus in describing migrants' health has added to usual major themes (births, voluntary abortions and infectious diseases) the analysis of indicators for utilization of services and health outcomes (hospitalizations, mortality, child mortality), themes that are also presented in the "Osservasalute" Report by the National Health Observatory in Italian Regions.

Different solutions are adopted at regional level. In Emilia-Romagna the Department for Social Policies Promotion and for Immigration yearly publishes a description of migrants, focusing on their presence in the labour world, education level, living conditions and relevant health events.

It is important to notice that in Italy migrant population is not defined according to their ethnical group as for example in England and in other countries. This method would lead to misleading errors because of the high number of Italians born abroad for consistent emigration flows in the past. On the contrary Italian regional and national health databases register people's citizenship and country of origin.

⁴ Caritas is a Pastoral Body created in 1971 by the Italian Episcopal Conference in order to promote, in cooperation with other bodies as well, the charity commitment of the Italian ecclesiastical community, in the forms that are appropriate considering time and needs, for a complete development of man, social justice and peace, with particular attention to the poor and with a mainly pedagogical function.



In demographic flows and in most scientific studies a difference is drawn between “foreigners” (who do not have Italian citizenship) and “born abroad”. It is possible, however, to use a more appropriate criterion to identify immigrant population by distinguishing people coming from countries with intensive emigration flows (PFPM⁵) in respect with developed countries (PSA)⁶.

The administrative condition is an important - even though dynamic - variable for migrant population. Keeping the definition of foreigner coming from a country with intensive emigration flows, it is possible to distinguish.

- regular - coming from an extra-European PFPM and with sojourner’s permit;
- irregular - coming from an extra-European PFPM, now without sojourner’s permit because it has expired and could not be renewed;
- clandestine - coming from an extra-European PFPM and who has never had and does not have now sojourner’s permit;
- community citizen coming from a PFPM of the European Union⁷, regularly resident in Italy or registered in municipal register⁸;
- community citizen coming from a PFPM of the European Union, that resides in Italy without being entitled to (it is possible for three months only) and therefore cannot be registered in municipal registers.

The visibility of a migrant in the various information flows (for example demographic, socio-health ones) depends then on having a sojourner’s permit - if extra-European Union citizen - or on being registered in municipal registers - if European Union citizen.

In demographic flows, only regular or resident migrants can be tracked down, that is people with sojourner’s permit or EU people that are allowed to reside in Italy; extra-EU clandestine immigrants and EU immigrants that live in Italy without being allowed to (not born in Italy) are not traceable.

In the following statistical elaborations, immigrant population - identified according to the above mentioned criteria - is compared to Italian population, to which citizens of advanced countries stably living in Italy are added.

⁵ PFPM (Countries with intensive emigration flows): Northern Africa, Eastern Africa, Southern-central Africa, Western Asia (apart from Israel), Southern-central Asia, Eastern Asia (apart from South Korea and Japan), Southern-central America, Europe (including Czech Republic, Slovakia, Estonia, Latvia, Lithuania, Poland, Slovenia, Hungary, Cyprus, Malta, Bulgaria, Romania).

⁶ PSA (developed Countries): 15-member-Europe and Switzerland, Israel, Japan, Northern America, South Korea, Oceania.

⁷ In 2004 citizens from Cyprus, Estonia, Latvia, Lithuania, Malta, Poland, Slovakia, Slovenia, Czech Republic became European Community citizens; in 2007 citizens from Bulgaria and Romania were added.

⁸ People who have a regular job and are registered in municipal registers. Decree n. 30 of February 6, 2007; Memorandum of the Minister of the Interior, Prot. n. 20070416315100/14865 of April 6, 2007.



1.4. Regulations and legal framework: five phases

The 1946 Italian Constitution (art. 32) underlines that health is a “fundamental right of the person and a community’s interest” and is protected by the Republic. The institution of the Italian National Health Service in 1978 thus represents the fulfilment of a constitutional obligation. The SSN is public, universalistic as it provides services to all citizens, based on solidarity principles as it is funded through general taxes and on shared rules to guarantee uniformity. However, the 1978 law that instituted SSN did not yet explicitly refer to care to migrants (Conti and Sgritta, 2004).

From the '80s the legislative framework has changed five times following the political changes of these years.

The first phase

The first phase begins in 1986 with the a law (Legge Foschi) that directly concerns migrants and “extra-communitarian” workforce. In 1990 wider legislative measures are adopted (“Legge Martelli” - Law n. 39/1990) that establish rules for political asylum applicants and refugees and for annual admittances for migrant workers, specify requirements to obtain residence permits and introduce new rules for migrants’ rejection and expulsion (Barbagli, 2007). Healthcare is not yet considered and will be included only later (Geraci et al., 2003). In this phase some emergency interventions for irregular migrants introduced significant new measures, then confirmed in later laws. The Decree n. 489/1995 (Decreto Dini) extended essential outpatient and hospital care for disease or accident as well as programs of preventive medicine and maternity care to “migrants temporarily present” (STP), even though irregularly. Some documents by the Ministry of Education (n. 400 of December 31, 1991 and n. 119 of April 6, 1995) allow school attendance also to irregular minors.

The second phase

The second phase begins in 1998 when Decree n. 286/1998 “Consolidation act on measures for immigration control and migrant’s conditions” is approved. It defines different aspects of foreigner’s juridical condition, migrant’s right and duties from the entrance in Italy till the complete integration in Italian society. In particular, the law stresses the need to contrast illegal immigration and criminal exploitation of migrant flows, to promote a policy of controlled and programmed legal accesses, to implement integration paths for new legal immigrants and for foreigners already living regularly in Italy.

New tools to favour major stability are proposed, such as the “residency permits”⁹; the right to protect one’s own family or to create a new one is underlined, as well as the fundamental rights

⁹ The residency permit is a non-expiring document that can be issued to foreigners regularly resident in Italy from at least 5 years, already holder of a sojourner’s permit with no renewal limits and who can demonstrate to be able to economically maintain themselves and their family.



to citizenship, healthcare, education, social care, representation and administrative vote are recognized.

Some initiatives are implemented to support:

- systematic adaptation of administrative structures at government level in their role established by the new law;
- collaboration among Municipalities, Provinces, and most of all Regions, that have a fundamental role in particular in promoting policies for reception, integration and rights protection;
- development of an international agreements system for cooperation and collaboration on immigration with countries with major emigration flows.

The inclusion of juridically regular immigrants in the rights and duties system of Italian citizens includes also health care. Residency, time limitations, different tax rates to be allowed to SSN services are no longer a problem. Immigrants legally resident in Italy or waiting for renewal of the sojourner's permit are registered at the National Health Service and have "full equality and equal rights and duties as Italian citizens", also for tax contributions (Barbagli, 2007).

For irregular immigrants an injunction preventive procedure to spontaneously leave the country and an expulsion procedure are activated. Some Centres for Temporary Permanence (CPT) are set up to detain foreigners meanwhile.

Rights of access to health care - and to school for minors - established by the 1995 Decree are confirmed and reinforced¹⁰. In particular, the following rights are granted: social care during pregnancy and maternity as for Italian women¹¹; minor's health protection as defined in the Convention on the Rights of the Child of November 20, 1989¹²; vaccinations according to legislation and within public prevention campaigns; international prophylaxis interventions; prophylaxis, diagnosis and treatment of infectious diseases.

Moreover, health structures are forbidden to signal to police authorities if they take care of illegal immigrants (Conti and Sgritta, 2004). Health services to these people are registered with a specific code (STP) recognized in all Italy. Healthcare expenses for STPs without sufficient economic resources are charged to the territorially competent Health Trust; if urgent or essential hospital care is needed, costs are charged to the Ministry of the Interior.

¹⁰ As established by Decree n. 286/1998, art. 35 "Health care for foreigners not registered in the NHS" and its applications (DPR 394/1999 "Regulation with application norms for the Consolidation Act", art. 43 on health services for irregular immigrants, and Ministerial Memorandum n. 5/2000).

¹¹ According to Laws n. 405 of July 29, 1975, and n. 194 of May 22, 1978, and to Decree of March 6, 1995 of the Health Minister published in Gazzetta Ufficiale n. 87 of April 13, 1995.

¹² Ratified and executive according to Law n. 176 of May 27, 1991.



The Law also includes a National Fund for Migration Policies to finance annual or multi-annual programs by the State, the Regions (to be considered as main receivers), the Provinces and the Municipalities in order to guarantee homogeneity of interventions at national level and equal opportunities for migrants living in the country.

The third phase

The third phase begins in 2002 as a consequence of new political conditions, only three years after the preceding 1998 Consolidation Act. The new law on immigrants ("Legge Bossi-Fini" - n. 189/2002) modifies some focal aspects, in particular concerning admission policies and expulsions, but not health protection (Geraci et al., 2003).

According to the new law, foreigners can enter and remain in Italy only if they have a legal job, even though only a temporary one. In order to obtain the sojourner's permit it is necessary to have a "contract of sojourn for employment", that also requires the involvement of the employer to guarantee a house to the foreign worker and to pay for the voyage back to the homeland if necessary.

New admission quotas are to be established each year with governmental decrees according to data on job offer. Some quotas are reserved to Italian workers resident in extra EU countries. The possibility to enter Italy looking for a job with a third person vouching (sponsorship) is on the contrary no longer granted. Finally, family reunion chances are radically reduced, as well as the duration of sojourner's permits, and the procedure to obtain political asylum is modified. Also rules for illegal migrants are changed. The standard procedure implies now immediate expulsion, being taken to the frontier by police forces, and the maximum permanence period at CPTs is lengthened to 60 days.

The fourth phase

The fourth phase takes place in 2007 with a new bill¹³ that proposed to review three key points: programming of immigration flows for employment reason; conditions to obtain sojourner's permit and the status of regularly resident foreigner; prevention of irregular immigration. The bill introduced new elements (as the triennial programming of immigration flows) and reintroduced procedures that had been cancelled by the "Legge Bossi-Fini", as the possibility to have a sponsor in Italy in order to be admitted to look for a job in our country and duration lengthening of sojourner's permits.

¹³ Amato-Ferrero Bill approved by the Council of Ministers of Prodi Government on March 15, 2007 but never approved by the Parliament because of the early fall of the government.



The fifth phase

The new Berlusconi Government, that has taken over in May 2008, has already faced the problem in a stricter way considering illegal immigration as a specific crime (Law n. 125/2008) and as an aggravating circumstance in case of crime, introducing the possibility to expel immigrants if definitely condemned to up to 2 years in prison (earlier it was necessary to receive a sentence of at least 10 years in prison), establishing severe sanctions to anyone renting a house to an illegal immigrant. The law also modified the definition "CPT - Centre for Temporary Permanence" into "CIE - Centre of identification and expulsion".

In July 2009 the Decree n. 733/2009 "Provisions on public safety" (the so called "Pacchetto sicurezza") was definitively approved; it:

- confirms the crime of clandestine immigration that can incur fines of 5,000-10,000 Euros, with the duty to report by public officers;
- lengthens from 60 to 180 days the period a migrant can be held at Centres for identification and expulsion;
- legalizes town patrols;
- introduces the registering of tramps in police records.

The cost of application for Italian citizenship and for sojourner's permit will double. An up to three-year imprisonment can be inflicted to anyone renting houses or spaces to clandestine migrants.

As for healthcare, the Italian laws in force forbid to health personnel to signal to police authorities if they take care of immigrants without the sojourner's permit: the prohibition to signal introduced with Decree n. 286/1998 seems to be confirmed, but its application is still extremely discretionary.

1.5. Service delivery

In the last years, a large process for reorganizing service delivery is going on. In this section, the situation in Emilia-Romagna will be described in particular where the interest was mainly addressed to improve the connections between local and hospital services and to guarantee care continuity.

This intervention takes place mainly for primary care at the Health District level, that is a geographically based division of the Local Health Trust area. In particular, in each District there is a Department for Primary Care that has clinical responsibilities and is in charge of providing health services and of their integration with Social Services. In this way, single services collaborate and interact to create a network that tries to follow the patient during the whole care path. It is also important to outline the role of the Departments for Mental Health that guarantees psychological, neuro-psychiatric and psychiatric assistance to young people and adults, and the activities of the Family Advisory Centres (Consultori) for gynaecological problems, pregnancy, cancer prevention, contraception, menopause, voluntary abortion, etc.



The Department for Public Health of each AUSL organize prevention networks, that work with health services and with other public structures for controlling occupational and environmental risks, as the Regional Agency for Environmental Protection (ARPA), the Department of Labour, etc. Prevention activities are highly influenced by the development of health risks and by health laws that simplify the relationships between Public administrations, companies, citizens, giving each of them more responsibility. This is particularly evident in food and occupational safety.

The regional hospital network is being reorganized according to the "hub and spoke" model: some regional specialized centers are established, and peripheral services send them patients with particular health conditions. This model is applied to emergency system, severe disabilities, diagnosis and care of rare diseases, stroke care, etc.

The best local distribution of all services is a main problem for the development of the Regional Health Service and requires a careful selection of efficacious and appropriate services to guarantee their balanced distribution and correct use.

The model of integrated networks has gradually involved all levels of the SSR with the goal to combine accessibility needs with quality and efficiency. Attention is focused on functional relationships rather than on physical location. The aim is to guarantee to all citizens equity in access to services rather than reproducing the same services in the various local areas. Staff is required to move in the different places, instead of patients.

1.6. Services and activities for migrants

In order to widen care capacity, in particular towards more vulnerable population groups such as migrants, at local level SSR structures are involved as well as all social actors interested in playing a role and that have specific experience in dealing with immigration problems.

In the field of migrants' health promotion, health voluntary organizations, both lay and catholic ones, have had a highly significant function, thus becoming fundamental strategic partners in the network collaboration to guarantee interventions efficacy and efficiency. The involvement of voluntary organizations has been stressed as necessary in the 1998-2000 National Health Plan and in the following ones, in the Consolidation Act on immigration matter (Decree n. 286/1998), in its Executive Regulations (DPR n. 394/1999), in the Memorandum of the Ministry of Health (Circular n. 5/2000), in some Regional Resolutions and in Trust Agreement Protocols.

At the beginning, the contribution of non governmental organizations focused on reading epidemiological data on these new populations and understanding their specific health needs, so contributing in reducing prejudices and hostility. This role has then widened in particular through the experimentation of innovative services offer (for example with active offer or cultural mediation) and personnel training.

NGOs act as a cultural and organization laboratory in a field which is typically of public health. The roles of the State and of NGOs are strictly connected and it is not possible to talk of one ignoring the other; thanks to this strong collaboration between voluntary bodies and institutional policies, nowadays in Italy - at least theoretically - access to care is guaranteed to all migrants present in the country, even if with some differences.



In order to have a more specific overview, some services offered by Emilia-Romagna SSR to respond to specific needs of migrant population are now described.

Family Advisory Centres and Spaces for immigrant women and their children

Immigrant women in Emilia-Romagna, even without sojourner's permit, can refer to Family Advisory Centres and to specific Areas for Immigrant Women and their Children, where intercultural professionals can help them in accessing services and in their relations with health professionals. Services offered to foreigner women concern: pregnancy, voluntary abortion, menopause, contraception, sterility, infertility. Children are guaranteed visits, health balances, vaccinations, control of tuberculosis and of other infectious diseases.

Health care to Roma children

Roma children not registered in the SSN are guaranteed care services - health balances, vaccinations, control of tuberculosis and of other infectious diseases - at Community Paediatric Services and at Areas for Immigrant Women and their Children.

Health care to extra-European Union children hosted in families and institutions

Each year in Emilia-Romagna many foreign children - coming, for example, from Chernobyl, Saharawi, Palestine - are hosted in families or institutions for some periods, as provided in specific solidarity projects. These sojourns are promoted by voluntary organizations and NGOs and primary health care is guaranteed.

Cultural mediation

The Regional Health Service promotes the collaboration of intercultural mediators in health structures, to facilitate migrants' access to services and relations with health personnel. With Regional Law n. 5 of March 2004 ("Norms for social integration of immigrant citizens"), the presence of these people is valorised in the whole territory. Referring to interventions specifically addressed to foreign people, the Law underlines the importance to consider their culture of origin and to develop information activities through intercultural mediators.

Toll free number for foreign people in Bologna metropolitan area

Foreign people can use a toll free number that offers an information service in many languages and a cultural mediation activity.



Campaigns and publications in different languages

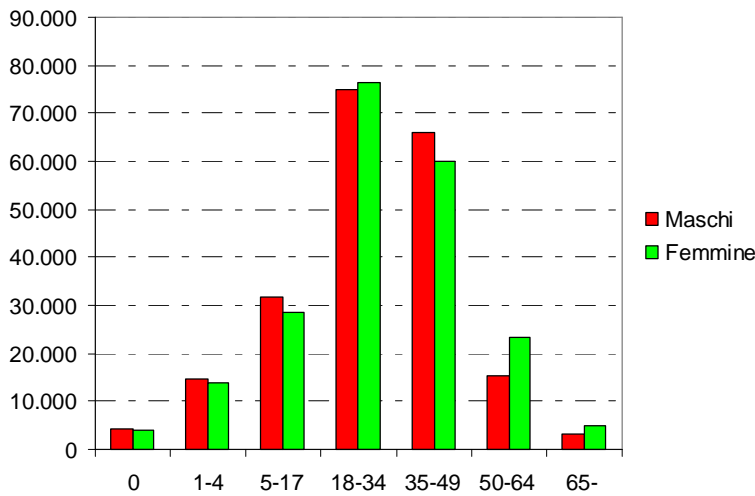
The Emilia-Romagna SSR has promoted some campaigns and publications in different languages, for example the information campaigns against violence to women and for Sudden Infant Death Syndrome (SIDS) prevention, and the information booklets on raising and caring for children in their first year of life and on contraception.

2. Migration phenomenon in Emilia-Romagna

2.1. Demography and occupation

According to the Regional Statistic Bureau, foreign residents in Emilia-Romagna amount in 2009 to about 421,500, representing 9.7% of total population, while the national average is 6.5% (ISTAT, 2009). Nearly 2/3 are 18-49 year old people; 3.9% are 18-34 years of age; minors are more than 97,000 (23%); over 65 are less than 2%. 50% are males, 50% are females, and no significant differences in the distribution for age class can be noted (Figure 2). In 2008 the number of foreigners increased by 55,789 people, 13.7% males and 16.4% females.

Figure 2. Foreign population resident in Emilia-Romagna at January 2009 by age and gender (Emilia-Romagna Region, 2009)

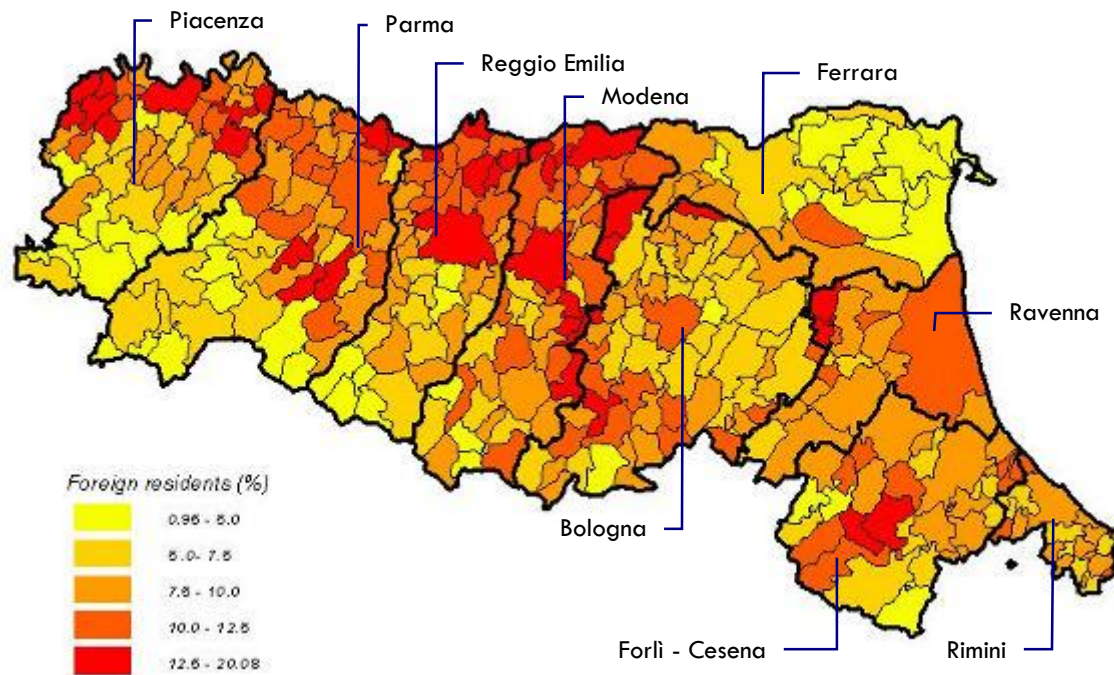


Foreigners without sojourner’s permits are estimated to be 1/10 of regular immigrants: about 42,000 people in Emilia-Romagna and 390,000 in the whole country (Fondazione ISMU, 2009).

Foreign residents in the Region are more numerous in western areas (Emilia): in Piacenza they amount to 11.6% of the total population of the province, in Reggio Emilia 11.4%, in Modena 11.1% and in Parma 10.6%. In Romagna they are less numerous: in Ravenna 9.5%, in Forlì-Cesena 9%, in Rimini 8.6% and in Ferrara 6.1%. In the province of Bologna (centre) they are 8.9% of total population. Figure 3 presents a detailed picture of geographical distribution.



Figure 3. Percentage prevalence of foreign population resident in Emilia-Romagna Municipalities (January 2009)

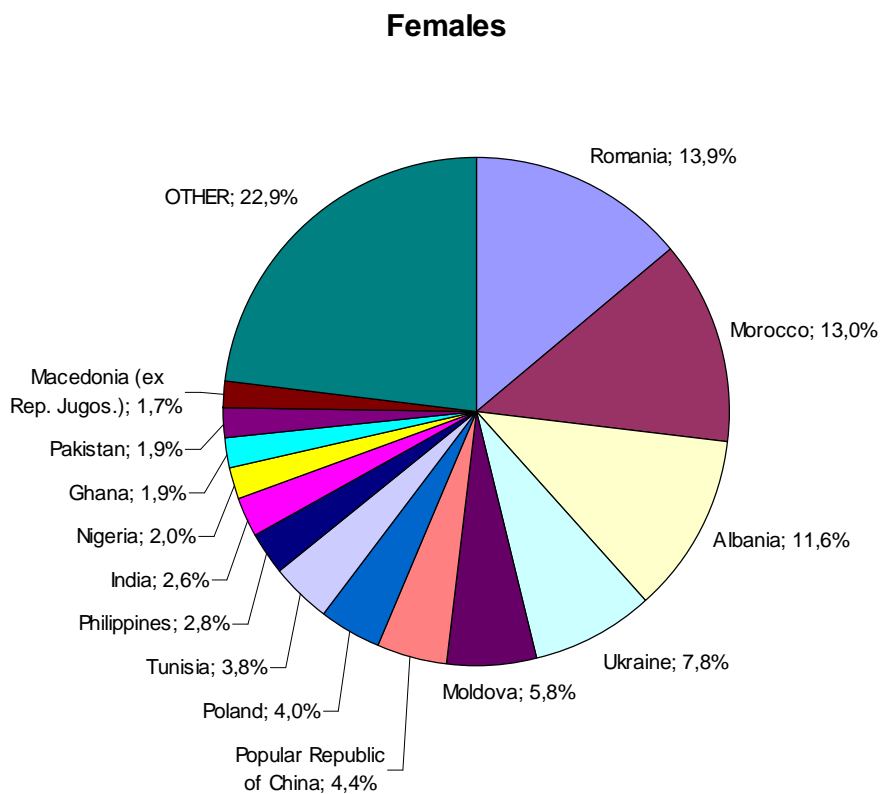
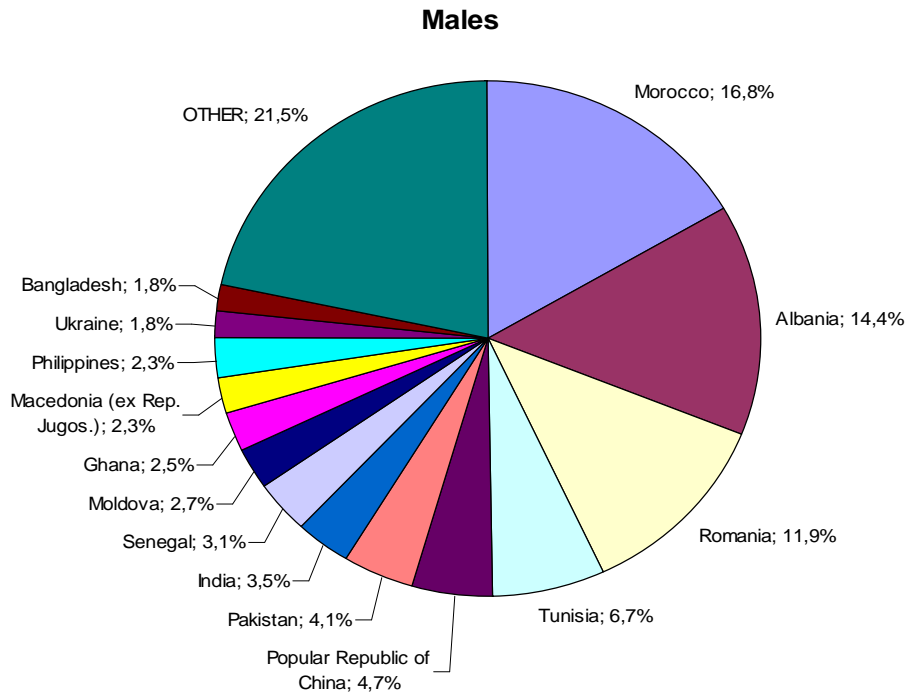


Foreigners come from many countries (Figure 4) and speak many different languages (Ermes RER, 2008). At the moment, immigrants from European countries that are extra 15-member-EU (45.7%) and from Northern Africa¹⁴ (21.7%) prevail. In particular, 14.9% come from Morocco, 13% from Albania, 12.9% from Romania. Many other groups constitute important nuclei with own characteristics.

¹⁴ Morocco, Tunisia, Egypt, Algeria, Sudan and Libya.



Figure 4. Distribution of foreign population resident in Emilia-Romagna per country of origin (January 2009)





Flows are highly dynamic and respond to different determinants. However, job offer is also in Emilia-Romagna one of the main reasons for immigration. As also the 2009 Report by the Regional Observatory on Immigration confirms, the number of immigrants is proportional to unemployment rate. For example in 2008 more than 13% hiring was of foreign people. Immigrants with a regular job contract are hired for nearly 27% as industrial workers (nearly 81,500 insured people)¹⁵, 14% as construction workers (about 41,000 insured people) and 13% in hotel and catering industry (nearly 39,800 insured people).

Foreign female population is now heavily entering occupational world and employment rate in the last decade increased much more than that of immigrant males. The percentage of working immigrant women is higher than that of Italian women: 53% vs. little more than 46%.

In particular, a great role was played by the increasing request of caregivers. More than half of these women are employed in house care or as caregivers (Osservatorio regionale dell'Emilia-Romagna sul fenomeno migratorio, 2008). Through INPS¹⁶ registration data, in 2007 there were nearly 30,000 "regular" workers and about 20-25,000 irregular workers, that can be estimated through regularisation requests. Nearly 10% of immigrant women - in particular from central and eastern Europe (Romania, Ukraine and Moldavia) - is employed in hotel and catering industry.

Immigration phenomenon is now becoming structural in Emilia-Romagna society and also more stable, due to increasing family reunions, mixed marriages and second generation youths.

In the last twenty years, birth rate in Emilia-Romagna has started to increase again, reaching 9.7‰ in 2009 (Regione Emilia-Romagna, 2009). This is due mainly to the increasing number of foreign women, that generally have more children (2.46 vs 1.26) and at younger ages (on average at 28.1 years of age vs 32.0) than Italian ones (ISTAT, 2010¹⁷). The percentage of childbirths by foreign women in 2008 was 26.5% of total births, vs 17.1% in 2003 (Regione Emilia-Romagna, 2009).

For these reasons, also the number of children has increased. Foreign students represent more than 12% of total population in primary and secondary schools. They were about 12,000 in the 1999/2000 school year and 59,000 in the 2008/2009 one (Table 2).

¹⁵ All workers are insured for health and safety by a national insurance agency (INAIL).

¹⁶ INPS is the biggest Italian social security institute. Nearly all workers of the private sector, some workers of the public sector and most of the autonomous workers are insured at INPS.

¹⁷ <http://demo.istat.it/altridati/IscrittiNascita/2008/T1.2.xls>



Table 2. Distribution of non-Italian students per school year and school level* in Emilia-Romagna

	non Italian students			total students			% non Italian students/total		
	Primary	Secondary	Total	Primary	Secondary	Total	Primary	Secondary	Total
1999/2000	6.256	5.573	11.829	150.882	227.004	377.886	4,15	2,46	3,13
2000/2001	7.069	6.937	14.006	150.876	286.936	437.812	4,69	2,42	3,2
2001/2002	9.206	9.050	18.256	154.043	231.840	385.883	5,98	3,9	4,73
2002/2003	11.668	11.677	23.345	158.890	241.257	400.147	7,34	4,84	5,83
2003/2004	14.022	14.283	28.305	161.277	242.529	403.806	8,69	5,89	7,01
2004/2005	17.321	18.041	35.362	167.327	251.491	418.818	10,35	7,17	8,44
2005/2006	19.533	21.634	41.167	171.670	257.130	428.800	11,38	8,41	9,6
2006/2007	22.101	25.769	47.870	177.484	263.433	440.917	12,45	9,78	10,86
2007/2008	24.878	28.950	53.828	182.312	268.289	450.601	13,65	10,79	11,95
2008/2009	26.879	32.256	59.135	185.980	273.527	459.507	14,45	11,79	12,87

* Primary school (5 years of school, from 6 to 10 years of age) and secondary school (8 years of school, 3 for the first level and 5 for the second) students were considered.

2.2. Use of health services and health perception

Foreign resident citizens coming from developed countries (PSA) are few (nearly 3% of all foreigners¹⁸) and are usually assimilated to Italian citizens in the analyses of health services use¹⁹; foreigners coming from countries with intensive emigration flows (PFPM) are the majority and are often in difficult socio-economic conditions. Among PSA, 15-member-Europe and other 12 countries, defined as other OECD countries or high-income countries (Andorra, Iceland, Liechtenstein, Monaco, Norway, San Marino, Switzerland, the Holy See, Japan, Israel, North America, Oceania) are included.

In the further analyses PFPM citizens are also distinguished in resident and not resident, aware that in the second group irregular immigrants are more likely to be included.

In 2009 720,331 hospitalizations²⁰ of Italians and foreigners from PSA were registered in Emilia-Romagna, versus 59,180 hospitalizations of people from PFPM (7.6% of the total), 6313 of which are referred to non resident PFPM citizens (0.8%). In 2004 hospitalizations of PFPM

¹⁸ Source: "Popolazione residente straniera per sesso età e cittadinanza" Regione Emilia-Romagna database 2009.

¹⁹ In the following report this group will be also indicated as "Italians and assimilated"

²⁰ Source: Sistema informativo Politiche per la salute e politiche sociali della Regione Emilia-Romagna; analysis of hospital discharge database. Including criteria are: acute hospitalization borne to the National Health Service.



people were 4.8% of the total. Among Italians and PSA residents, hospitalization frequency, by means of health demand analysis, increases as age increases; among residents from PFPM, whose population represents 10.2% of the total²¹, the frequency is highest in 18-34 age group. The distribution per gender as well shows great differences in the two groups (Figures 5 and 6).

Figure 5. Hospitalization distribution per gender and age group for Italians and citizens from PSA resident in Emilia-Romagna (2009)

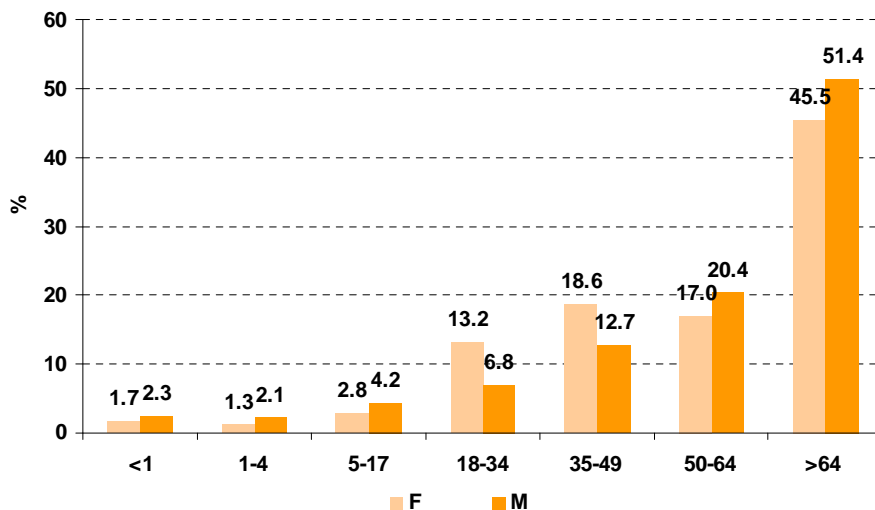
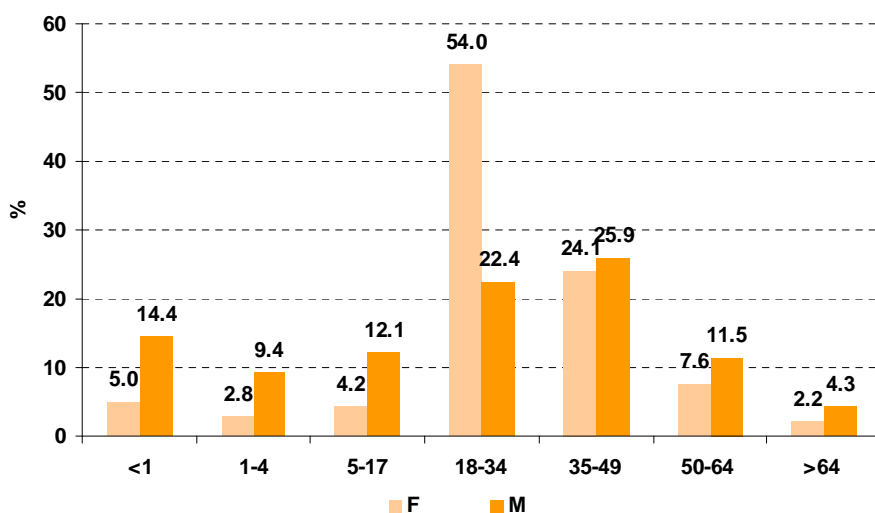


Figure 6. Hospitalization distribution per gender and age group for immigrants from PFPM in Emilia-Romagna (2009)



²¹ Source: Emilia-Romagna Region, 2009.



Non residents from PFPM countries have similar to PFPM residents gender and age-class profile
 Among Italians and assimilated an increasing trend can be observed, with a peak in the oldest age groups; among people from PFPM peaks are registered in fertile and productive ages. This can be explained by looking at the different age distribution and the most frequent pathologies (traumas in men; childbirth and pregnancy complications in women - Figures 7 and 8) in population from PFPM.

Figure 7. Ordinary hospitalization diagnosis for male patients from PSA (resident) and PFPM (resident, non resident) in Emilia-Romagna (2009)

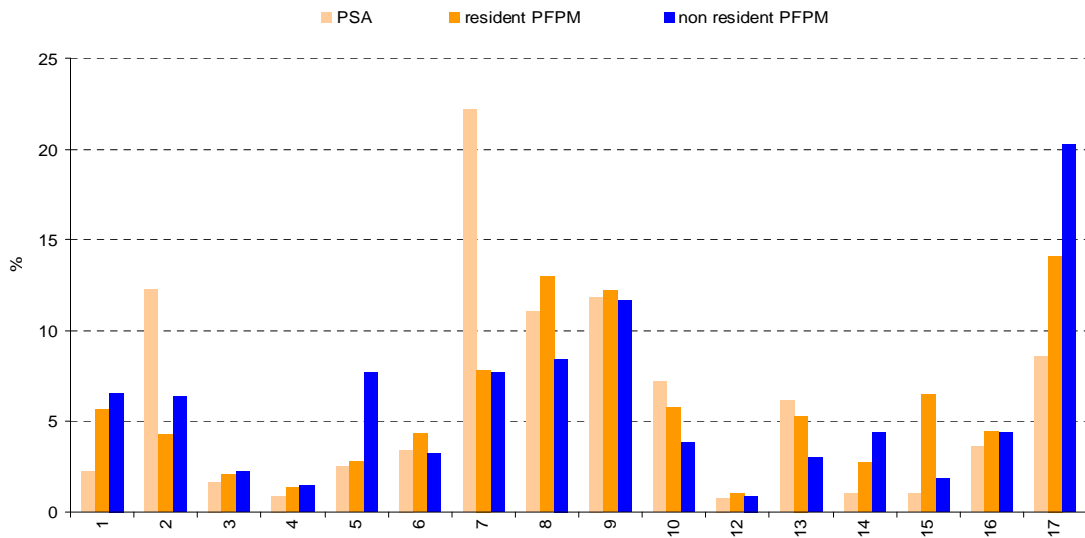
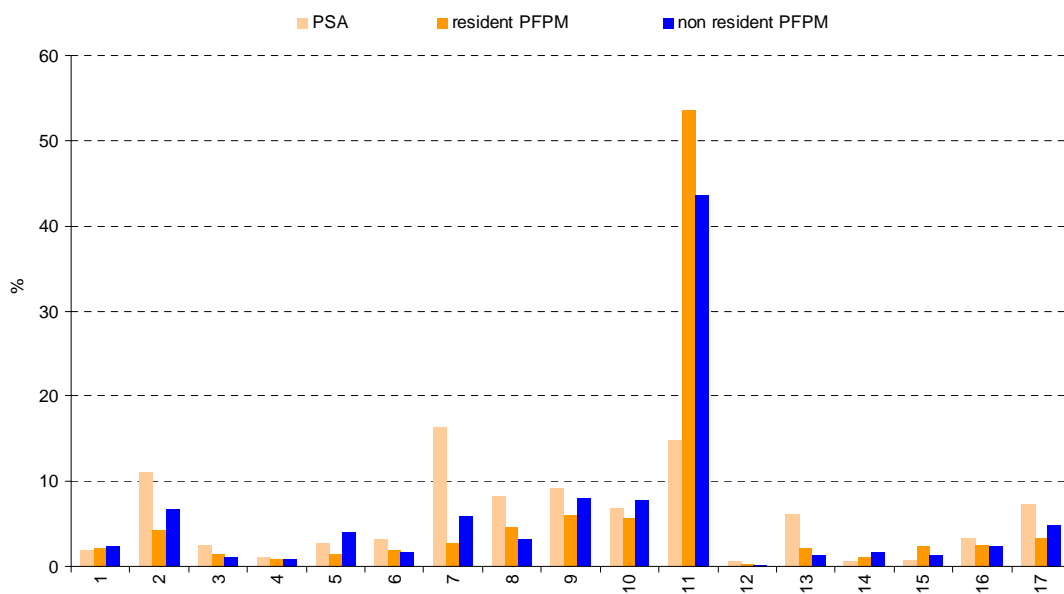


Figure 8. Ordinary hospitalization diagnosis for female patients from PSA (resident) and PFPM (resident, non resident) in Emilia-Romagna (2009)





Legend for Figures 7 and 8

- 1 Infectious and parasitical diseases
- 2 Neoplasms
- 3 Endocrinal, metabolic, nutritional diseases and immunisation disorders
- 4 Diseases of blood and blood-forming organs
- 5 Psychic disorders
- 6 Diseases of nervous system and sense organs
- 7 Diseases of the circulatory system
- 8 Respiratory system diseases
- 9 Digestive diseases
- 10 Diseases of the genitourinary system
- 11 Pregnancy complications
- 12 Skin and under skin system diseases
- 13 Diseases of osteomuscular system and conjunctive tissue
- 14 Congenital malformation
- 15 Some morbid conditions of perinatal origin
- 16 Symptoms, signs, morbid conditions not well defined
- 17 Traumas and poisonings

Generally however, the tendency to hospitalization, expressed through hospitalization rates²², is much lower in immigrants from PFPM than in Italians and assimilated. This observation is valid at a national level, where rates for 1,000 residents are 117 for people from PFPM and 187 for Italians and PSA residents²³ (2008). The phenomenon is more evident in Emilia-Romagna Region (Figure 9).

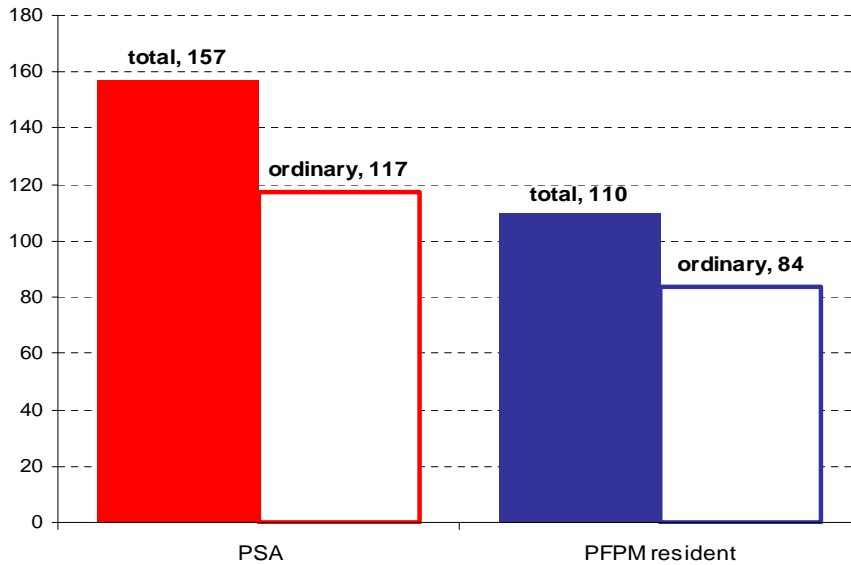
A first evaluation of ordinary hospitalization costs in 2007 shows that expenses percentage absorbed by people from PFPM is 2.8% (while hospitalizations represent 3.5%). Non resident PFPM absorb an expense amount of 0.5%, with 0.6% of hospitalizations.

²² Raw rates, influenced by the younger age of immigrant population. They indicate general hospitalization inclusive of hospitalized people's ages. Rates regarding non resident PFPM can't be calculated for lack of denominator

²³ National technical-scientific group for the CCM project "Health profile of immigrant population in Italy" (2007-2008; coordinated by Marche Region).



Figure 9. Hospitalization (total and ordinary) raw rates (x 1,000) in Emilia-Romagna structures per citizenship (2009)



In 2009 the proportion of ordinary hospitalizations in Emilia-Romagna structures (day hospital ones are excluded) for PFPM resident, non resident and for people from PSA and Italians was similar, respectively: 76%, 74.8% and 74.8%. The percentage of urgent ordinary hospitalization was 52.8% for Italians and people from PSA, 65.6% for residents from PFPM and 74.4% for non residents from PFPM. In 2004 they were respectively 53.0%, 69.6% and 76.5%.

Traumas are the most frequent hospitalization cause for men from PFPM (respectively 20% and 14% for non resident and resident), while they represent only 9% for Italians and assimilated (Figure 7).

The most frequent causes of hospitalization for migrant women both for non resident and resident, are childbirth and pregnancy complications (respectively 44% and 54% vs 15% of Italian women from PSA). A consistent amount is represented by voluntary abortions, sensibly higher than that of Italian women and women from PSA (Figure 10, Regional informative system SDO).

In 2009 hospitalizations for abortion among immigrant women from PFPM were 4,485 (862 of them by non resident PFPM; Figure 10) out of 55,607 total hospitalizations of PFPMs, representing 8.2% of all 674,078 hospitalizations. Voluntary abortions by Italian women and women from PSA were 5,382.

To give hints to the study of social determinants of migrants' health, it is important to clarify that in these researches reference is to foreign population (non Italian citizens). Through 2005 ISTAT survey on health and health services utilization, it is possible to underline the interaction between the condition of immigrant and the socio-economical status (ISTAT, 2008). Also for foreigners, people with lower social status have less favourable health conditions.

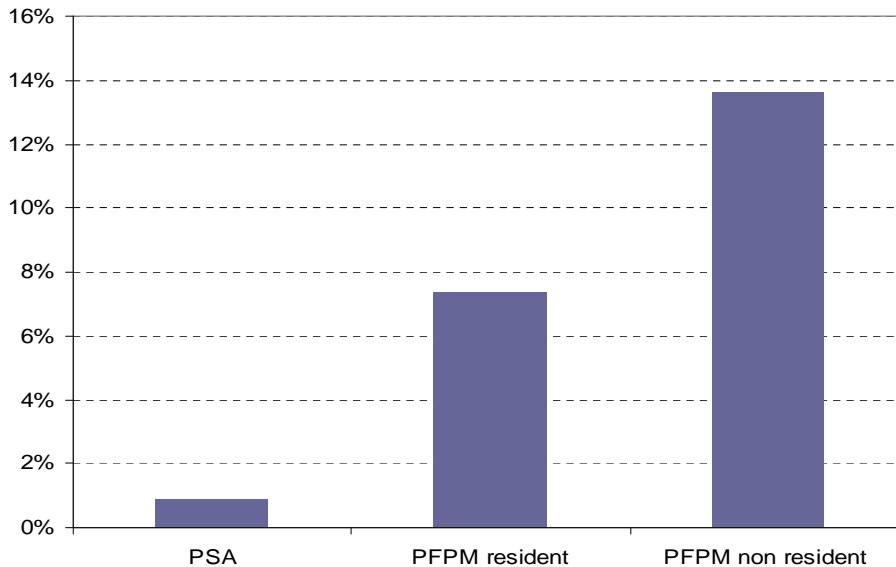


Immigrant population benefits from a general health advantage due to the selection in the decision to emigrate, more likely in healthy people (healthy migrant effect); the assessment of such advantage would probably be reduced if also irregular migrants were described.

Moreover, the National Health Service equally guarantees access to services, but foreign population is subjected to some limitations. This is evident in particular for female cancers prevention and for prevention in general, for access to specialist services and in the birth path.

As for birth path, lots of information can be taken from regional data flows, such as the certificate of birth care. The analysis of 2005-2008 data shows that the condition of migrant woman highly influences many aspects of pregnancy (for example, low attendance of control visits), of childbirth (for example, higher frequency of induced labour) and of child (for example, lower birth weight) (Regione Emilia-Romagna, 2008a, 2009).

Figure 10. Hospitalization percentage for voluntary abortion/all hospitalizations in Emilia-Romagna (2009)



In the period April 2007 - December 2008 a surveillance system on health-related behaviours was started in Italy (Progresses for health in Italian Health Trusts - PASSI System; Istituto superiore di sanità, 2007); also Emilia-Romagna participated in the system, involving all its Health Trusts (Regione Emilia-Romagna, 2006c, 2007b). PASSI system investigates aspects related to health (perceived health, prevalence of cardiovascular risk factors and depression symptoms), to life styles (diet, physical activity, smoking, alcohol abuse), to the offer and utilization of prevention programs (cancer screenings, rubella vaccination, influenza vaccination) and to road and home safety). A random sample of 18-69 year old residents is selected from health registers and interviewed by phone by trained personnel.



In the 2007-2008 survey also immigrants were included, but only of 18-49 years of age because of the little number of immigrants over 50. The analysis of results (AAVV, 2009a) reveals that interviewed foreign people perceive their health status more favourably than Italians, but it is necessary to remember that the group of less integrated and more deprived migrants is not considered. Interviewed immigrants quote also some healthier behaviours than those of Italians: they smoke less, drink less alcohol and use road safety devices more often. On the contrary, they appear to be less involved in physical activities.

Data also underline that the relationship between migrants and health personnel can be improved, as these professionals ask less information on immigrants' risky behaviours and offer less advice than with Italian patients.

3. Policy agenda, good practices and projects

3.1. Policy agenda in Emilia-Romagna

With the institution of the National Fund for Migration Policies (Law n. 40/1998, art. 45), Regions, that are the principal receivers, become central in policies for migrants, as established in art. 58 of the Implementation rules of the Consolidation act. Regional Annual and Multi-annual Programs have to foresee agreements with Local Authorities with clear indication of goals, interventions, modalities, timetable, costs and resources. According to the law, Regions can also collaborate with foreigners' associations and organizations involved with migrants, listed in a specific register.

Emilia-Romagna was the first Italian Region to adopt a law on policies for migrants' integration after the reform of Constitution in 2001 and the "Law Bossi-Fini" in 2002. The Regional Law n. 5/2004 "Norms for social integration of migrant citizens" faces the theme of immigration from all points of view (education, health, employment, housing, etc.) and with a universalistic approach to guarantee real exercise of social citizenship rights within public services and to prevent the creation of a parallel or separated welfare system.

The previous approach mainly meant to face emergency problems is abandoned, and policies for migrants are oriented towards ordinary and structural planning. Among the major new aspects there are:

- three-year Program for Social Integration of Foreign Citizens, defined as a new inter-departmental planning tool (DGR n. 45/2006) and meant to promote the integration of different policies to jointly answer needs;
- opportunities in local institutions to promote foreigners' participation in public life;
- Regional Committee for Social Integration of Foreign Citizens (DGR n. 224/2005);
- Regional Plan of Actions against Ethnic, National and Religious Discriminations and the Regional Centre Against Discriminations;
- the Regional Observatory on Migration, besides the already existing provincial ones;



- economic support to Provinces, Municipalities and other no-profit subjects for interventions for social integration, as information centres, courses to learn Italian language, activities of cultural mediation, intercultural centres and initiatives; particular attention is paid to appropriately train operators directly involved with foreign citizens and to enrol intercultural mediators in public services;
- interventions for housing policies (promoting estate agents to favour the encounter between of demand and supply, social housings, centres for first reception, etc.);
- economic support to school for its role in cultural integration through teachers' training and cultural mediators;
- promotion of an efficacious healthcare policy;
- strengthening of international cooperation activities, in particular those concerning training.

In particular, the 2006-2008 Program for Social Integration of Foreign Citizens stresses the issue of the increasing migrants' presence in the region. The complex and integrated approach aims not only at adding specific services for migrants in each sector, but also at promoting a constant thinking on emerging needs and identified solutions. In line with European Union's indications, the Program intends to favour an universalistic access to the regional welfare services, without any urban or social barrier and with particular attention to the specific juridical condition of foreign citizens. The Program also promotes the institution of a Regional Observatory on Migration phenomenon, the implementation of a Regional Centre Against Racial Discriminations, and a Monitoring Report on the three-year activities.

The Regional Committee for Social Integration of Foreign Citizens takes over in February 2005; it is chaired by the Regional Committee for Immigration and it is constituted of institutional subjects, social partners and social private associations. It involves also 18 representatives of foreign citizens (half of them are women), two for each Province, coming from 14 foreign countries. The Committee, in charge till 2010, meets at least twice a year to discuss on regional decisions concerning immigrant citizens with a multisectorial approach (education, housing, cultural, social, health policies, etc.). Among its main functions, it is included to:

- elaborate proposals to the regional Government to modify laws and measures concerning immigrants in order to meet new needs;
- elaborate proposals and advices on the Triennial Program for Social Integration of Foreign Citizens;
- support the activities of the Regional Observatory on Migration phenomenon.

In May 2008 the Regional Assembly approves the new 2008-2010 Regional Social and Health Plan, aiming for the first time at creating an integrated system of social and health services to realize a new universalistic and equal welfare, rooted in local communities and in the region (Resolution n. 175/2008). The process was started with the outline Law n. 2/2003 on social services and with the Regional law n. 29/2004 on re-organization of the Regional Health Service.



The new Plan underlines the need to guarantee the provision of social and health services at district level (as indicated by national and regional legislation) and to support immigrants with actions of social aid, listening and information in collaboration with Local Authorities and other public and private subjects (voluntary organizations, associations for social promotion, social cooperatives, non governmental organizations).

Intercultural mediation is considered as an essential resource in the health and social services that have more contacts with citizens having different cultures and lifestyles (also to support workgroups and training), to overcome language and cultural difficulties and to favour knowledge and comprehension of "other" viewpoints and perceptions on health/disease conditions. In this perspective, the ability to inform and orient foreign citizens to improve their access and use of services becomes a fundamental requirement to prove health services' quality.

In the new Plan, childbirth, children's care and childbearing are seen as meeting opportunities with services and are therefore the best contexts for prevention and integration interventions, for example through meetings with local families, education activities, school support. Particular attention is also paid to preventive and care interventions during pregnancy, to child and primary care, to vaccinations, all aspects that represent the most frequent reasons to access health services.

The Plan underlines the opportunity to identify suitable informative tools on contraception and on access rights to health services, also to reduce the number of (often recurrent) abortions by immigrant women.

Among Plan's priorities there are also: protection from infectious diseases, health care for foreign citizens enlisted for SSR, provision of health services to irregular immigrants. In particular, the aims are:

- facilitate access to dedicated services, such as Areas for Immigrant Women and their Children";
- facilitate access to primary care, in particular for childbirth and child care, through the activation of social and health care paths at Family Advisory Centres;
- promote training initiative for health professionals on migrants' acceptance and care.

In line with planning strategies and tools of the past years, the new Regional Social and Health Plan stresses the need to guarantee:

- spreading of correct information on different aspects of the migration phenomenon, to involve foreign citizens in the definition of local public policies and to valorise the reciprocal knowledge of different cultures;
- equal access to education, services, labour market and housing, focusing attention in particular on interventions at schools for foreign students and their families;
- correct knowledge of rights and duties established by national and European rules;
- development of actions against discrimination.



3.2. Good practices and projects: examples in Reggio Emilia and other areas

To better describe the effects of regional laws and of planning tools proposed, the experience in the province of Reggio Emilia is presented, as it has dedicated particular attention to the issue of immigrants and of their access to health services.

The Local Health Trust of Reggio Emilia has faced the change of needs of the new multiethnic society by implementing strategies to improve access and utilization of health and social-and-health services by immigrants and to create an organizational context that is culturally competent. Through a network collaboration system to spread and share experiences at trust and provincial level, the aim is to increase knowledge in health professionals and in users, to monitor needs evolution, to guarantee a fair use of resources, to homogenize the organization, to diversify offer and to assure the definition and monitoring of quality standards.

A Trust Table in Reggio Emilia

A Trust Table for action coordination was established to favour access to health services by regular and irregular immigrants. The Table is composed by staff members of Trust's Head Office; by representatives of Hospital and local Departments and Services that daily deal with migrant population: Women's Care Services, Paediatric Spaces, Mental Health Services and Public Health Services; and by representatives of the associations involved in the implementation of a service of language-cultural mediation: in the context of collaboration in the Migrant Friendly Hospitals Project of the WHO Health Promoting Hospitals European Network, led by Reggio Emilia Local Health Trust, in 2005 a language-cultural mediation service was established to overcome linguistic barriers and obstacles strictly connected to cultural behaviours and approaches, that often prevent an efficacious use and access to care by immigrants. The service began to work in Emergency Units, Women's Care Services, Child Care Units, and is now active in all sectors. 16 mediators speak the most common languages: Chinese, Arab/French, Indian, East European languages, South/Central African languages; they all have a medium-high level of education (nearly all of them have a University degree), were trained and are constantly updated. To face all the different problems and organizational needs, the mediation service offers various types of interventions: stable offices in the hospital, programmed or urgent interventions, phone counselling, written translation of health documents. The mediators also collaborated with health professionals to prepare procedures for admissions, hospitalization, treatment and discharges.

The main goal of the Trust's strategy is to guarantee reception, primary healthcare and response to emergencies to all immigrants, STPs included. In particular, some public health interventions were implemented to face health emergencies such as infectious diseases, tuberculosis and hepatitis. Some specific actions were also implemented to introduce migrants in services ordinary circuits, so as to guarantee equity in access.

Reggio Emilia Local Health Trust organized specific training programs for health personnel in daily contact with migrants and other actions to promote a full awareness of the values of inclusion and integration. Particular attention was paid to admission, hospitalization, care and discharge procedures.



According to the results of analyses on needs, migrants' health profile and priorities evaluations, specific care paths for immigrants were established, in particular for pregnancy, voluntary abortion, post-partum depression, contraception, vaccinations, control of tuberculosis and other infectious diseases.

Migrants' empowerment is considered a critical aspect that needs to be faced involving single persons and groups through interventions in communities, workplaces, places of worship; information initiatives addressed to migrants concern access and utilization of services; policies for health promotion in women and children, feeding, weaning and nourishing; diabetes, health education on most common diseases.

To increase access to health structures, information materials and signals were produced in different languages. Intercultural mediation was spread in all provincial social-and-health services. Specific information campaigns with multilingual printed materials were promoted also through meetings at the main reception communities for migrants.

Meanwhile, ad hoc training was offered to health professionals and mediators to increase their trans-cultural competence. The specific education needs of each professional were carefully analysed, so as to propose training models and courses that could guarantee good knowledge of the various phenomena (migration and health, cultural integration, politics and legislation, inequalities, medical anthropology), full awareness of working context (working in a multicultural context in a sensitive way, stereotypes and prejudices, health concepts and beliefs) and specific abilities (management of intercultural relationships, getting information from patients).

Centre for Foreign Families' Health in Reggio Emilia

An interesting experience is the Centre for Foreign Families' Health, opened in October 1998 in collaboration between Reggio Emilia Local Health Trust and Caritas to face social and health problems of irregular migrants living in the area, as established by the "Legge Turco-Napolitano" on migration of March 1998, confirmed by the Legge "Bossi-Fini". The Centre depends on the Health Service, and guarantees services for psycho-physical health, prevention and containment of infectious diseases, help on social problems for foreign citizens temporary present in the province that are irregular, clandestine and without social-and health care.

The structure offers free-access outpatient spaces (twice a week), also on special projects, for example "Eva Luna Space" for street-walkers, paediatric space every 15 days, tuberculosis space once a month, nursing spaces once a week, obstetric consulting room 3 times per month on appointment, etc. The Centre also promotes:

- health education paths for immigrants - for example courses for African women, pre-partum courses for Chinese women (156 hours in a year);
- obstetric and gynaecological counselling - in 2005 973 women were followed, 538 were new users (nearly 55.1% of the total), for a total of 4,860 visits in a year. The service also deals with voluntary abortions, pregnancy care, fertility control;



- primary care;
- paediatric care - visits for pathologies, infectious diseases (vaccinations, controls, etc.).

When first accessing the Centre, the foreigner has to show an identification document to demonstrate his/her nationality; the person is then registered and is given a STP card. First visits (controls, vaccinations, blood examinations, etc.) take place at the Centre; further specialist's examinations take place at Caritas offices operating with the AUSL. For health problems that cannot be solved in this way, the person is addressed to the city hospital by paying a ticket. The Centre and Caritas offices collaborate in some public health interventions on tuberculosis, hepatitis and other infectious diseases. In 2006 2,516 irregular migrants were taken care; 1,754 of them were new users (nearly 69.7% of the total).

Number of new users at the Centre for Foreign Families' Health passed from 500 in 2000 to 1,800 in 2005 and the total number of accesses in the same period passed from 2,000 to 7.,000.

Professionals involved at the Centre are: paediatricians, gynaecologists, obstetricians and nurses of the Local Health Trust, social workers of the Municipality, and North-African, Central-African, Albanese, Russian, Chinese, Indo-Pakistan language-cultural mediators. The presence of the mediators is fundamental to improve access to services by these users: they contribute in overcoming the linguistic barrier and they help professionals and users to understand the value of the culture of origin and the concepts of health and care.

The Centre for Foreign Families' Health represents an example of efficient network collaboration between institutions (AUSL, Municipality, Province, Region) and voluntary organizations, with Caritas in the foreground. The Centre constitutes a well rooted reality for health services in Reggio Emilia Province, a privileged observatory of health and social-care problems of irregular and/or clandestine migrants at provincial level, and it is a clear reference structure for immigrants just arrived in the area. Its main strengths are:

- cultural mediation;
- the agreement with Caritas and the collaboration with other voluntary associations;
- the network connection with Municipality, Province and Region;
- the multidisciplinary workgroup.

In Emilia-Romagna many other experiences and structures are dedicated to care to regular and irregular migrants, and they represent reference points for the whole region.

Two of these experiences are described below, as they are strongly rooted in the territory and are considered good practices.



SOKOS in Bologna

The Association for Care to Outcasts and Immigrants (SOKOS) was founded in 1993 in Bologna by a group of physicians who already had experiences in war situations, poverty and marginalization contexts, refugee camps; as quoted in the Statute, the aim of the Association is to answer health need-right of any person that for any reasons (social marginalization, deviancy, migration, etc.) is not satisfied in his/her request. Since 1993 SOKOS' intervention fields have increased to face new emergencies, from war refugees from former Yugoslavia to those from Kosovo and Kurdish ones, and have then dealt with the continuous and increasing immigration flow from Eastern Europe, South America, Africa and South-Eastern Asia.

The voluntary activity is address to people that, for social, cultural or personal conditions, cannot or are not able to use the public health services (95% of people who refer to SOKOS are immigrants without sojourner's permit); the Association offers them care, defence and health protection. Around 50 people (physician and other professionals) are now working at SOKOS.

Since 1996 an agreement was signed with the Local Health Trust of Bologna to cover current expenses necessary to run the structure. As established in this agreement, SOKOS can request the STP card, so that the person can access - with SOKOS doctor's orders - drugs, laboratory and instrumental examinations and if necessary also hospitalization. Up to now, 14,000 people were visited at least once. In 2008 nearly 6,000 primary care and specialist visits were performed.

Recently, a Study and Documentation Centre on Health and Migration was also established in collaboration between SOKOS and Bologna's AUSL to collect, analyse and spread materials and updated data on health issue related to migration and to offer tools and knowledge for research, updating and education.

SALEM in Cesena

The Project SALEM for care to outcasts, Roma and irregular immigrants was implemented in Cesena in response to the strong need expressed by the coordinators of the Counselling and First Reception Centres and of the Centres for Foreigners. They had referred to the Local Health Trust to overcome difficulties in offering health care to irregular migrants, whenever more complex therapies or examinations were necessary and access and costs could not be afforded.

Therefore in 1999, in agreement with the associations involved in migrants' care, Cesena Local Health Trust promoted the so called "Salem Project", to guarantee access to health services for the excluded population groups, such as irregular migrants, Roma and outcasts.

The Project was in line with the 1998-2000 National Health Plan, that had among its goals the increased protection of the weak and that invited Regions to promote projects to contrast inequalities in access to services and AUSL to activate interventions to facilitate access to health services, to spread information and knowledge, to train health professionals.

A 2000 protocol details health care offered by the Health Trust and how to get it (documentation, addresses, costs, etc.) for each user group.



Care to STPs is organized in a network of primary care outpatient structures that belong to Salem voluntary association. About 40 physicians offered health care for free, receiving foreigners in their offices.

The strategy to use existing outpatient structures of family doctors instead of establishing a specific structure for care to irregular immigrants was meant to contrast inequalities and to favour their integration by offering them the same health paths as for Italian citizens: primary care physician, District and hospital facilities. Moreover, these outpatient structures were spread all over the area, open every day, and so more easily accessible.

Users' access to the network of voluntary physicians was at the beginning filtered and mediated by voluntary associations (Caritas, Counselling Centre, etc.) and by the Centres for Foreigners. In a second phase, it was automatic after the registration as STP at the competent AUSL office.

Health care to migrants is offered also at the structures of the Department of Primary Care (Paediatric Spaces and Family Advisory Centres), of the Department of Public Health (vaccinations) and at the Hospital in case specialist visits, diagnostic examinations or hospitalizations are needed.

The care service established through the Project is still active. Its evaluation is very positive, both for the efficacy in responding to needs, and for the low costs of management.

From January 1, 2008, Cesena Local Health Trust has decided to overcome the voluntaristic-based organization in order to strongly structure the experience and to guarantee its work in the future; therefore, this activity was included in the local Agreement with family doctors (MMG). Nowadays, all 150 MMG offer health care to STPs in their consulting rooms, and receive by the AUSL a reimbursement for each visit performed. For foreigners that seek assistance, the visit is free of charge; they have to pay a prescription charge for drugs, examinations and specialist visits like any Italian citizen.

Activity data are monitored and presented yearly in the so called "Salem Report", that can be downloaded from the Local Health Trust's website <http://www.ausl-cesena.emr.it>

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Regional Office for Europe
Regions for Health Network



Migrants and Health Care: Responses by European Regions (MIGHRER)

Complete reference material

V. Regional report North West England

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Summary

Currently it is not possible to accurately measure the movement of people in and out of the UK or the North West (NW) region. Since the mid-1990s population movement has been a large component of demographic change- with an increase in both inward and outward migration.

In the NW region, some aspects of the national picture is reflected at regional level: long term migration (intention to stay over 12 months) increased from 320,000 in 1997 to 574,000 in 2006. People move for a variety of reasons such as to study, to work, for economic reasons, for a better life, to join family or friends, to seek asylum or as trafficked persons.

At any time in the UK there are a number of people, including visa-overstayers without documentation or permission to stay. The actual number is not known but may be around 14%-17.5% of the total migration population. a proportion of these live in the North west

National policies, health strategies and public service agreements demonstrate the national and regional focus to address inequalities and promote community cohesion. Equality impact assessment is part of strategy development, planning and service delivery in order to ensure that the specific issues for marginalised groups including migrants are taken into account.

In response to increasing migration in the NW region, many strategies and projects have been developed. These include the "Community Cohesion and Wellbeing - Developing the NHS Contribution", which invites NHS Boards to examine what their organisations are doing to foster community cohesion; the "Polish migrant community support project", which is creating a mechanism for easier access for polish migrants to services; the "Liverpool patient profiling initiative" profiling patients on a geographical basis. In addition, there are organisations with specific skills and expertise such as the "REACHE NorthWest" which assists refugees into work; the "Wigan homeless and vulnerable persons team" which supports vulnerable people to maintain health; "Cheetham Hill Advice Centre" managed by a local voluntary committee, enabling local people to make their own decision about their life and bring about improvements in their standard of living.



The North West of England and its 5 sub-regions

Context

The North West (NW) region is the largest (with a population of approximately 7 million) of the 9 English regions outside of London and the South East and is characterised by its varied geography, architecture, work and life opportunities, cultures and people groups, income levels and health status. There are 5 sub-regions divided into districts or boroughs administered by Local Authorities (LA). Most of the region is rural but the majority of people live in urban areas.



The regional economy stands at £106 billion, which is larger than that of Finland or Denmark³ but average weekly earnings, employment rate, house prices per head in the NW is lower than in the UK as a whole. The region has several boroughs with the lowest life expectancy in England.

It has a long history of people-movement - both in and out of the region - and like the rest of the UK, it is influenced by global migration.

Census data informs us that overall population numbers have fluctuated. In 2006, the NW population was greater than in 2001 but less than in 1981⁴. Population numbers are expected to increase. However, the picture is very different at local levels with one Local Authority (LA) seeing a 20% population increase within the same time span. A proportion of these changes is attributable to international migration flows.

³ <http://www.northwest.nhs.uk/whatwedo/publichealth/>

⁴ <http://www.ons.gov.uk/ons/index.html>



Terminology

An important point to make at this early stage is the wide ranging interpretation of the term "migrant". In the UK, there are no agreed definitions in common use and the delineation between "migrant" and "immigrant" is nebulous; there is no clearly defined point at which a migrant becomes an immigrant.

To add to the confusion, the terms migrant, immigrant, refugee, asylum seeker, foreign worker or foreign national are often understood or used interchangeably. International students, although probably the most clearly defined group, may belong to one of the other groups - such as a refugee or a migrant worker. Indeed, many make one or more transitions between "categories" over time.

This paper considers four broad groups - international students, asylum seekers and refugees, economic or migrant workers, and people coming to join families.

Generally speaking, for the purposes of describing populations and service provision, the category of BME (Black and Minority Ethnic) group is used to encompass people who might otherwise be defined as an immigrant (or second and third generation immigrant) and having lived in the UK for a number of years.

The focus here is mainly on the issues associated with movement of people in the last 10 years. This is because:

- people who have lived in the UK longer, are considered as BME and part of a longstanding migration phenomena;
- since 2000, asylum seekers are accommodated and supported in every region of the UK, including the North West;
- since 2004, there has been a rapid increase of numbers of people coming to the UK from countries joining the EU.

1. Health system overview, national and regional situation

1.1. Health system functions - national overview

There are some differences in laws and applications of regulations in relation to health between England, Scotland, Northern Ireland and Wales.

The National Health Service (NHS) is the name given to the health care system in the UK and provides the most health care - the majority of which is "free at the point of delivery" for people who are normally resident in the UK. The NHS is mostly funded through general taxes and national insurance contributions. Its Chief Executive is the main policy advisor to government ministers on the NHS which, incidentally, has one of the largest workforces in the world. Most doctors and nurses work for the NHS.



In England, the Department of Health⁵ (DH) is the body that develops the legislative framework, strategy, establishment of standards, regulation of the system and allocation of resources for the NHS and Adult Social Care. Its "overall purpose is to ensure better health and well-being, better care and better value for all". The DH is accountable to both parliament (the Secretary of State for Health) and the public. It also leads on issues such as environmental health, infectious diseases, health promotion and medicine safety.

DH is the lead department across government for the promotion and protection of the public's health, and the reduction of health inequalities.

The biggest single delivery arm for public health is the NHS, both for health protection programmes such as immunization or infectious disease surveillance, and for health improvement programmes that operate through Primary Care Trusts (PCTs), such as tobacco reduction.

Partnered organizations

As stand-alone national organisations sponsored by the Department of Health, a number of organisations work closely with local services to carry out specified functions. These include:

- The Health Protection Agency (HPA)⁶ - set up by the government in 2003, works toward protecting the public from infectious disease and environmental health threats through research and by providing advice and information. A national organisation, each region is served by a Health Protection Unit (HPU).
- The Health and Safety Executive (HSE)⁷ - helps protect people against the risk of injury and ill-health and death in workplaces and work activities through research, information and advice, training, regulations, inspection, and enforcement.
- National Institute for Health and Clinical Excellence (NICE)⁸ - provides assessment and guidance on the prevention of ill health, the promotion of good health and appropriate disease treatment.
- Since April 2009, safety and quality regulation of all health and social care providers is undertaken by the Care Quality Commission (CQC)⁹ which is independent from both government and the NHS.
- The National Treatment Agency for Substance Misuse (NTA)¹⁰ - is a special health authority within the NHS, established by Government in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

⁵	Department of Health	http://www.dh.gov.uk/
⁶	Health Protection Agency	http://www.hpa.org.uk
⁷	Health and Safety Executive	http://www.hse.gov.uk
⁸	National Institute for Health and Clinical Excellence	http://www.nice.org.uk
⁹	Care Quality Commission	http://www.cqc.org.uk/



- NHS Direct¹¹ and NHS Choices¹² - offer open-access telephone and web-based health information. Some interpretation and translation is available in languages other than English.
- Public Health Observatories - are regionally based members of a national network providing regional public health information and intelligence to support public health professionals and health providers.

Adult Social Care

The DH provides the policy and legal framework and funding for LAs providing adult social care. LAs are responsible for commissioning appropriate support to people in their localities who have specific care needs due to age or disability or other vulnerability.

Private healthcare has for many years run alongside the NHS and is voluntary - usually via private (personal or company) insurance. It is used in some cases as an "add on" to the NHS and can offer a full range of services available from chiropody to hysterectomy to cosmetic surgery. Approx 11% of the population have private health insurance (Goddard 2008) and approximately 8% of the population use private health care.

1.2. Structural organization at regional level

Many of the above described organisations have a regional presence or dedicated unit.

Strategic Health Authorities (SHA) are accountable to the DH for the performance and management of the health care system within each region. They oversee health care provision through Primary Care Trusts (PCTs) which are generally co-terminus with Local Authority boundaries. Approximately 80% of the NHS budget is with PCTs.

The SHA in the region is NHS North West and it oversees the work of:

- 1 Ambulance Service
- 8 Mental health care trusts
- 7 Specialist trusts (including children's cancer and learning disability)
- 23 Acute (hospital) trusts
- 24 Primary Care Trusts

¹⁰ National Treatment Agency <http://www.nta.nhs.uk/>

¹¹ NHS Direct <http://www.nhsdirect.nhs.uk/>

¹² NHS Choices <Http://www.nhs.uk/>



PCTs commission providers of secondary care (hospitals) and primary care; they manage General Practitioners (GP) and community-based health services, as well as developing health promotion and addressing health inequalities.

Provider organisations include hospital trusts, mental health trusts, ambulance trusts, some public health departments, GP practices, dental practices, community pharmacists, optical practices, and NHS Direct. Most services are provided by NHS bodies but independent and third sector organisations including charities, voluntary groups, social enterprises and co-operatives may also be commissioned to provide NHS care.

NHS trusts and NHS foundation trusts administer hospitals, treatment centres and specialist care, including mental health services.

General practitioners (GP) are the main gateway to primary care services. They commission services for patients registered with their practice. To some extent, through the Quality and Outcomes Framework, their work is structured according to their performance against indicators such as numbers of patients treated, what treatments were administered, and the health of their catchment area.

Maternity and Mental Health Services generally require referral by a GP, secondary or primary care worker.

Other services may be accessed without referral from a medical practitioner and include:

- Pharmacy - (but relatively few medications can be bought without prescription)
- Walk-in Centres - providing first level treatment
- Community Drugs Team, Substance Misuse and Treatment Services
- Sexual Health Services and Family Planning
- Orthopaedists
- Dentists

The NW Strategic Health Authority has developed an Equality and Diversity Strategy (Ali 2008) which aims to ensure equality of health access across the themes of ethnicity, age, gender, disability, sexual orientation and transgender, religion and belief. Migrant groups are identified within the strategy which has as its main goals:

- increased diversity and representation in the workforce
- development of data, information and knowledge
- development of targeted, effective services
- initiation of best practice
- development of specialists and leaders



In response to the rapid recent increase in number of international migrants to the UK, the DH has augmented its support to the regions in managing the potential impacts. In the North West, this has resulted in the production of a report on health and migration (Ricketts 2008) in the region and the development of a Health Interest Group (a sub-group of the NWRSMPP) which has as its main aims:

- facilitate the equitable provision of health, wellbeing and service delivery for recent arrivals from overseas (migrants) in the region
- raise awareness, foster sharing of good practice
- maintain a key focus on the health and wellbeing of asylum seekers and refugees
- develop recommendations on research and development needs

1.3. Intersectoral actions

A number of regional organisations work together on strategies impacting the social determinants affecting community health. Migrants, as members of communities, are influenced by these but may not be "singled out" or may be considered within other categories such as "workforce" or "marginalised".

There is no single regional strategy specific to "migration" and/or migrants as a whole, although it has been put forward.

However, there are a number of multi-agency collaborations:

- NW Regional Strategic Migration Partnership (NWRSMPP) initiated by the United Kingdom Border Agency (UKBA) with membership from Housing, Local Authorities, Regional Development Agency, Government Office, Third sector and Voluntary Organisations, Health and Social Care organisations, Refugee and Asylum Seeker groups, and Migrant Worker organisations has a strategic remit to:
 - o promote co-ordination and partnership working between agencies
 - o consider the social impact of new arrivals from abroad upon the region.
 - o influence and shape the regional/national dispersal of asylum seekers by the following:
- Local Strategic Partnerships (LSP) - multi-agency partnerships with a wide local remit are responsible for ensuring that Local Area Agreements (LAAs) are implemented. In relation to health, LAAs respond to Joint Strategic Needs Assessment - local community profiles, identifies health and equality issues, setting and working toward targets. The level to which migration and migrant needs are considered is dependent on the LSP membership.
- Investment for Health (I4H) in the North West is a new campaign, supported by regional leaders from all sectors, aimed at ensuring that public investment becomes a force for the creation of health and wellbeing for all communities in the region. Public



investment decisions will explicitly aim to have a positive impact on the living and working conditions of the population, with policies that give equal priority to supporting the health and wellbeing of the whole population and to sustainable economic growth.

1.4. Health information system

It is not possible to extrapolate information in relation to migrants directly from health service sources. Hospital episode statistics, GP registrations, disease registries, and the England Health Survey may incorporate ethnicity and country of origin but migrant status cannot be inferred from this.

Census information and research estimates that the proportion of people in the NW described as:

- A foreign national in 2006 was 5.5%¹³
- From a non-UK country of birth in 2007 was 6.98%¹³ (10% in UK as a whole)
- From a "Black or Minority Ethnicity (BME)" group in 2005 was 11%

Other sources of data are being combined to make useful but general demographic estimates at national and regional level. A new Migrant Databank is being set up to make this information more readily available and a number of areas in England are piloting local projects. (See appendices and "A Resource Guide on Local Migration Statistics" (Green et al. 2008).

A considerable number of academic institutions, e-networks, thematic or minority group-focused organisations undertake research, share good practice and raise awareness about specific issues related to migration, migrants and/or BME groups.

There is a long history of work undertaken with specific ethnic groups, mainly on health risks and outcomes. Fewer studies and surveys are available on migrants as a generic group. The noticeable exceptions are for asylum seekers and refugees - around which there is a wealth of national and regional health information, and for infectious diseases. (See Welfare 2007).

Health organizations are required to ensure services are not discriminatory on grounds of race. Ethnic monitoring is an important component in addressing this as well as in mapping local population (although it does not in itself identify recent arrivals from overseas) (Department of Health 2005).

Detailing of ethnicity in the NW health services is approximately 65% (APHO 2005). The current 16-code national standard however, does not take into consideration important differences within ethnic categories. Thus, Ugandan, Somali, and Nigerian all come under the "black African" category and the majority of people from the new European countries are incorporated within "white other" category.

(See Good example - Liverpool Patient Profiling Initiative)

¹³ Office for National Statistics <http://www.statistics.gov.uk>



Laws on health information

Health organisations are required to ensure that services are accessible and provided without discrimination on grounds of ethnicity, age, gender, disability, religion or faith, sexuality or transgender.

In relation to migrants, this may focus specifically around:

- Ensuring understanding about services available
- Informed consent
- Provision of interpretation and/or translated material
- Access to information/data

The provision of these varies in extent, type and quality across services and locality. At a national level, there is much translated material available (although less in some of the languages of new EU members) via NHS Choices and NHS Direct and the DH and a number of voluntary organisations also produce culturally appropriate material. At least 2 PCTs in the NW provide unrestricted access to interpreting services for their service providers. A number of Local Authorities or joint bodies have developed welcome packs (see good practice example).

1.5. Regulations and legal framework (See list in appendices)

Health

The rules underpinning entitlement to health care services are complex and not widely understood at front line service level.

There are aspects of the regulations and guidelines requiring discretionary interpretation. Implementation is further complicated by the recent and considerable changes of policy and NHS organisational structure.

The Department of Health and Home Office are currently jointly reviewing the rules governing access to the NHS by foreign nationals.

The majority of migrants are entitled to use NHS services. Eligibility for free NHS care is dependent on a number of factors, including:

- Reasons for being in UK such as to live, work, study, visit, holiday
- Length of time in (or away from) UK
- Country of origin such as from the European Economic Area or from a country with bilateral healthcare agreement
- Type of service being used



Secondary care

The current charging and entitlements systems are the result of the NHS (Charges to Overseas Visitors) Regulations 1989 and subsequent amendments. In 2004, the Department of Health issued guidance on charging: "Implementing the Overseas Visitors Hospital Charging Regulations: Guidance for NHS Trust Hospitals in England" (Department of Health 2007).

Decision making on entitlement to free hospital treatment lies with the hospital providing treatment. Broadly speaking, hospital service charging is centred around whether a person is considered to be "ordinarily resident".

"Anyone who is deemed to be ordinarily resident in the UK is entitled to free NHS hospital treatment in England. "Ordinarily resident" is a common law concept interpreted by the House of Lords in 1982 as someone who is living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, with an identifiable purpose for their residence here which has a sufficient degree of continuity to be properly described as settled" (Department of Health 2007).

This is commonly understood as someone who has lawfully lived in the UK for at least a year before accessing the service. Anyone who is not "ordinarily resident" is considered an "overseas visitor" whatever their nationality. As such they are liable for charges, unless they fulfil certain criteria for exemption. Hospitals may ask for documentation to establish entitlements and individuals may choose what to supply.

Exemption criteria include:

- Currently working for an employer whose principle business is in the UK
- Self employed with principle business in UK
- In full-time study of at least 6 months or substantially funded by UK
- (exemptions also apply to spouses, civil partners and children if living in the UK permanently)
- Asylum seekers (who have formally applied for asylum)
- Anyone granted "discretionary leave to remain", "humanitarian protection" or "refugee status"
- Anyone identified (by UKHTC or UKBA) as a victim of human trafficking and their spouse/dependant children (NHS 1989)
- Members of countries with which UK has bilateral healthcare agreements are entitled to some NHS Hospital Treatment i.e. treatment required for any condition that occurred after arrival in the UK

The following treatments are free to all:

- Treatment given in an accident and emergency department (excludes emergency treatment given elsewhere in the hospital)



- Treatment given in a walk-in centre providing similar services to those of a hospital accident and emergency department
- Treatment for certain communicable diseases (excluding HIV/AIDS where it is only the first diagnosis and connected counselling sessions that are charge free) including Pandemic Flu
- Compulsory psychiatric treatment
- Family planning services

Primary care

With a few exceptions, it is the General Practitioner (GP) that facilitates access to primary care services. GPs have discretion as to whether undocumented persons, including refused (failed) asylum seekers are registered with their practice and services.

1.6. Service delivery

Service availability to migrants

Migration status is not a defining criteria for entitlement to services. Health and social care availability is the same for migrants as non-migrants, according to regulations described above. That said, it is well known that availability does not equate to accessibility or appropriateness of service. Minority groups can face a number of challenges in accessing health-enhancing conditions and services.

A variety of factors combine to influence the use by migrants of services. These include:

- Lack of clarity and changing health service environment and attitudes leading to difficulty in implementing guidelines
- Non-awareness of services available
- Language and cultural differences
- Different expectations
- Prefer to go home for treatment as entitled to specific service it is cheaper, it is more acceptable in terms of language, culture and expectation
- Lack of perceived need

Voluntary and faith organisations are often the first port of call for recent arrivals from overseas; many working as informal preventative services influencing the type and number of services used by recent arrivals and filling in gaps left by statutory services.

(See Good Practice example)



The cost of some services may impact on their use. Dental care, orthoptic care and prescriptions are charged for except for those who are exempt. People who are "ordinarily resident" and exempt include over 60s, children under 16/19 years, those on low income, those with certain medical conditions.

Example costs:

- Sight test (April 2007) £19.32
- Prescription charges (April 2009) £7.20 in England (£3.00 in Northern Ireland, £4.00 in Scotland, free in Wales)
- Dental treatment varies depending on whether provided by NHS dentist or private

Shadow practices

There seems little empirical evidence on the extent of "shadow practices". However, they are undoubtedly going on and will not be restricted to use by migrants. Anecdotal examples include obtaining advice and medication via the internet and the use of "alternative" therapists, doctors, traditional healers that may not be registered with UK professional body. It seems likely that some will be therapeutic, others harmless and others potentially harmful - particularly for the most vulnerable

2. The migration phenomena

2.1. General characteristics and extent of the migration phenomenon in the region

Estimations and calculations about the numbers of people from overseas, where they come from and how long they intend/have stayed in the UK is highly complex. It is widely recognised that there is no single source of robust migration data; nor it is currently possible to measure accurately the movement of people in and out of the UK (Audit Commission 2007; Tankard et al. 2007; Department for Communities and Local Government 2008) or the NW.

Data are collated for very specific purposes and use different criteria, measures, time-frames, terminology, definitions and there may be gaps. It is rare for data to be disaggregated by age, gender, ethnicity (and disability, belief, sexual orientation) and people may be included in more than one data set. Others, such as short-term workers who are a significant proportion of recent arrivals from overseas may not be included in any data set. National figures may not do not always reflect what is happening at local level.

UK

Both inward and outward migration have increased in the last decade. Since the mid 1990s, in a number of regions, including the NW, population movement has been a larger component of demographic change than births and deaths (NWDA 2008a). It is however difficult to measure



at regional level and the current data is more accurate in establishing trends (Institute of Community Cohesion 2007) than actual numbers.

Out-migration

- An estimated 5.5million UK nationals lived abroad in 2005 (Sriskandarajah 2006) with up to 1 million living in Spain (Holt 2009)
- Nearly half a million British nationals live for part of the year abroad (Communities and Local Government 2008)
- Nearly 1:10 British pensioners live abroad
- Between 1996 and 2005 there was an estimated total net loss of around 2.7 million British Nationals. It had been considered that this emigration would continue (Sriskandarajah 2006)
- It is difficult to verify the numbers of international in-migrants who leave the country but it has been suggested that approximately half of A8 migrants have returned to their home countries (IPPR 2008)

In-migration

- Long-term migration (intention to stay over 12 months) increased from 320,000 in 1997 to 574,000 in 2006 (Institute of Community Cohesion 2007).
- Since 2004, one in 3 of these new migrants are from the A8 countries (UKBA 2009).
- In 2004, of 582,000 immigrants to UK, 91.4% were of working age (Finney, Simpson 2009).
- Estimated that people from A8 countries intending to stay in the UK long-term (over 12 months) rose from 20,000 in 2003/2004 to 77,000 in 2004/2005, reducing to 74,000 in 2005/2006 (Institute of Community Cohesion 2007).

NW

In some aspects the national picture is reflected at regional level; to a much less extent do local situations reflect the regional picture. The picture is constantly changing. Some urban areas such as Manchester, Liverpool, Lancaster, Chester and Blackpool experience high population movement or "churn". There is migration of marginalised groups (including "undocumented" migrants) to localities of traditional migration (Institute of Community Cohesion 2007) and some areas of higher deprivation.



Factors affecting migration

Current:

- New member states of EU and (with Eire and Sweden but unlike other EU countries) the UK has not applied any limiting measures for A8 nationals to access work
- English language
- Presence of family / friends / social networks
- Invited to work
- Seen as more "tolerant" towards ethnic differences than many other European countries (Finney, Simpson 2009)
- Humanitarian crises in other countries
- British historical links
- Current policy, political & economic desire
- Accommodation of asylum seekers in areas other than the South East and London (since 2000)
- Education and work opportunities

Future:

As above and

- Restricted access to work in other EU countries will be lifted in 2011.
- Climate change
- Global economic situation and weakened pound (sterling)
- New Immigration policy including Points Based System
- Expansion of the EU

2.2. Composition of migrant flow

The range of people moving within, to and from the region is diverse; moving for a variety of reasons such as to study, to work, for a better life, to join family/friends, to seek asylum, as "trafficked" persons.

People moving within the region

Approximately 8% of households move within the region, mostly for lifestyle choices and characterised by move from urban to rural/coastal areas (NWDA 2008a). It is not clear what proportion of these might be recent arrivals to UK.



People leaving the region

There is movement of people out of the region but this more or less balances with the numbers moving into the region.

People coming into the region

- International students
 - o In 2005/06, the number of international higher education students studying in the NW was 25,345¹⁴ - approximately 25% of the recent arrivals from overseas.
 - o In 2007/08 this was 33,195 with 25% from other EU countries and 75% from non-EU countries¹⁴
 - o Predominantly in urban areas such as Manchester and Merseyside.
- Economic migrants / migrant workers
 - o Since 2004 there has been a significant increase in migrant labour in particular from the Accession countries, however
 - o The number of migrant workers from the new European countries make up a small percentage of the total number (approximately 16% nationally) (Institute of Community Cohesion 2007)
 - o Between May 2004 and March 2008, 75,000 new worker registrations were documented (UKBA 2009)
 - o There is a regional predominance of A8 workers from Poland but this is not reflected in all localities with one locality seeing equal numbers of people from Lithuania and Poland and another from Czech Republic as from Poland
 - o In 2005/06, the number of people registering for a National Insurance Number (NINo) in the NW included approximately 45% from the accession countries. In 2006/2007 51,500 foreign nationals registered for NINo (NWDA 2008a)
 - o These figures do not include the number of people who have not registered or their family and dependents. Neither does it reflect the numbers of people who may have left the region
 - o The national percentages of NINo registrations for men and women is 53.5% and 46.4% respectively and the range of countries of origin is wide.
 - o The majority of in-migrants are between the ages of 15 & 44, with the number of 15-24 year olds increasing (UK) (Green et al. 2008). A higher percentage are male but the proportion of women is increasing.
 - o People vary in their intentions to stay and actual length of stay

¹⁴ Higher Education Statistics Authority (HESA) <http://www.hesa.ac.uk/>



- Family/friends joiners
 - o Approximately 25% of recent arrivals from overseas are people coming to join family or friends (NWDA 2008a)
 - o They are predominantly from countries with which the UK has had historical links such as Pakistan, India, Bangladesh
- Asylum seekers and refugees
 - o The numbers of asylum seekers supported in dispersal accommodation in the North West fluctuated in the early years from 3,420 in 2000 to 10,310 in 2002 but has remained at between 6,000 to 7,000 up to 2007¹⁵
 - o The number of refugees in the region is not known but asylum seekers residing in the North West when granted "leave to remain" in the UK in 2007 was 1,253¹⁶
- Returning British Nationals
 - o The numbers of people who have emigrated and returned or will return to the NW is unclear
- Undocumented

At any time, there are numbers of people in the UK without documentation or recognised permission to stay. These range from visa-overstayers to clandestine migrants to trafficked persons to failed asylum seekers. For obvious reasons, the numbers are not known but recent studies suggest that the level in the UK is somewhere between those of France and Italy, i.e. 400,000-500,000 people, accounting for 14-17.5% of the total migrant population (Flynn, Williams 2007). It is reasonable to assume that this group are distributed across the UK and that an unknown proportion will live in the NW at any given time.

2.3. Migrant impact on social and economic standards

There has been broad agreement that international in-migration has a positive benefit to the British economy with net gains from remittances (Finney, Simpson 2009) and considered as fundamental to the economic development of the region, particularly given its ageing population.

There is no evidence that migrants are displacing indigenous workers (EHRC 2009) nor that increased migration has had a significant impact on the unemployment claimant count.

However, the prevailing public perception and some media presentation is probably the opposite - and this has been heightened since the economic downturn and increasing unemployment. There are reports of community tensions in some localities.

¹⁵ UK Border Agency.

¹⁶ Central Stakeholder Team, UK Border Agency.



Some localities have been accustomed to welcoming people from other countries; others less so and therefore the community response has been different. This is not necessarily related to actual numbers of migrants or the proportion they make up of the general population. Nor does it seem related to country of origin.

In some areas, there is considerable "churn" or continuous in and out-migration, impacting on service access and provision as well as continuity for service users.

Health Service impact

Since its establishment, the NHS has benefited from the work of doctors, nurses and ancillary workers from overseas. Today, the NHS and social care sectors are dependent on recent arrivals from overseas and longer-established ethnic minorities (McGregor 2007; International Organisation for Migration 2005). Of all doctors in the UK, 38% qualified abroad and nearly half of new dentists are from abroad (Bell et al. 2008).

In the UK as a whole in 2004, 44,000 health care staff from overseas were issued with work permits (TUC 2005) and in 2006 approximately 6,200 nationals from accession countries registered as care workers (Byrne et al. 2007).

There are no exact figures on the numbers of recent arrivals from overseas working in the Northwest's health and social care services, but approximately 8.4% are from BME groups of which a proportion will include recent arrivals from overseas. There are migrant workers from the A8 countries registered as GPs, nurses, doctors, medical specialists, care workers and dental practitioners (NWDA 2008a).

A local study undertaken in 2006 suggested there was little evidence that migrant workers increased strain on services apart from a reported increase use of Health Visitor services (Pemberton, Stevens 2006). Most migrants are young, usually single, paying taxes and not high users of services or benefits. A later study implied the same - with no additional strain being reported by doctors and dentists. Some health practitioners identified an increasing number of families - women and children - joining workers and the likely implications for service demand (Pemberton, Stevens 2007).

Overall, migrants as a group make few demands on health services but the impact is both service and locality specific. For example, between 2001 and 2006, one locality has seen a five-fold increase in GP registrations of people born overseas.

2.4. Migrant social determinants of health and healthcare needs

There is an increasing body of literature on the health issues of established minority ethnic groups living in the UK but accessible information on ethnicity-related health issues, attitudes and lifestyle patterns of recent arrivals from overseas - particularly for minority groups and those from refugee-generating countries is limited.



Certain issues are common to migrant workers, asylum seekers and refugees. They include:

- A desire to integrate and live life in a new community
- Separation from family and sense of isolation
- English language level influencing integration and access
- Education level is often higher than employment or non-employment reflects (Pemberton, Stevens 2006)
- Experience of exclusion and disadvantage as members of minority groups (NWDA 2008a)
- Differences in culture, beliefs, lifestyle, health practices
- Different expectations - which may be higher or non-existent - of services, including the NHS
- Lack of awareness on entitlements and infrastructures and difficulty in negotiating various systems such as transport, employment and public services
- Different experiences of health service provision in home countries, including preventative care such as screening and immunisation
- Susceptibility to stereotyping, racism, media presentation, public perception

Marginalisation and discrimination

Some men, women and children have a number of compounding factors influencing the level of marginalisation and discrimination they experience - specifically: unaccompanied children, the elderly, those of minority ethnic, faith, sexual orientation groups, the disabled (including survivors of torture) the undocumented (including trafficked, exploited, destitute) and the detained.

It seems likely that the experience of migrant workers from the accession countries (who are predominantly white) have different experiences of ethnic discrimination or racism from migrant workers and asylum seekers / refugees from elsewhere in the world (who are predominantly non-white).

Roma - the largest minority ethnic group in Europe who form a percentage of the Bulgarian, Slovakian, Hungarian, Romanian populations - have been identified as at high risk from social exclusion (NWRA 2005).

Destitution

In the NW, there is a sense that the numbers of people from abroad, experiencing destitution has recently increased and is likely to continue to do so with the changes in accessibility to services and legal employment.



Work and income

- The sectors and occupations of migrant workers vary, with higher concentrations in agriculture, manufacturing, construction, hotels and catering, health and social care (Green et al. 2008).
- Immigrants are more likely to experience employment conditions that do not meet minimum standards (Finney, Simpson 2009) and their status as new workers may place them at added risk, due to their limited knowledge of the UK's health and safety system (RR502, 2006)
- Employment rate for white immigrants is significantly higher than for the migrant population as a whole

Workers from the Accession 8 countries:

- Between 2004-2006, of those registered with Workers Registration Scheme, 78% were earning £4.50-£6.00/hr which is between 47-63% of the average UK earnings (UKBA 2009)
- Employment rate is estimated at 83% compared with 72% population in NW (NWDA 2008b)
- 80% of migrant workers in the region over-qualified for the relatively unskilled jobs they are doing

Housing

Settlement patterns for recent arrivals from overseas seem similar to those of BME communities. There are increased reports of multiple-occupancy housing with concomitant health risks. Some areas report that in-migration has led to empty housing stock being occupied and contributing to regeneration.

Refugees and asylum seekers

Abundant research undertaken with asylum seekers and refugees at local, regional and national levels confirm similar issues in relation to health and make similar recommendations. Some have been commissioned by health organisations such as PCTs, others stem from voluntary organisations or charities.

Existing determinants and previous experiences, the experiences of migration itself and conditions in the UK, combine to influence the health of asylum seekers.

Asylum seekers tend to be keen to settle into and contribute to their local community, and are likely to be regarded as good neighbours by those around them. However, some have experienced hostility from individuals within established communities.



Asylum seekers do not have permission to work during the period their application is being considered. For some, this has meant unemployment for several years with the concomitant health consequences. A recent change in the asylum system means that asylum seekers can now undertake a number of hours voluntary work.

Once refugee status or some form of "leave to remain" in the UK is granted, Home Office asylum support ends and individuals become eligible for work and state benefits. Refugees have the same rights to work and benefits as UK nationals; some may be highly skilled but barriers to employment or claiming benefits may be considerable e.g. due to limited language skills. In some cases, individuals may be left without accommodation (albeit temporarily) and therefore be more vulnerable. Families with dependent children should be able to access local authority homeless assistance as they fall within a "priority need" category.

Asylum seekers and refugees are at higher risk of developing:

- Mental health issues include depression, post traumatic stress disorder, anxiety, fear, powerlessness
- Physical issues include impairment or disability from previous injury or torture, communicable and chronic diseases, poor dental and nutritional health
- Sexual health issues include unwanted pregnancies, sexually transmitted diseases, female genital mutilation, abuse
- Maternal mortality which is 3 times more likely in women seeking asylum (Taylor, Newall 2008)

3. Policy agenda

3.1. Policy agenda at a national level

DH

The Department of Health facilitates the policy development, stakeholder networks and information dissemination on migration and health related issues. See for example "Health is Global. A UK Government Strategy 2008-13" (Department of Health 2008).

UKBA

The UK Border Agency (of the Home Office) is the body responsible for managing immigration and asylum and is part way through a five year strategy aiming to strengthen borders and simplify the processes of immigration. It has involved significant legislative and structural changes.

In 2008 a new Points-Based System was introduced to moderate international in-migration (although it does not apply to members of the EU). Applicants earn points for their skills, potential, competency in English language and ability to support themselves and dependants. Entry is via one of 5 tiers - the criteria for which is modified according to labour demand.



The Migration Impacts Forum (MIF) established in 2007 and co-chaired by the Minister for Immigration and the Minister for communities includes experts from local government, health, education, police and criminal justice system, voluntary sector, Trade Union Congress, Confederation of British Industry. It provides evidence to the government on the wider impacts of migration and suggests areas of research.

The Migration Advisory Committee (MAC), established in 2007 provides the government with independent advice specific to the labour market and where labour shortages may be filled by migration. It feeds into the Points Based System and tier criteria

Many independent organisations have specific remits in relation to migrants with the aim to influence policy. See for example IPPR¹⁷, PICUM¹⁸, MEDACT¹⁹, The King's Fund²⁰.

3.2. Policy agenda at a regional level

See previously described

- Equality and Diversity Strategy in the NW
- NW Regional Strategic Migration Partnership (NWRSMPP)
- Health and Migration in the NW report

Health Protection Agency (HPA) - Travel and Migrant Health Section, Centre for Infections:

- Infectious Disease and Migration in the NW
- Migrant workers from the EU Accession countries: A demographic overview of those
- Living and working in England and Wales and a comparison of infectious disease and immunisation rates in the Accession countries with those in the UK
- Foreign travel-associated illness - a focus on those visiting friends and relatives.

Service delivery

Numerous factors combine to influence service delivery. National policies, health strategies and Public Service Agreements (see for example those listed in the appendices) demonstrate the national and regional focus to address inequalities and promote community cohesion.

¹⁷ Institute for Public Policy Research

<http://www.ippr.org/>

¹⁸ Platform for International Cooperation on Undocumented Migrants

<http://picum.org/en>

¹⁹ MEDACT

<http://www.medact.org/>

²⁰ The King's Fund

<http://www.kingsfund.org.uk/>



Equality Impact Assessments are applied across all areas of strategy development, planning and service delivery. This ensures that the specific needs of marginalised groups, including migrants, are considered.

There has been much work to increase the accessibility to health for BME groups. In some localities this has expanded or developed to incorporate new migrants. In other areas, new projects have been developed. See good practice examples as well as below:

- Guidance on healthcare provision for asylum seekers and refugees produced by DH and various voluntary organisations
- Awareness-raising amongst practitioners and policy makers of information sources such WHO²¹ and Mighealthnet²² and national networks such as JISCMail²³ and Race for Health²⁴
- Multi-agency forum functioning at local level - coordinating activities and information-sharing around migration issues
- Close collaboration between statutory and voluntary organisations working with people who are HIV+ve or who have AIDS
- Ongoing work to ensure that the additional time required by GPs seeing asylum seekers or patients requiring interpreters is reflected through Quality Outcome Framework (QOF) and income.
- Joint government and voluntary organisation work such as Refugee Integration & Employment Service, which supports refugees to integrate and become economically self sufficient.

Sources of Finance in addition to PCT Allocations

- Migration Impacts Fund raised through increased fees for (non EU) immigration / visa applications. For use by local service providers to manage transitional impacts of recent migration and promote innovative management.
- Ongoing work with countries with bilateral healthcare agreements
- Department of Health funding for regional use in research, development, work towards incorporating and sustaining migrant health issues within establishment.

²¹ World Health Organisation

<http://www.who.int/en/>

²² Mighealthnet

<http://www.mighealth.net/>

²³ National Academic Mailing List Service (JISCMail)

<http://www.jiscmail.ac.uk>

²⁴ Race for Health

<http://www.raceforhealth.org/>



4. Good practices and projects

Community Cohesion and Wellbeing - Developing the NHS Contribution

Developed by the Department of Health North West and the North West Strategic Health Authority, this document will be published in autumn 2009

The document invites NHS Boards and senior executive teams to examine what their organisations are doing to foster community cohesion. It challenges organisations to work on the agenda consistently and strategically, in partnership with other agencies and groups, to address inequalities and promote equality and diversity.

The NHS executive are asked to take Ten Challenging Questions into their own organisations and to find answers through conversations with staff, patients, carers, the public and partner organisations. These discussions will focus on how the NHS can add value to what is already happening in local areas to develop community cohesion and on how the NHS can play a greater role in influencing this agenda.

Polish Migrant Community Support Project

In the last couple of years, there has been a significant number of people from Poland living and working around Crewe. A development project with community outreach posts was set up with a number of activities, including creating mechanisms for easier access to services. Through working together, it was noted there appeared to be a high prevalence of smoking within the community.

Smokefree Northwest²⁵, working with members of the community, the PCT, Crewe and Nantwich borough council, Cardio-Wellbeing and the Health Promotion Foundation in Warsaw are part way through a project aimed at reducing that prevalence. Funded by the Department of Health, there is a strong emphasis on community involvement and a particular focus on pregnant women. Three phases include:

- profiling patterns of smoking behaviours and attitudes, social and behavioural barriers to cessation. Comparison of reports between Polish and UK Stop Smoking Services and bringing together different models
- the development of a toolkit for Stop Smoking specialists and Midwives working with Polish communities
- the consolidation of links between each country service and development of a proposed link between European Quitlines

Aspects of the first phase have been achieved through focus groups and a survey of over 500 participants. It has shown that 53% of men and 43% of women smoke and that 62% of households with children are not smoke-free. The survey has served as a baseline and

²⁵ Smoke Free Northwest <http://www.smokefreenorthwest.org/>



highlighted some key issues for service providers and for the toolkit development. These include:

- The need for a service provided in Polish
- What information would be useful in written format
- How services could be modified to address specific needs of Polish community

The full report is available on request.

Liverpool Patient Profiling Initiative²⁶

In Liverpool, Patient Profiling has become core business for 97 GP practices within the PCT. The enhanced profiling incorporates ethnicity, language, religion and access needs for all newly registered patients and those on disease registers. General Practices are offered support, training and tool kits. The tool kits include data collection templates, information on BME health, leaflet advice in different languages and community group contacts.

The project has contributed to geographical profiling and confirmed that local communities include people from 279 different ethnic groups, from 147 countries with 81 different spoken languages, 48 read languages and 54 religions.

By cross-matching the profile information with CHD, BMI, Diabetes and smoking status, a much clearer, more useful and equitable picture has been obtained; differences in ethnicity-related health status and gaps in health care can be identified. The process has enabled improved service provision and reduction in health inequalities through:

- Enabling equitable commissioning
- Developing health equity audit tools
- Ensuring services are relevant
- Identifying "hot spots" for health promotion and targeted services
- Helping PCTs and general practices better understand patients

A project that has taken a number of years to become incorporated into mainstream practice, it nevertheless clearly demonstrates the importance of enhanced profiling in supporting equitable planning and response to a diverse and changing population.

²⁶ http://www.raceforhealth.org/resources/library/patient_profiling/liverpool_pct_patient_profiling_report_2007



REACHE Northwest²⁷

Reache NW works with NHS organisations and higher education bodies to assist asylum seekers and refugees in registering appropriate professional health related qualifications and seeking employment in the NHS.

It provides support in a number of ways which may include career guidance, English language courses, CV and interview preparation, access to computers, clinical updates, apprenticeship and work placements for doctors, nurses, dentists, pharmacists and other allied professionals.

For one doctor who qualified in his home country and gained a paediatric specialism in France, REACHE has provided "overwhelming support" during the 5 years it took him to meet GMC requirements. He is now happily working as a clinical medical officer.

Based at Salford Royal NHS Foundation Trust and funded by NHS Northwest, the Refugee and Asylum Seeker Centre for Healthcare Professionals Education (REACHE Northwest) has been recognised for innovation and excellence in healthcare, winning awards for Education and Training and as Outstanding Learning Providers.

Wigan Homeless and Vulnerable Persons Team

The needs of specific vulnerable groups of people and a gap in services was identified in Wigan a number of years ago. In partnership with the strategic health authority, local authority, voluntary and faith groups, the PCT service has been evolving and now incorporates a team including community nurses, mental health nurses, health visitors, support workers, assistant practitioners and a GP.

The team work in close collaboration with other organisations and the work is pro-active and outreaching. A nurse-led "One-Stop Shop" offers health needs assessments, food, clean clothes, health-promoting and diversionary activities, peer support plus some GP consultations.

Team members have a special interest around specific marginalised groups such as BME, homeless, asylum seekers, travellers, Roma and recent EU migrants as well as in themes such as alcohol, substance misuse, domestic violence, alternative therapies. The project is an example of how recommendations from national policies such as those addressing social exclusion, NHS improvement, sustainable communities and health inequalities can be implemented at a local level.

The project in its current form has been in existence since September 2008 and has a number of objectives including:

- Mapping the community wellbeing needs and opportunities
- Providing interpretation at existing "drop in" services
- Influencing mainstream services in addressing specific needs

²⁷ Refugee and Asylum Seekers Centre for Healthcare Professionals Education (REACHE)
<http://www.reache.wordpress.com>



- Preventing rough sleeping and alleviating destitution
- Improving access to primary care and medical treatment
- Empowerment through advice and information-sharing on health and wellbeing

Performance indicators including attendance and referral numbers, satisfaction surveys and case studies are collated to contribute to the annual evaluation. Previous reviews have demonstrated the positive impact on the health and wellbeing of marginalised individuals.

For more information, contact the team: homeless@alwpct.nhs.uk

Cheetham Hill Advice Centre²⁸

Cheetham Hill Advice Centre has been serving the people of Cheetham and Crumpsall for over 30 years. Managed by a local voluntary committee and supported by partners it has developed and responded to the changing local population. The centre aims to "enable local people to make their own decisions about their life and future and bring about improvements in their standard of living" and wellbeing. It provides help, advice and support on a wide range of issues such as benefits, employment, housing, consumer, financial and family concerns, immigration and asylum, education, access to health and other local services.

Last year, several families from Eastern Europe who were living together in overcrowded, unhealthy accommodation were supported to find appropriate housing, access to work, schools and health services.

Local residents are actively encouraged to become involved as volunteers and training is offered. One recent arrival from overseas describes how "volunteering gives him the opportunity to help others ... and ... has made him part of a community".

Welcome Packs

Partnerships within Lancashire have developed Welcome Packs²⁹ for people moving to the area from overseas and other parts of the UK. The packs have been adapted and translated for the specific needs of the different communities in East Lancashire (English, Polish, Czech and Lithuanian), Lancaster (English, Chinese and Polish), West Lancashire (English, Portuguese and Polish) and South Ribble (English and Polish); they include useful information on health and well-being, employment, housing, police and emergency services, local services and community networks, financial, education, travel. The health and well-being section outlines how to register with a GP, access emergency services, NHS Direct, pharmacies, dental and optician services.

²⁸ <http://www.cheethamadvice.org.uk/>

²⁹ <http://www.lancashire.gov.uk/corporate/web/view.asp?siteid=2966&pageid=6037&e=e>



West Lancashire³⁰ has had several years' experience of welcoming migrant workers to the area. A welcome pack was designed in 2005 as part of a multi-agency strategic plan which also included outreach work.

The pack has recently been updated and includes additional requested information following consultations with migrant workers. They considered the pack to be "really useful" and the revised format will be launched in October. Packs will be distributed to GPs, employers, churches, schools, libraries.

How to use the NHS

The Black Health Agency³¹ has produced a short film clip on "How the NHS works" for refugees, asylum seekers and other recent arrivals from overseas. Filmed in English, but with voice-overs in French, Polish, Arabic, Somali, Urdu, Sylheti, Kurdish and Farsi/Dari, the film clip is available in DVD format and via the internet. It covers simple messages such as registering with a GP, keeping appointments, requesting interpreters and using NHS Direct for advice. The film was written by a GP working with asylum seekers, and most of the acting and voice work was done by refugee health professionals giving their free time to help their own communities. It is hoped that more languages will be added in the future.

5. Conclusions

Recent arrivals from overseas in the NW experience similar health and well-being issues to the rest of the UK population - many of which are related to wider determinants such as level of income and social inclusion. Their health and well-being is affected by age, gender, genetic factors, ethnicity, country of origin, circumstances of migration, circumstances in the UK and lifestyle as well as individual resilience and coping factors.

The EU expansion and larger than expected in-flow of migrants from accession countries has brought migration issues into the spotlight. This rapid increase in numbers and demographic change (where people are coming from, their language, cultural and socio-economic characteristics) has been one of the key challenges for service providers and planners. In particular, in localities that have not been accustomed to international in-migration and cultural diversity. It has also stimulated innovative practice and adaptations.

It is perhaps too early to determine the impact of the economic downturn on migration flows but it is likely that the region will experience continued demographic change and diversity. The attention on recent international migration, is therefore an opportunity to build on lessons learned and the good practice developed. It offers an opening to further the NW's vision of "Health for All" in the NW, to continue the drive towards reducing inequalities in health access, service and outcome.

³⁰ <http://www.westlancsdc.gov.uk/business.aspx>

³¹ The Black Health Agency <http://www.thebha.org.uk/>



Challenges

- Improving data collection and analysis which relates determinants such as ethnicity, country of origin, language, access needs to health access and outcome.
- Establishing workable models of combining existing data with qualitative information for improved community profiling and service provision planning.
- Managing the implementation of guidance following review of entitlements to health care for overseas visitors, and being seen to be fair, given the polarised views.
- Mitigating the potential public health risks associated with restricted health care access.
- Supporting the NHS role in addressing prejudice toward migrants.
- Generating, pooling and making accessible, information on health and cultural issues increasingly likely to be encountered.
- Equipping practitioners to manage diverse and changing health behaviours.
- Ensuring that recommended practice in relation, for example, to asylum seekers and refugees becomes part of the mainstream work; is supported at strategic level and is adequately resourced.
- Availing of opportunities for economic and social investment within depressed economic climate.
- Supporting services to become robust in managing demographic change and increasing diversity.
- Balancing the need to recruit and retain migrant workers in health and social care with considerations of responsibilities to sending countries.
- Ensuring migrants are considered in regional health strategies such as smoking cessation, alcohol reduction, healthy eating and exercise.
- Resourcing the voluntary organisations, community groups, individual friends and contacts that offer considerable support, facilitate access to statutory services and mitigate negative impact for migrants.
- Determining and addressing the implications of "churn" in areas of deprivation and inequalities.
- Addressing social determinants of health within specific groups such as underemployed Somali and Yemeni men, such as educational underachievement of some migrant children.



Appendices

Regulations and legal framework

Regulations / Legislation	Notes
1951 Refugee Convention	The UK has been party to the convention since 1954.
Human Rights Act 1998	The Human Rights Act came into effect in the UK in October 2000 making the 1950 European Convention on Human Rights enforceable (Department for Constitutional Affairs 2006).
The Equality Bill 2009 (to become statute in 2011)	Brings together and amends existing legislation in order to harmonise and strengthen the law to reduce discrimination and support progress on equality (Government Equalities Office 2009). It will place a duty on some public authorities to consider socio-economic disadvantage and undertake equality impact assessments including the "strands" of gender, age, ethnicity, disability, religion or belief, sexuality, transgender.
Equality and Human Rights Commission ³²	A statutory body that has the responsibility to protect, enforce and promote equality across the seven "protected grounds" of age, disability, gender, race, religion and belief, sexual orientation and transgender.
The Council of Europe Convention on Action Against Trafficking in Human Beings	Came into force in the UK on 1 April 2009 and aims to prevent and combat trafficking in human beings; identify, protect and safeguard the rights of victims of trafficking; promote international co-operation against trafficking.
The NHS Constitution for England ³³	First NHS constitution, launched in January 2009. Establishes the principles and values of the NHS in England; setting out the rights, responsibilities, duties and pledges for staff and patients. All NHS bodies and suppliers of NHS services will be required by law to take account of the constitution in decisions and actions.
Local Information Networks (LINKs)	NHS bodies (SHA, PCTs, NHS Trusts and NHS Foundation Trusts) have a legal obligation to involve service users and community members. Local Involvement Networks (LINKs) are independent bodies set up to give a voice to local people on health and social care services. NHS organisations are required to respond to recommendations made by LINKs.

³² <http://www.equalityhumanrights.com/>

³³ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093419



Regulations / Legislation	Notes
NHS (Charges to Overseas Visitors) Regulations 1989 and The NHS (Charges to Overseas Visitors) Charging (amendment) Regulations 2004 ³⁴	Sets out the regulations and basis for guidance to hospitals and Primary Care. Currently under review by the Department of Health and Home Office.
Borders, Citizenship and Immigration Bill (Jan 2009 - may become an Act in summer 2009)	Aims to strengthen the border by providing better integration of customs and immigration functions; ensure migrants earn the right to stay by implementing the new "Path to Citizenship".

Relevant Health and Wellbeing strategies and guidance

- Commissioning framework for health and well-being (2007) Department of Health³⁵
- Our Shared Future (2007) Commission on Integration and Cohesion³⁶
- Our NHS Our Future: NHS Next Stage Review - Leading Local Change (2008) Department of Health³⁷
- Tackling Health Inequalities: A Programme for Action (2003) Department of Health³⁸
- The NHS in England: The operating framework for 2008/9 (2007) Department of Health³⁹
- Independence, Well-being and Choice: Our Vision for the Future of Social Care for Adults in England (2005) Department of Health⁴⁰
- Commissioning framework for health and well-being (2007) Department of Health⁴¹

³⁴ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4080313

³⁵ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604

³⁶ <http://image.guardian.co.uk/sys-files/Education/documents/2007/06/14/oursharedfuture.pdf> (pdf 1.2 Mb)

³⁷ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084644

³⁸ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008268

³⁹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094

⁴⁰ http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4106477

⁴¹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604



Sources of information and data relevant to migration

From the Office of National Statistics:

- Migration Indicators for local authority areas in England & Wales⁴²
- Population by Country of Birth and Nationality⁴³

From the Department of Work and Pensions (DWP):

- National Insurance Number (NINo) allocations to adult overseas nationals⁴⁴

From the Higher Education Statistics Authority (HESA):

- International students in higher education⁴⁵

From PCTs: New registrations with GPs with previous address outside the UK

From Local Authorities: Pupil Level Annual Schools Census

From the UKBA

- Workers Registration Scheme (WRS) (migrant workers from A8 countries)
- Seasonal Agricultural Workers Scheme (SAWS)
- Work Permit (migrant workers from outside the EEA)
- Asylum seekers

From Local Sources:

- Local surveys
- Community and migrant groups
- Church and faith-based organisations
- Citizen's Advice Bureaux
- Libraries
- Housing Associations, Landlords
- Local Authority Departments & Schools
- Health Services
- Police & Fire Service
- Employment Agencies
- Electoral Register

⁴² <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-52298>

⁴³ <http://www.ons.gov.uk/ons/publications/all-releases.html?definition=tcm%3A77-21594>

⁴⁴ <http://www.dwp.gov.uk/asd/tabtool.asp>

⁴⁵ <http://www.hesa.ac.uk/>



- Commercial sources
- Trade Unions

Relevant Public Service Agreements

- PSA 3 Ensure controlled, fair migration that protects the public and contributes to economic Growth
- PSA 9 Halve the number of children in poverty by 2010-11, on the way to eradicating child poverty by 2020
(NI 116: Proportion of children in poverty)
- PSA 12 Improve the health and well-being of children and young people
- PSA 15 Address the disadvantages that individuals experience because of their gender, race, age, sexual orientation, religion or belief, disability
(NI 140: Fair treatment by local services)
- PSA 18 Promote better health and well-being for all
- PSA 19 Ensure better care for all
- PSA 21 Build more cohesive, empowered and active communities
(NI 1: % of people who believe people from different backgrounds get on well together in their local area)
(NI 2: % of people who feel that they belong to their neighbourhood)
(NI 4: % of people who feel they can influence decisions in their locality)



Countries and their nationals' rights to movement and work in the UK

EU 15 Countries - Spain, Sweden, Greece, Portugal, Ireland, Austria, France, Germany, UK, The Netherlands, Italy, Luxembourg, Denmark, Belgium, Finland.

EU15 nationals can enter other member states without a visa for a period of up to 6 months, therefore no entry requirements to UK required. Free movement rights. Full rights to work.

European Economic Area - European Union Countries, Norway, Iceland, Liechtenstein.

No entry requirements to UK required. Free movement rights. Full rights to work (except for nationals of Accession Countries - see below)

Accession 10 Countries (May 2004) - Malta, Cyprus, A8 Countries

No entry requirements to UK required. Free movement rights. Full rights to work (except for nationals of A8 Countries - see below)

Accession 8 Countries (May 2004) - Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia

No entry requirements to UK required. Free movement rights. Restricted access to work in EU countries during transitional period until 2011. Unlike other EU countries, the UK has not applied any limiting measures for A8 nationals to access work. May need to register with WRS

Accession 2 Countries (Jan 2007) - Romania, Bulgaria

No entry requirements to UK required. Free movement rights. Transitional measures regulating access to work. Require accession worker card unless exempt

Commonwealth Countries - 53 countries

Require visa to enter UK which may include conditions such as being able to maintain and accommodate themselves and dependents without recourse to public funds. May enter as worker (work permit required), or self-employed, student, working holidaymaker, retired person, as a spouse, civil partner or fiancé of someone entitled to reside in UK.



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Regional Office for Europe
Regions for Health Network



Migrants and Health Care: Responses by European Regions (MIGHRER)

Complete reference material

VI. Regional report Sicily

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¹ CEFPAS, Caltanissetta, Sicily



Summary

In Sicily 2% of total population are migrants. The family context is changing. Many migrants arrive by sea. The increase of the arrivals coincides with an increase in the number of victims. Many children and high level of school dispersion. Region of transition because it doesn't offer many job opportunities for foreigners.

The Sicilian Regional Government has issued several directives to the Regional Health Service organisations regarding the provision of "essential and continuative treatments" to the immigrant population. These include:

- Regional Law n. 5/2009 on Health Care Assistance to Foreigners coming from outside the EU countries;
- Regional Law n. 55 of 1980 on New Provisions in Favour of Emigrant Workers and their Families;
- Decree of the Health Councillorship of the Sicilian Region Guidelines for the Health Care of Foreigners coming from outside the EC countries;
- Sicilian Region Circular 17 April 2008 regarding health care assistance to the new EU citizens living in Italy.

Regional Program of Social and Socio-Health Policies 2010-2012 aims to strengthen the integration between social policies, labour policies and macro-economic policies, within a framework of economic and social development that is balanced and sustainable. The intention is to develop roads to integration and to improve the employment of the disadvantaged and to fight all forms of discrimination in the labour market

One of the most important projects currently underway at regional level is the European project "Praesidium IV". The general aim of the project is to strengthen the capacity of reception of illegal immigrants who land at Lampedusa and at other places on the coasts of Sicily. This is done through information activities and legal counselling about rights and duties of immigrants.

Another project is "ASASI" aiming to open a "Health Point", an ambulatory that, in specific hours and on certain days, provides free health care to those who are temporarily in Sicily and have health problems. In this ambulatory cultural mediators, from the University of Messina, work on the simplification of doctor/patient relationship and to give immigrants information about health services.

The "Liaison Project" provides free courses of the Italian language and culture for foreigners (150 hours) with the aim of acquiring linguistic, cultural and civic-legal skills.

Many research on epidemiological observatory on migration, on violence, on training for socio-health professionals who work with elderly people, on health inequalities, etc. is also being done.



1. Health system overview, national and regional situation

1.1. Health system functions

In Italy, health protection, as a fundamental right of individuals and in the interest of the population, is provided for in Article 32 of the Constitution and it is guaranteed through the National Health Service (SSN), in respect of the dignity and freedom of human beings. Established by Law n. 833 of 1978, the Italian SSN provides health care to all citizens irrespective of gender, residence, age, income and employment. The key principles on which the SSN is based are:

- public responsibility of health care;
- equity of access to health services for all;
- global coverage, based on the need of assistance of each person, according to what has been established as essential health care assistance;
- public financing through general taxation;
- equal rights of care in all regions irrespective of the patient's residence.

The SSN provides an access to services in accordance with the principles of human dignity, health needs, equity, quality and appropriateness of health care and economy in the use of the resources (effectiveness and efficiency). The population has freedom of choice of professionals and places where to receive health care among the accredited public and private organisations and exercise their "right to health" in order to obtain health services for prevention, care and rehabilitation.

The SSN is governed mainly by the State and the Regions. State legislation has the task of determining the essential levels of assistance that must be guaranteed on the national territory. The Regions are responsible for providing health care.

A "White Paper on the Fundamental Principles of the National Health Service" was produced for the thirtieth anniversary of the SSN, by the Ministry of Health to describe the organization and activities of the SSN.

Following the constitutional "subsidiary principle", the SSN is structured according to the various levels of responsibility and governance:

- central level - the State has the responsibility of assuring all citizens the right to health through the essential levels of assistance;
- regional level - the Regions have the direct responsibility for governing health assistance and the related costs in order to achieve the National health objectives. The Regions have the exclusive jurisdiction in the regulation and organization of services and activities for health protection. They also have established the criteria for funding the Local Health Trusts and Hospital Trusts.

The SSN is composed of organisations and bodies at different institutional levels which contribute to the achievement of the health goals of citizens. These include the Ministry of Health and others national institutions:



- National Council of Health (Consiglio Superiore di Sanità - CSS)
- National Institute of Health (Istituto Superiore di Sanità - ISS)
- National Institute for Occupational Health and Safety (Istituto Superiore per la Prevenzione e Sicurezza del Lavoro - ISPESL)
- National Agency for Regional Health Services (Agenzia nazionale per i Servizi Sanitari Regionali - AGENAS)
- Scientific Institutes for Research and Healthcare (Istituti di Ricovero e Cura a Carattere Scientifico - IRCCS)
- Veterinary Research Institutes (Istituti Zooprofilattici Sperimentali - IZS)
- Italian Drug Agency (Agenzia italiana del farmaco - AIFA)

It includes also institutions at local level:

- Regions and Autonomous Provinces
- Local Health Trusts
- Hospital Trusts

1.2. Structural organization in Sicily

In April 2009 the Sicilian Regional Government issued a new law for the re-organization of the Regional Health System (Regional Law n. 5/2009 Norms for the Re-organization of the Regional Health System). This law, a major reform, marks a new path for the Sicilian health sector in order to end a long lapse characterised by inefficient and ineffective health care delivery in the region.

The Regional Ministry for Health of Sicily, within the national general frame, and with the possibility given by the autonomous status of the Sicilian Region, include additional requirements, means to pursue the following general objectives:

- to develop regional policies and plans in order to guarantee to the population equal levels of access to basic assistance and care;
- to carry out activities of direction, co-ordination and supervision;
- to evaluate the performance of the Local Health Organisations through appropriate outcome indicators;
- to coordinate the Health Information System;
- to realize the integration of health and social services;
- to identify and quantify the resources to be allocated in order to satisfy the needs included in the levels of assistance and defined in programmes and projects directed to specific populations.



The Regional Health Minister establishes the health programs and investments at regional level in a three-year document - The Regional Health Plan.

Through the executive plans, the Provincial Health Trusts (ASP) and the Hospital Trusts (AO) develop their operational health plans, based on the Regional Health Plan, defining the activities to be carried out within the limits of their available resources.

The Regional Health Service (SSR) provides citizens with health services for diagnosis, care and rehabilitation, prevention activities and health promotion. These services are provided through: 9 Provincial Health Trusts (ASP), 3 Regional Hospitals Trusts, 2 National Highly Specialized Hospitals (ARNAS), 3 University Hospitals and other public and private health organizations accredited by the SSR. Each ASP is composed of hospital districts (total 20), which are aggregations of more hospitals.



The Health Districts represent the territorial articulation of the ASP and provide preventive, diagnostic, treatment and rehabilitation services, as well as health promotion.

The territorial assistance services will ensure the extensive provision of assistance in the following areas:

- primary care (reception, basic and specialist health services);
- public health services integrated with social assistance;
- services for minors and families with complex needs;
- mental health services;
- drug addiction recovery services (SERT).

The Hospital Trusts, as national and regional references, ensure highly specialized services through advanced and innovative diagnostic and therapeutic technologies.



The Sicilian Region ensures immigrants (with or without a resident permit) the right of access to preventive services and to maternal and child health care, including access to vaccinations and emergency services. Health care workers have no obligation to report illegal immigrants to the competent authorities.

In the year 2003, the Sicilian Government issued Guidelines for the Health Assistance of Immigrants from non-EU Countries (DA n. 1270/03). Through these guidelines, in each public Health Trusts, specific clinics have been created to provide illegal immigrants with:

- primary care
- social assistance services
- issuing of the Foreigners Temporarily Present (STP code)
- specialist examinations
- diagnosis and treatments

It is important to note that services for immigrants are addressed mainly to illegal immigrants, as those who have a regular residence permit may turn to general practitioners (MMG), just as Italian citizens do.

The Immigrants' Services are present in 5 out of 9 ASP in Sicily:

- In Palermo - the "Civico" Public Hospital and the "Buccheri La Ferla" Hospital (plus a specific outpatient department reserved for immigrants), the "P. Giaccone" University Hospital (plus a specific outpatient department), the "V. Cervello" Public Hospital and the ASP (only for issuing STP code; in districts n. 13 and 14 there are outpatient departments reserved for immigrants).
- In Catania - the ASP, the "V. Emanuele" Public Hospital, the "Garibaldi" Public Hospital (plus a specific outpatients department) and the "Cannizzaro" Public Hospital (plus a specific outpatients department).
- In Messina - the ASP and the "Papardo" and "Piemonte" Public Hospitals.
- In Ragusa - "Médecins sans frontières" (MSF), in agreement with the ASP, has opened specific outpatient departments within the Health Districts of Santa Croce Camerina, Vittoria, Scicli and Ispica.
- In Caltanissetta - the ASP.

The organisations that provide services for immigrants at regional level are:

- The Regional Centre of reference and coordination for Migrant's Medical Services, within the Department of Clinical Medicine and Emerging Diseases of the "P. Giaccone" University Hospital in Palermo. This Centre is involved in the training and updating in the field of migration medicine, working closely with the Regional Health Inspectorate and its groups that have specific competences (the Social Medicine Group and the Regional Epidemiological Observatory). In agreement with the Regional Health Inspectorate, the Centre has also the task of coordinating all volunteer health care



activities for the health care of foreigners living in the Region, those coming from EU and non-EU Countries alike.

- Regional Health Inspectorate where the Social Medicine and Regional Epidemiological Observatory groups work.
- National Reference Centre for the promotion of migrant populations' health and for the adoption of the measures to contrast diseases linked to poverty, located at the "San Giovanni di Dio" Public Hospital in Agrigento, in collaboration with the National Institute for Health Migration and Poverty (INMP), which currently provides outpatient medical services to guarantee basic health care to migrating populations and to contrast endogenous situations of health and social vulnerabilities.

Health care for regular immigrants

Foreign citizens residing in Italy with a valid residence permit are entitled to health care services provided by the SSN, with equal treatment and equal rights compared to those of Italian citizens. In order to obtain health care, the foreign citizen must register with the SSN at the ASP of the area of residency to:

- choose the general practitioner and the family paediatrician,
- obtain medical certificates and requests for tests and specialist check-ups,
- request home care assistance,
- receive mandatory vaccinations.

The ASP issues a health care card, which is the document that proves the registration with the Regional Health System.

There are two types of registration with the SSN:

- Compulsory registration - All legally employed foreigners provided with a residence permit must apply for their registration with the National Health Service at the ASP office of the Municipality of residence. Health care assistance is also provided to family members living with the applicant, provided that they are legally present in Italy. This assistance is also provided for: foreigners with a residence permit who are in Italy for family reason, for political asylum, for human rights asylum, for request of asylum, for adoption, for those who have requested citizenship. An immigrant is entitled to register with the SSN even in the case of renewal of the residence permit. Since the 1st of January 2000, imprisoned foreigners are automatically registered with the SSN for the period of detention, whether they are regular or illegal immigrants and they are excluded from the payment of the health ticket. Semi-custody convicts or those undergoing alternative measures of punishment are also registered.
- Voluntary Registration - in the case of legal immigrants who are not obliged to register with the SSN, these must take out a health care policy with an insurance company. Otherwise they can voluntarily register with the SSN.



Compulsory or voluntary registration with the SSN is valid for the duration of validity of the residence permit. A payment is required for the registration with the SSN. Foreigners with a permit for studies must pay a reduced fee. Registration with the SSN is free if the foreigner is:

- unemployed with a residence permit and listed in unemployed persons departments;
- refugee with a valid certificate declaring the refugee status and the asylum application;
- married and dependant of an Italian citizen;
- minor with a parent resident in Italy and belonging to one of the categories listed above.

Health care for irregular immigrants

The foreigner who does not comply with the regulations required for residency, because of not having a residence permit or whose permit has expired 60 days previously, is entitled to urgent or essential hospital and outpatient health care, even if continuative, for illnesses and injuries, in public hospitals and in those operating within the SSN.

In order to receive medical care, it is necessary to apply for a STP card (Foreigners Temporarily Present) at any ASP, that is valid for a period of 6 months and can be renewed. Access to health services does not require any type of reporting to public authorities, except in serious cases where a medical report is necessary, and this also applies to Italian citizens. For example, reporting is required for reasons of public order or if the health care was necessary due to criminal offences (e.g. wounds from weapons).

Those having a STP card are entitled to basic primary health care, to emergency and non-emergency hospitalization and to day-hospital admissions. In particular, the following services are provided:

- outpatient and hospitalized care, emergency or essential services, even if continuative, for illnesses or injuries.
- preventive medicine treatments and health care services related to them, in order to assure individual or collective health, such as protection during pregnancy and motherhood, health protection of minors, vaccinations, international prophylaxis, diagnosis and treatment of infectious diseases, prevention activities, treatment and rehabilitation for drug addiction.

Family Health Services

Family Health Services (FHS) are located at each ASP and provide free assistance. FHS provide assistance and information related to drug addiction, mental disorders, motherhood and childhood assistance, vaccinations, preventive controls, etc. FHS are required to assist all pregnant women, even those without a residence permit, and their children until adult age. FHS also provide health care services to women with other gynaecological problems. FHS provide



health care services regarding: family mediation and adoption information services, vaccination against rubella in women of childbearing age, and so on.

Intersectorial actions

A key role of health care for immigrants is played by voluntary associations that are affiliated with the LHS. These include:

- "Missione di Speranza e Carità" in Palermo, in agreement with the ASP, provides immigrants medical, nursing and specialist assistance in 3 communities. Volunteer doctors make daily medical, surgical as well as specialist examinations (eye, ears, dental, ENT, dermatological and paediatric); nursing care is also given to chronically ill patients who need specific and frequent health care assistance.
- "Emergency" which, thanks to the "Migrants" project, opened an outpatients clinic in Palermo in April 2006 to provide free health care to immigrants (with or without a residence permit) and to residents in need. Almost all health and non-health care and administrative personnel work on a voluntary basis without a salary. In association with the ASP of Palermo, the outpatient clinic offers the following services free of charge: medical care, dentistry, ophthalmology, paediatrics, obstetrics and gynaecology, cardiology and metabolic diseases, psychological - neuropsychiatric support, ENT, dermatology, infectious diseases, public health orientation.
- The Inter-institutional Observatory dedicated to the social condition of the population in the city of Palermo is run through the collaboration between the City of Palermo and the Union of Councils for Social, Health and Labour Policies. This Observatory responds to the need to implement a structured system for collecting, processing and divulging information on the socio-health and labour conditions of that area.
- In May 2009 the "Intercultural Outpatients Department" was opened at the "Buccheri La Ferla" Hospital in Palermo. This is a clinic which deals with obstetrics, gynaecology, paediatrics and neonatology. Once a week it gives free health care to immigrant mothers and children of Palermo without a residence permit, but in possession of the FTP code. A team of gynaecologists, obstetricians and paediatricians, with the support of a cultural mediator is present. The initiative, proposed and organized by the Citizens in the World Association, in collaboration with the "Buccheri La Ferla" Hospital, is funded by regional financing.

1.3. Health information system

The sources for the collection and analysis of data on the socio-health field can be divided into three main categories:

- the ministerial statistical sources - These data are provided by the Ministries responsible for the reception, residence, employment, recognition of professional qualifications or current professional studies: Ministry of Health, Ministry of Education, University Education and Scientific Research, Ministry of Labour and Ministry of Interior. The



Immigration Database, published on-line by the National Council for Economy and Labour (CNEL) is elaborated by the Immigration Statistical Caritas / Migrants Dossier. The databases on health care are provided by the National Institute of Statistics (ISTAT) and the Epidemiological Observatory Department of the Sicilian Region (DOE);

- the labour market sources - These are the databases elaborated by the National Insurance Institute for Occupational Accidents (INAIL) and are used for recruitment; data provided by the National Institute for Social Security (INPS) are used for remuneration and contributions, and data provided by "Unioncamere" - Ministry of Labour Excelsior Information System - are used to estimate the annual needs of additional immigrant manpower;
- the category sources - various professional bodies, institutions and associations working in the Italian socio-health sector, among which, the Italian Association of Medicine for Immigrants (SIMM), provide these data.

The following are the main data sources consulted:

- Caritas. Dossier statistico immigrazione 2007
- Caritas/Migrants. XVIII Rapporto sull'immigrazione Dossier 2008
- CNEL. Ricerca sugli indicatori dell'integrazione in Italia e in Europa 2008
- ISTAT. La popolazione straniera residente in Italia 2007
- ISTAT. La popolazione straniera residente in Italia 2008
- Ministero dell'Interno. 1° Rapporto sugli immigrati in Italia 2007
- Sistema di protezione per richiedenti asilo e rifugiati (SPRAR). Rapporto annuale del Sistema di protezione per richiedenti asilo e rifugiati 2007/2008
- IRES-FILLEA CGIL. II Rapporto "I lavoratori stranieri nel settore edile" 2007
- Rapporto dell'Osservatorio salute 2007 - Società Italiana di Medicina delle Migrazioni
- Rapporto IRES CGIL. I volti del sommerso. Percorsi di vita dentro il lavoro irregolare. 2007
- Lavori minorili nelle grandi città italiane. Sintesi dell'indagine realizzata dall'IRES CGIL, in collaborazione con l'Osservatorio sul lavoro minorile. 2005
- IRES CGIL e Save the Children. Minori al lavoro. Il caso dei minori migranti. 2007
- IRES CGIL. Lavoratori immigrati nel settore delle costruzioni. Emanuele Galossi e Maria Mora (a cura di) Primo rapporto dell'osservatorio sui lavoratori immigrati nel settore delle costruzioni in Italia. 2005
- IRES. Combattere le discriminazioni in Europa: esperienze di lotta contro le discriminazioni verso le donne migranti. 2001



Websites:

- the National Centre for the prevention and control of diseases (CCM) of the Ministry of Labour, Health and Social Policies <http://www.ccm-network.it>
- the Epidemiological Department Observatory of the Sicilian Region <http://www.doesicilia.it>
- the National Epidemiology, Surveillance and Health Promotion Centre http://www.epicentro.iss.it/focus/globale/immigrati_istat05.asp
- the Italian Ministry of Finance <http://www.finanze.it>
- INMP - the National Institute for Health Migration and Poverty <http://www.inmp.it/index.php/eng>
- the Italian Ministry of the Interior <http://www.interno.it/mininterno/export/sites/default/en/index.html>
- the Citizens' Portal <http://www.italia.gov.it>
- the National Statistics Institute <http://www.istat.it/en/>
- the Inter-institutional Observatory regarding the social condition of the city of Palermo <http://www.osservatoriopalermo.it>
- Italian Police <http://www.poliziadistato.it/articolo/10619-English/>
- the Immigration Portal <http://www.portaleimmigrazione.it>
- the Sicilian Regional Government <http://pti.regione.sicilia.it>
- the Italian Observatory on global health <http://www.saluteglobale.it>
- the Italian Association of Medicine for Immigrants (SIMM) <http://www.simmweb.it>
- the Italian Ministry of Social Solidarity <http://www.solidarietasociale.gov.it>
- the new citizens' portal <http://www.stranieriinitalia.it>

Laws on health information

The Italian legislation regarding health protection of citizens is among the most advanced in Europe, as it extends the right to health and health care to all the people present on the Italian territory. This includes foreign nationals living in conditions of irregular residency, assuring them emergency, essential and continuative health care and preventive medicine, the same health care services as those available to Italian citizens. Immigrants can find information on the regulations regarding health care at the following web sites that can be consulted free of charge:

- the Italian Ministry of Health <http://www.salute.gov.it/>
- the Health Regulations portal <http://www.normativasanitaaria.it>



- the Italian Ministry of the Interior
<http://www.interno.it/mininterno/export/sites/default/en/index.html>
- the Citizens' Portal <http://www.italia.gov.it>
- the Immigration Portal <http://www.portaleimmigrazione.it>
- the Italian Ministry of Social Solidarity <http://www.solidarietasociale.gov.it>
- the Italian Association of Medicine for Immigrants (SIMM)
<http://www.simmweb.it>
- the Sicilian Regional Government <http://pti.regione.sicilia.it>

Information is also available at the local Immigration Health Groups (GRIS), which are territorial units of the Italian Association of Medicine for Immigrants (SIMM), with the aim of:

- providing information and promoting debates on specific national and local regulations, on initiatives regarding public services and on voluntary and private social services;
- networking services, people, skills and educational and welfare resources;
- developing political-organizational proposals;
- carrying out "advocacy" consultancy within the institutions.

The "Rainbow Window" has been operative in Palermo since February 2008. It is an information service run by the Citizen Defence Movement and by the Consumers' Movement and it is funded with resources from the Ministry of Social Solidarity. Thanks to this project 17 offices have been opened across the national territory to support immigrants who reside in Italy. The objective of this project is to protect foreign citizens in Italy by informing them about their rights and guaranteeing their active participation in the development of the society where they live. The information is supplied by: a website, multi-lingual vademecum handbooks, a free-phone number 800 912637 and information leaflets distributed by the immigrant communities, city halls, province authority offices and internet points.

1.4. Regulations and legal framework

At a national level

The provision of health care for foreigners in Italy is regulated by National Law n. 40/98. In regard to the provision of primary health care, the Italian Regions were delegated the task of organizing health care services, namely, establishing who will provide health care and where it will be provided, by the National Law n. 394/99.

The Italian Government has implemented European laws with regard to immigration:

- Leg. Decree n. 30/2007 - Implementation of the Directive 2004/38/EC regarding the right of citizens of the EU and their family members to move freely in all EU State Member territories



- Leg. Decree n. 140/2005 - Implementation of the Directive 2003/9/EC which establishes the minimal laws regarding the acceptance of those requiring asylum in the EU States

The principle legislative reference at national level includes:

- Law n. 68/2007 - Regulations regarding short stays of foreigners on business, on holiday and for study
- Law n. 7/2006 - Provisions concerning the prevention and prohibition of female genital mutilation practices
- Law n. 296/2006 - Finance Act 2007 c. 1267 - Establishment of the Fund for social inclusion of immigrants
- Law n. 189/2002 (Legge Bossi-Fini) - Modification of the law regarding immigration and asylum
- Law n. 40/1998 - Rules and regulations regarding immigration
- Law n. 91/1992 - New regulations regarding citizenship
- Law n. 176/1991 - International Convention regarding minors' rights, ONU 1989;
- Leg. Decree n. 195/2002 - Urgent regulations regarding the legalization of irregular immigrant labour
- Leg. Decree n. 286/1998 (Legge Turco-Napolitano) and further modifications - National law regarding the regulation of immigrants
- Decree n. 174/1991 of the Ministry of Health - Regulations establishing criteria and standards for the application of Law. N. 39/90 which allows foreign citizens with nursing qualifications acquired in their homeland to take up nursing within the National Health Service
- Decree 8 October 2008 of the Ministry of the Interior - Formation of a Central Body for the protection of unaccompanied EC minors and for the implementation of the bilateral Agreement between Rumania and Italy on the issue of Rumanian unaccompanied minors
- Ministry of the Interior and Ministry of Justice 7 December 2006 - Directives regarding foreign unaccompanied minors applying for asylum
- Circular prot. n.1363 of 2 April 2009 issued by the Department for Civil Liberties and Immigration of the Ministry of the Interior - Local Councils for immigration
- Joint Circular of the Ministries of the Interior and Labour, Health and Social Policies n. 1, 14 January 2009 - Transitional arrangements concerning the rights to employment of Rumanian and Bulgarian citizens
- Circular prot. n. 1706 of 11 April 2008 and Circular prot. n. 762 of 13 February 2008 - Agreement Protocols among the Ministry of the Interior, the Ministry of Social Solidarity and National Associations representing employers regarding the activities of the Immigration Assistance Offices



- Circular prot. n. 16 of 14 June 2007 - The monitoring of intolerance, racism, xenophobia and anti-Semitism events
- Notice of the Ministry of Health n. 3152, 19 February 2008 - Specification regarding health care assistance to E.C. citizens living in Italy

At a Sicilian level

The Sicilian Regional Government has issued several directives to the regional Health Organisations regarding the provision of "essential and continuative treatments" to the immigrant population. These include:

- Regional Law n. 5/2009 - Norms for the re-organization of the Regional Health System - Art. 28 - Health care assistance to foreigners coming from outside the EC countries
- Regional Law n. 55/1980 and further modifications - New provisions in favour of emigrant workers and their families
- Regional Law 2 March 2009 - "Regional Program of the Social and Socio-Health Policies 2010-2012" which regards programming of activities suggested for the period covering from 2010 to 2012
- Decree of the Health Councillorship of the Sicilian Region (D.A.) n. 1270 of 4 July 2003 - Guidelines for the health care of foreigners coming from outside the EC countries
- D.A. n. 30447 of 28.10.1999 - Recognition of the Regional Reference Centre for travellers', tourists' and migrants' Medical Care
- Sicilian Region Circular 17 April 2008, prot. DIRS/2/0781 Note of the Ministry of Health 19 February 2008. "Clarifications regarding health care assistance to the new E.C. citizens living in Italy"

1.5. Service delivery

Health care to legal immigrants is provided through public or private and accredited institutions belonging to the Regional Health Service (SSR) and through volunteer centres, the same institutions and associations that provide care and assistance to Italian citizens.

Irregular migrants, on the other hand, receive hospitality and health care in centres that are often managed by the major catholic or lay voluntary associations such as: Caritas, Emergency, the National Association of Emigrant Families (ANFE), the "Santa Chiara" of Palermo Association, Migrantes, the Hope and Charity Mission Association of Palermo, the "Astalli" Centre Association (Italian branch of the Jesuit Refugee Service) of Catania and Palermo, the "Madre Speranza" Centre entrusted to the "Apostle Saint Philip" Association of Caltanissetta, and many other minor associations that operate locally.

The facilities that accommodate and assist illegal immigrants are divided into three types:



- Reception Centres (CDA) (Law n. 563/95) which are infrastructures designated to guarantee first aid to illegal immigrants. The accommodation in these centres is limited to the time that is strictly necessary to establish the identity and the legitimacy of the immigrant's stay in the area. The centres currently operating in Sicily are:
 - o Agrigento, Lampedusa - 804 places of accommodation (First Aid and Accommodation Centre)
 - o Caltanissetta, Pian del Lago Quarter - 360 places of accommodation
 - o Syracuse, Cassibile - 200 places of accommodation
 - o Trapani, Pantelleria - 25 places of accommodation (First Aid and Accommodation Centre)

- Reception Centres for Asylum Applicants (CARA) (DPR n. 303/2004 - Leg. Decree n. 25/2008) which are infrastructures that accommodate, for a period that varies from 20 to 35 days, foreigners applying for asylum, who are not in possession of an identification card or who have escaped from the border control. Their permanence in the CARA allows the authorities to finalise the formalities for the identification of the foreigner or for the definition of the procedures for granting them the status of refugee. The Centres currently operating in Sicily are:
 - o Caltanissetta, Pian del Lago Area - 96 places of accommodation
 - o Trapani, Salina Grande - 260 places of accommodation

By decree of the Minister of the Interior, the CDA's of Bari and Syracuse are also used as CARA.

- Identification and Expulsion Centres (CIE) which are infrastructures used for the detention of illegal immigrants awaiting expulsion. These Centres are intended to prevent the dispersion of illegal immigrants in the territory and allow Police authorities to enact the expulsion measures issued against illegal immigrants. The maximum length of stay of the foreigners in these Centres is totally 60 days. Centres currently operating in Sicily are:
 - o Caltanissetta, Pian del Lago Area - 96 places of accommodation
 - o Trapani, Serraino Vulpitta - 31 places of accommodation

The activities of the CIE are planned by the Central Directorate of Civil Services for Immigration and Asylum and are managed by institutions, associations and cooperatives conventioned with the Local Government Offices (Prefetture - Uffici Territoriali del Governo). Services provided through these conventions are:

- o Assistance to the person
 - assistance to the persons (accommodation, personal supplies, etc.)
 - health care



- psycho-social assistance
- Cultural and linguistic mediation
- Catering
- Cleaning and environmental hygiene services
- Facility and installation maintenance.

An important role is carried out by the Protection System for Asylum Applicants and Refugees (SPRAR), established by Law n. 189/2002, and run by the network of Local Authorities. The aim of SPRAR is to implement territorial projects of reception and integration of immigrants, using the National Fund for Asylum Policies and Services (FNPSA). Local Authorities, with the fundamental support of the private sector, provide "integrated reception" assistance, that is more than the mere distribution of food and accommodation (known as material reception services). They provide also legal and social guidance to improve the socio-economic integration of immigrants. In Sicily the SPRAR network has realised 14 territorial projects, promoted by Local Authorities, that have ensured reception to refugees, to those who have applied for asylum and humanitarian protection.

On a national and local basis, the following organizations are also engaged in the field of immigration:

- The Italian Society for Migrant's Medical Care (SIMM), established in early 1990, is a national "policy network" for the exchange of experiences, data and scientific evidence. The organization's objectives are to:
 - promote, connect and coordinate health services in support of immigrants in Italy;
 - promote activities aiming to increase studies and research on migrant's medical care;
 - provide a forum for exchange of national and international information and methods to approach immigrant patients;
 - sponsor educational activities in the field of health care of immigrants.

Over the years, doctors, psychologists, anthropologists, sociologists, nurses, cultural mediators, and other Italian and foreign health and social care professionals have joined the SIMM. There was the emergence of local groups (GrIS) organized in regional networks for immigration. Actually Territorial Units of the SIMM have been organized in order to place knowledge and information in a network, to maximize welfare strategies and to promote policies and initiatives in favour of "health care without exclusions".

They are present in various Italian Regions: Lazio, Trentino, Sardinia, Sicily and Lombardy.



- The National Association of Public Assistance, a national organization that comprises 850 volunteer associations, distributed over Italian territory, operating in all fields of population assistance.
- The CeSVoP, one of the Centres for Volunteer Services established in accordance with the Law on volunteer services n. 266/91. It aims at supporting the activities of volunteer organizations, promoting their growth, consolidation and qualification, free of charge. In Sicily, there are 3 Service Centres which were established in 2001: the CeSVoP for the Provinces of Agrigento, Caltanissetta, Palermo and Trapani, the CSV Etneo for Catania, Enna, Ragusa and Syracuse; the CESVI for the Province of Messina. The associations that have formed the CeSVoP are: Regional ANPAS Sicily, Regional MoVI Sicily, Regional Auser Sicily, Regional G.V.V. Sicily, Regional Arciragazzi Sicily, Regional AVULSS Sicily, the Life Help Centre of Palermo, Bagheria, Partinico, Trapani, Mazzara del Vallo, Gela, Regional AVIS Sicily.
- The "Santa Chiara" Association of Palermo which has provided socio-legal support for immigrants over the past 20 years. In close collaboration with the Oratory of "Santa Chiara", it carries out assistance for the basic needs of children, families and immigrants through food and clothing distribution services, consultations regarding bureaucratic matters, health care assistance, reception and accommodation.
- The provincial sections of the Caritas voluntary association for those in need. In particular: the "Cittadella di Carità" (citadel of charity) in Caltanissetta, provides medical, legal, social and psychological consultations in support of the most disadvantaged people. The "Cittadella di Carità" promotes activities such as:
 - o assistance, through a medical staff consisting of 25 doctors specialized in general practice, pneumology, cardiology, gynaecology, dietetics, urology, dermatology, oncology, otorhinolaryngology, eye care for children, orthopaedics, pregnancy and post-pregnancy dietary care. The medical staff is supported by 19 volunteers: 16 nurses and 3 community entertainers. A tax advisor, 2 psychologists and 4 civil lawyers are also part of the assistance team.
 - o prevention: an average of 4-5 courses on "health training and information" and an "anti-smoking" course are carried out yearly.
 - o interventions on drug addiction, placing of people who seek help for drug problems in Drug Addiction Services, Day Centres, Associations for self-help, ect.
- MSF (Médecins sans frontières)
- Emergency
- Associations for Legal Studies on Immigration
- Federation of all Medical Councils
- Social Workers Association
- Psychologists' Association



- National Federation of Nurses and Obstetrician Boards
- The Italian Global Health Observatory
- Migrantes
- ANFE - Associazione Nazionale Famiglie Emigrati (National Association for Emigrated Families)
- Astalli Centre Association (the Italian office of the Jesuit Refugee Service)
- Mother Teresa of Calcutta Sisters
- Various NGOs.

Service availability to migrants

Law n. 40/1998 provides compulsory membership to the SSN for legal foreigners living in Italy; it defines the modalities for voluntary registration and for the drawing up of insurance policies. The same health care provided for Italians is also available to immigrants with a valid residence permit.

For foreign citizens on the national territory, not in compliance with the entry and residency regulations, Foreigners Temporarily Present (STP) "are insured essential or emergency first-aid and hospital treatment, even continuative, for illnesses and injuries. These services are provided in public and accredited institutions. Programs of preventive medicine to guarantee individual and collective health are also extended to illegal immigrants and those not registered with the SSN".

Among the insured benefits to illegal immigrants, the following services are guaranteed:

- social protection during pregnancy and maternity
- minor's health protection
- vaccinations
- international prophylactic interventions
- prophylaxis, diagnosis and treatment of infectious diseases.

These health services are provided at the decentralized Regional Health Service facilities, such as outpatient clinics of the Provincial Health Services, health districts, hospitals and the accredited organisations affiliated with the Regional Health Service.

Shadow practices

There is no information available regarding this topic.



2. The migration phenomenon

2.1. General characteristics and extent of the migration phenomenon in the region

Due to its geographical position, Italy represents one of the points of entry into Europe for African migrants. Since the nineties, the Trapani and Lampedusa coastlines have been particular landing points for immigrants coming from Tunisia. Today immigrants come from all over the Maghreb area even from sub-Saharan Africa. Currently Sicily is a crossroad for Mediterranean migrants.



The data of the Ministry of Interior show that, between January and August 2008, 20,967 migrants have arrived in Italy by sea, 55% more than the previous year (13,529 people came during the same months in 2007). Among these, 19,323 immigrants arrived in Sicily for a total of 346 landings on the Sicilian coastlines.

The majority of migrants arrive in Lampedusa. The Coast Guard, Revenue Officers and the Navy are engaged in intercepting all the boats at sea escorting them to Lampedusa, where migrants are retained before the completion of all the bureaucratic procedures. Not all these boats are intercepted.

Over the past 5 years, an increase in arrivals of migrants on the island of Lampedusa has been registered: in 2003 they were 8,800, 10,477 in 2004, 15,527 in 2005, 18,047 arrived in 2006 and 11,749 in 2007. In 2008, as many as 31,250 arrived on the island. Out of the total number of adult immigrants, 86% (21,002) are men and 14% (3,389) women.

The immigrants, who arrived by sea in Italy, between January and August 2008, were from: Somalia (19.36%), Nigeria (17.62%), Eritrea (11.76%), Tunisia (9.05%); Ghana (7.13%), Algeria (6.73%), Egypt (5.68%), Morocco (4.46%), the Ivory Coast (2.12%) and India (1.76%). This shows that, together with the change in landing sites there has been a change in departure points as well. Currently there is a strong prevalence of migrants from African countries, while other migrants are arriving from the Middle East and South-East Asia.



The increase in arrivals coincides, inevitably, with an increase in the number of victims. 387 victims of the sea were declared by the press in the first half of 2008; in 2007 556 were declared by the press for the whole year. Since 1988, the total number of victims in the Canal of Sicily have been at least 2,962.

With regards to minors, the most represented countries of origin are: Egypt (25%), Eritrea (15%), Nigeria (13%) Palestine (11%) and Somalia (9%). There is also a significant number of minors coming from Tunisia (7%) and Ghana (6%), and a very small number from Morocco (2%) and Togo (2%). This may suggest that the Egyptian migration towards Lampedusa is heavily or almost exclusively characterized by a very young population and that, in most cases, they represent an important resource in terms of economic support to their families at home.

Unaccompanied minors arriving in Lampedusa are generally between the ages of 16 and 17, but there are others even younger (13 and 14 years). In general, unaccompanied minors are mostly boys - approximately 90%. In particular, almost all children coming from Egypt are male, while the unaccompanied female minors come mainly from Nigeria, Eritrea and Somalia.

According to the Ministry of the Interior, not more than 15% of the immigrants now living in Italy without a residence permit have arrived by sea. The others are overstayers, who have entered Italy with a tourist visa that later expired. In 2007 the Italian Government requested the entry of 170,000 foreign workers and 80,000 seasonal workers.

According to the United Nations High Commissioner for Refugees (UNHCR), almost 60% of the 14,053 requests for political asylum applied for in Italy in 2007 were from immigrants who landed on the Italian coastlines. Of these, 10% of the applicants were accepted and 47% received humanitarian protection.

Today, in Italy, an "exclusive system of reception" has been organized, with a specific course for asylum applicants and immigrants entitled to "international protection". With this model of cooperation between central and local administration, the Ministry of the Interior and the network of Municipalities have acquired a main role in the development of policies and strategies in this field. This system of reception has been found to be extremely positive with regard to social integration.

Targeted projects have been developed aiming at vulnerable individuals such as unaccompanied minors seeking asylum, pregnant women, the elderly, single parents, the disabled and those who have suffered physical, psychological or sexual abuse. In 2008, the "exclusive system of reception", with 114 projects set in the territory in 92 municipalities, 7 Provinces and 19 Regions, has reached a reception capacity of 2,541 places.

Every year a decree is issued by the President of the Council of Ministers which regulates the entry flows of foreign seasonal workers inside the jurisdiction of the State (the last is the "flow decree" in 2009): the Ministry of Labour, Health and Social Policies awarded Sicily 5,700 entries in 2009, 1,395 more compared to the 4,305 entries in 2008.



Given the nature, mainly economic, of migration flows coming to Italy, the immigrant population tends to concentrate in areas that offer the greatest opportunities for employment, that is in central-northern Italy. The immigrant presence, in any case, appears widespread throughout the country, even in areas less attractive in terms of pure economic productivity.

Compared to the territorial attractiveness index, which measures the potential of each local context to attract and permanently retain as many immigrants as possible, Sicily lies in the minimum range, in 15th place on a national ranking. The indicator of immigrant receptivity shows a prevalence of flows toward the central-North areas and a prevalence of the outflows from the South: Sicily is located at the bottom of the list with a negative balance equal to - 8.9 (-1,319 immigrants), highlighting how this region does not offer many job opportunities for foreigners. These data are also confirmed by the labour requirement index, regarding the percentage of applications submitted during the flow decree (through which you determine the annual entry quota of foreign workers in Italy), according to which, Sicily still ranks at the bottom of the list (3.14% - 15,754 applications submitted) with percentages almost half of the national average (8.47%).

2.2. Composition of migrant flow

On the 1st of January 2008, there were 98,152 immigrants living in Sicily (48,055 males and 50,097 females), 2% of the regional population. The male - female ratio, distinctly in favour of men in the past, is counterbalancing, due to a slow but progressive increase in family rejoining. Immigrants are prevalently young people with an average age of 29.1 years old.

Palermo is the province with the highest number of immigrants, that is 21,242, followed by Catania with 17,027, Messina with 16,034 and Ragusa with 14,275.

A great number of immigrants come from Europe (38,831), mainly from Rumania (17,470), Albania (5,874) and Poland (4,475). 25,951 immigrants come from North Africa, and the Maghreb region is the origin of the highest number of them: Tunisia (14,803) and Morocco (9,374). There are 7,806 coming from Sri Lanka, 4,520 from China, 3,684 from the Philippines and 8,432 from the rest of Eastern Asia.

About 50,955 immigrants have obtained a residence permit in Sicily. The reasons given for application were mainly for employment (56.7%), family (30.9%), humanitarian (5.6%), study (1.7%), religion (1.2%), asylum or asylum requests (1% and 0.4%), for health reasons (0.5%), and for other reasons (2%).

Many immigrants (1,307) have obtained Italian nationality (470 males and 837 females). Also the family context is changing, in fact in 50,581 Italian families there is at least one foreign component and 38,870 families have a foreign head of family.

Foreign children under 18 in Sicily reach a total of 20,876 (10,748 males and 10,128 females), 21.3% of the immigrant population. The main areas where immigrant children are living are: Palermo (5,330), Catania (3,439), Messina (3,345) and Ragusa (3,052). About 6,328 foreign children have been born in Italy.



There has been a steady increase in the presence of foreign students in Sicily over the past few years, even if the percentage was higher than in Northern Italy. For the school year 2007/2008 there were 14,726 students registered in Sicilian state schools. Of these, there were: 2,581 in infant schools, 5,883 in elementary schools, 6,262 in secondary schools (3,356 in middle schools - first 3 years - and 2,906 in higher education). Considering the country of origin, 6,327 foreign students came from European countries, 4,597 from Africa, 2,637 from Asia, 843 from America, together with a small group coming from other countries.

The data on school dropout of foreign students in State public schools of the Sicilian region, with reference to the school year 2004/2005 (5,758 foreign students in total), are as follows:

School Orders	Deviance	Abandonment	Dropouts	Not Promoted	Global Dispersion Index	Total Foreign Students
Elementary School	1.30%	0.33%	0.18%	2.25%	4.01%	2,765
Middle School (from the age of 11 to 14 years)	1.80%	0.69%	0.84%	7.49%	10.61%	1,894
Secondary School	2%	2.46%	1.64%	15.70%	20.66%	1,099

In primary school, for example, 4.01% of total dispersion is about five times more than the dispersion observed in the general school population (0.67%). Even in the other school orders, there is a more serious situation of dispersion of foreign students (middle school 10.61% versus 5.29% - secondary school 20.66% versus 15.76%). It is obvious that the observation of this data on foreign student dispersion must be commensurate with the general situation of precariousness, transitoriness and discomfort in which the families of immigrant children are found. The data regarding the situation of minor nomadic children reveals that they have a particular influence on the percentages of deviance and abandonment.

2.3. Migrant impact on social and economic standards

During the 90s, there was a high and growing demand for additional labour from the Italian labour market: currently one recruitment out of four is in favour of a worker born abroad, specially in some working fields. The recent statistics from the National Institute for Social Security (INPS) shows that the foreigners employed in looking after the elderly and disabled, approximately 5 out of 6, are about 500,000 and this figure is likely to increase in the future.

Other important working fields are construction and agriculture, in which the contribution of non-EU workers is becoming more and more constant throughout the country. In particular, the



main areas where immigrants are employed are those of services (42.9%), especially in hotels and restaurants, fishing and agriculture (19.2%), and trade (14.6%).

Here is a list of the areas of employment of INAIL (National Insurance Institute for Occupational Accidents) employees born abroad (2007):

Area of Employment	Employed	%	New Recruitments
Fishing and Agriculture	13,149	19.2	4,296
Industry	7,574	11	1,880
Metallurgy	1,465	2.1	458
Textile	346	0.5	82
Food	2,181	3.2	653
Mechanics	435	0.6	116
Other kind of industries	3,147	4.6	571
Building	8,462	12.3	2,591
Trade	10,015	14.6	2,210
Services	29,394	42.9	6,860
Enterprises	4,842	7.1	901
Families	3,051	4.4	1,131
Hotels and restaurants	9,043	13.2	2,866
Transportation	2,167	3.2	344
Other kinds of services	10,291	15	1,678
TOTAL	68,594	100	17,837

Considering the country of origin of the regular employees, the largest percentage comes from European countries (57.9%), mainly from the former 15 EU countries (24.4%) and the new 12 EU countries (22.3%). 18.3% comes from North Africa, while only 9.5% comes from Asia.



Table of the countries of origin of those employed by the INAIL, born abroad (2007)

Country of Origin	Employed	%	New Recruitments
UE 15	14,698	24.4	1,519
New 12 UE	15,263	22.3	10,970
Central - Eastern Europe	4,979	7.3	866
Other European countries	4,752	6.9	303
<i>EUROPE</i>	<i>39,692</i>	<i>57.9</i>	<i>13,658</i>
North Africa	12,584	18.3	1,706
Western Africa	1,008	1.5	161
Eastern Africa	1,765	2.6	162
Central - Southern Africa	137	0.2	10
<i>AFRICA</i>	<i>15,494</i>	<i>22.6</i>	<i>2,059</i>
Western Asia	159	0.2	28
Central - Southern Asia	4,161	6.1	911
Eastern Asia	2,167	3.2	431
<i>ASIA</i>	<i>6,487</i>	<i>9.5</i>	<i>1,370</i>
North America	2,105	3.1	149
Central - South America	3,883	5.7	526
<i>AMERICA</i>	<i>5,968</i>	<i>8.7</i>	<i>675</i>
<i>OCEANIA</i>	<i>638</i>	<i>0.9</i>	<i>34</i>
Not Declared	295	0.4	41
TOTAL	68,594	100	17,837

Considering those working in the health sector, there are about 12,000 doctors who are foreigners. These come mainly from the EU countries and their number will not increase significantly in the future because Italy has already a high number of qualified Italian doctors who are unemployed. Foreign nurses, instead, are mostly non-EU citizens and their number is bound to increase quite significantly, either because the ageing of the Italian population exerts greater pressure on the health care system, or because young Italians are no longer attracted to this kind of work. It is therefore easy to imagine a scenario in which the health care of the Italians in its most demanding forms, i.e. in cases of hospitalization or care for the elderly, will be increasingly characterized by a "foreign presence".



Analyzing the process of immigrant integration in Italy, based on social indicators (access to housing, school dropout, family reunification, citizenship acquisition, deviance levels) and employment indicators (employment, professional standards, labour income, rate of entrepreneurship), it appears that the areas of central and northern Italy (and particularly the north-east) are those that, in absolute terms, have the highest potential for socio-occupational integration of immigrants. However, the integration processes of immigrants in Italy have the best chances to occur in smaller areas rather than in great urban centres, where the heavy demographic concentration and its resulting complexity, makes the process of integration much more difficult.

The index of potential socio-occupational integration of Sicily is high in both absolute and relative terms, in fact the Region comes between the 8th and 7th place. In Sicily the living conditions between native and immigrant populations shows little difference. Considering the Sicilian provinces, it appears that Catania and Palermo are those that provide greater integration; Syracuse, Agrigento, Messina and Trapani are in mid-range, and Ragusa, Enna and Caltanissetta rank at the bottom of the list.

Considering the index which measures the level and quality of immigrant integration employment in the local market, Sicily is at the 11th place in a national ranking. This is a mid-range ranking. The immigrant workforce employed in Sicily is about half the national average (5.65% in Sicily, and 12.5% in Italy). This low percentage is also influenced by the fact that there are fewer available jobs in the Region as compared to the rest of Italy (Source: *VI Report on Immigrant integration in Italy* (2009) of the CNEL (National Council for Economy and Labour)).

However, it must be noted that some immigrants occupy important positions in the work market. In Sicily 14.37% occupies these positions (managers and personnel) against the 7.49% at the national average.

For the Indicator of Entrepreneurship, i.e. the percentage of company owners, using the over 18 population reference, Sicily is in the middle range with 4.75% (4,237 immigrants holding companies), compared to the national average of 4.35%. The national data regarding 2008 shows the vitality of immigrant entrepreneurship, which continues to increase, despite the overall downward trend of small businesses run by Italians. This reveals a workforce and an entrepreneurial ability among immigrants and their perseverance and resistance. In detail, it has emerged that there has been an increase of non-EU businesses in all the Sicilian provinces, except Enna, whose figure remains unchanged. In all the other provinces there has been a decline in the Italian entrepreneurships. The highest percentage of immigrant businesses in total, is in Palermo (5.6%, 3,410 companies), followed by Ragusa and Messina. The majority of owners of companies run by immigrants are Moroccans (they were 3,464 in 2007, and 3,618 in 2008). Also the number of small Chinese businesses is increasing (there were 1,608 in 2007, and in 2008 they numbered 1,757).

This shows that in Sicily, immigrant workers are given the opportunity to establish themselves professionally: those who produce represent a resource that should be valued and defended, because they effectively contribute in maintaining the economic and production system. In fact,



starting businesses, not only gives life to the labour market, but also produces wealth (in terms of GDP) and integration (there are some companies run by non-EU immigrants in which Italian nationals are employed).

As for accidents at work, an increase of 17% in recruitment was registered in 2004 in Sicily compared to that of 2002. The accidents that have occurred in this category of workers have increased significantly if compared to the statistics in 2001: there was, in fact, an increase of 41% in the Region and 57% in the entire nation. The greatest number of injuries that occurred in the industry and services field with 560 cases. The province mostly concerned is Ragusa (260 cases), which traditionally employs foreign workers in the activities related to greenhouse crops. Followed by the provinces of Messina and Catania.

On a national level non-EU workers earn an average of €11,712 per year while Italian nationals earn €18,943. In Sicily, a non-EU employee receives an annual average income of €9,059.10, placing the region in a minimum range. The wage gap between non-EU workers and all the workers in the same territories is nearly €6,000.

For workers employed in the health sector, the salary for immigrant nurses, in the case of regular recruitment, is the salary provided for the category by the National Collective Agreement (CCNL) or the one provided in the private contracts of "social cooperation". The latter contracts are those with less advantageous economic and regulatory treatment. Social cooperation covers 90% of the social welfare field and nurses who provide service in cooperative associations, compared to their colleagues recruited directly from public health organisations, have more working hours (165 hours against 156), lower salaries and often are not entitled to any kind of further indemnities. In Northern Italy, salaries are an average 20-25% lower compared to the hospital nurses and elsewhere even more than 42%. Furthermore the salaries of nurses working in the cooperatives are not the same throughout the Italian territory. For their first professional experiences, foreign nurses generally earn a net monthly salary of around €1,100.

One aspect that is taken into great consideration, is the fact that many medical graduate refugees have great difficulty, once in Italy, in having their scholastic qualifications acknowledged in order to be included in the Italian health organisations: there are some doctors with many years of work experience who are limited to low-skilled occupations such as petrol-pump attendants, labours and caretakers, etc.

2.4. Migrant social determinants of health and health care needs

The most frequent pathologies are those which regard: stomach/bowels, heart, orthopaedics, urology, the respiratory system, infectious diseases and gynaecology. Health professionals have difficulties in creating therapeutic relationships (assistance and care), depending on the lack of specific training courses based on linguistic and cultural aspects. Trans-cultural medicine becomes more and more important to increase levels of comprehension between different cultures.



The "Salgari's syndrome" does not exist: there are very few imported pathologies (tropical diseases) and there is a minimum risk of any kind of transmission to the hosting population.

Risk factors related to poverty depend on the precarious living conditions, insufficient attention in the work place and unbalanced alimentation. Psychological disadvantages are related to: lack of psycho-affective support and cultural uprooting. There are also difficulties in gaining access to social health services (judicial, bureaucratic, organisational, inter-relational barriers), and absence of services linked to cultural needs in the Local Health Trusts.

In general, hospital care for immigrants is mainly related to physiological events (pregnancies) or accidents (traumas), and this may indicate that the population has fairly good health.

Specific studies on the health determinants of immigrants have not been carried out. The data of studies, conducted on a national level, have all been grouped together, therefore, it has not been possible to point out information in a regional context. There are no disease-specific registers for immigrants or health prevention programs dedicated to them. Immigrants are provided with the same services and benefits provided to Italian nationals, so all data is recorded together with that of the native population.

3. Political agenda: the generations of resources and continuing medical education

3.1. Policy agenda

In April 2009 the Sicilian Region issued the Regional Law n. 5 - Norms for the Re-organization of the Regional Health System - Art. 28 on health care to non-EU citizens - guarantees urgent and essential hospital and outpatients care to all those who are in the region, without distinction of sex, race, language, religion, political opinion, personal and social conditions. This is without involving any kind of notification to the authorities, unless it is mandatory due to legal provisions by law and with the same procedures provided for Italian citizens.

Subsequently, the Regional Minister of Health has sent circulars to public Health organisations clarifying that in order to protect the right to individual and collective health, access to health structures to all foreign citizens, even if not in compliance with the rules of residency, must be guaranteed and there is the absolute ban on any kind of report to the authorities, except in cases in which - with equal conditions to Italian citizens - a medical report is required.

The circulars also provide managers with the information regarding access to urgent and essential health services, in order to standardize health care to all EU citizens residing in Italy who have not got the requirements to be registered with the health service. "The right to health care, urgent or essential, even if continuative due to illnesses and injuries, including preventive medicine programs to protect the individual and collective health" must be assured to these citizens. In particular, the services that must be guaranteed are pregnancy, motherhood, child health protection, mandatory vaccinations and prevention, prophylaxis, diagnosis and treatment of infectious diseases. The public health care organisations must issue to EU citizens an "ENI"



code (European members not registered in the Italian National Health Service) that will be necessary to receive health care, and to request that the expenses for the treatment be covered by the patient's country of origin.

Stewardship

The Sicilian Region, 2 March 2009, published the "Regional Program of Social and Socio-Health Policies 2010-2012" regarding the planning of the resources of the National Fund for Social Policies of the years 2007-2009, with initiatives to be addressed also to immigrants.

The Councillorship for the Family, Social Policies and the Local Authorities of the Sicilian Region, in line with the targets of the so-called Lisbon Strategy and National Strategic Framework for the period 2007-2013, aims to strengthen the integration between social policies, labour policies and macro-economic policies, within a framework of economic and social development that is balanced and sustainable. In fact poverty and social exclusion are also distinguished by multi-dimensional peculiarities and elements that require the necessary coordination and involvement of all the governmental levels and the stakeholders involved. In the section III of this Law - Social inclusion - of the Regional Operational Program ESF 2007-2013, the global goal is "Promoting social inclusion, providing opportunities and resources necessary for full participation of all in socio-economic life and culture". The intention is to develop roads to integration and to improve the employment of the disadvantaged and to fight all forms of discrimination in the labour market, through activities designed to:

- enhance social integration and prevent the occurrence of poverty through strategies which aim to provide employment;
- give greater support to people who are disadvantaged with regard to employment and training opportunities;
- improve care services by supporting immigrants' integration through active labour market policies.

Service Delivery

As for the social, cultural and linguistic integration of immigrants, there is no data available on the initiatives undertaken at regional or local level. In the main provinces of the Sicilian Region, many Italian language courses for foreigners are organized each year, by private schools or voluntary organizations, in order to give them the opportunity to learn Italian with qualified teachers and personalized programs.

At the level of regional institutions, there is a marked interest in the spread of the Italian language among non-EU citizens, a basic requirement to enhance the process of social integration of immigrants. In fact, the Immigration Service of the Regional Labour Councillorship has recently issued a document calling for the funding for a project of teaching the Italian language to immigrants.



An interesting initiative is the opening of the "School of the Italian Language and Culture for Foreigners" within the University of Catania, which organizes four-week courses for foreign students in Italy under the Socrates project.

There is even an Italian Language School at the University of Palermo where foreigners participating in the Erasmus project and other immigrants can learn the Italian language.

In order to facilitate the social integration of immigrants, special offices are active in all the Local Government institutions to guarantee them several services related to residence permits, family reunification, search for accommodation, etc.

Similar activities are carried out at the premises of the main labour unions.

In the health sector, cultural mediators are present in some hospitals and local health organisations, such as at the General Hospital in Palermo and at the AUSL of Ragusa. One of the main goals for the improvement of health care to immigrant populations in the Sicilian Region is helped by the inclusion of cultural mediators in the main Sicilian health organisations.

Financing

From a political perspective, there is a National Fund for Immigration to which a part of the financial resources is assigned each year through financial acts. Now, in 2009 this Fund is empty because the Italian Government reduced, through the Financial Act, sums dedicated to the social spending.

Among the political measures to combat the social impact of immigration in Italy, the Regional Councils for Immigration play key roles in the development and implementation of policies relating to all immigration aspects. In this respect, the Head of the Department for Civil Liberties and Immigration of the Ministry of the Interior sent the Circular N. 5, 2 April 2009 to all prefects. This circular gives top priority to the management of foreign minors present on the national territory, not only because they represent "vulnerable" subjects, but mainly because they represent the future and the hope of social integration.

Regarding the presence and integration of immigrants, the following aspects must be considered: the situation of housing, the promoting of access to credit facilities, employment and vocational training, strengthening of public services, the initiatives to promote the Italian language and the basic principles that govern our law and society. Also much attention should be given to the use of UNRRA Funds (United Nations Relief and Rehabilitation Administration) and the European Fund for integration.

In reference to the funds set apart for interventions in favour of immigrants, the Minister of the Interior, for the year 2008, assigned €7,000,000.00 from the UNRRA Funds to projects for children, young people, marginalized people, drug addicted people, and also projects related to the prevention of social deviance. In particular:



- € 5,000,000.00 to finance programs aiming to integrate immigrants into the social context to prevent risk behaviours and social deviance;
- € 2,000,000.00 to finance the programs for the creation or strengthening of social welfare services for children, the elderly and disabled persons.

The Councillorship for the Family, Social Policies and Local Authorities of the Sicilian Region has awarded a total of €149,945,654.00 to section III - Social inclusion - of the ESF Regional Operational Program for the period 2007-2013, for activities promoting a society that ensures opportunities and resources necessary for the full participation of everyone in the social, economic and cultural aspects of life.

In March 2009, the Department for Equal Opportunities allocated €4,600,000.00 to finance projects aimed to provide assistance for social integration to immigrant women who wish to escape from violence and from the trafficking of human beings or their exploitation.

3.2. Resource generation

In Sicily much attention has been given to the training of cultural mediators employed in dealing with the social inclusion of immigrants. In fact, degree courses with these goals are active in the main universities of the Region such as:

- Degree Course in "Cultural Mediation and Euro-Mediterranean Cooperation" at the University of Enna
- Degree Certificate in "Mediterranean Intercultural Sciences and Techniques" at the University of Messina
- Degree Certificate in "Intercultural Educators" at the University of Palermo
- Degree Certificate in "Linguistic Mediation Sciences" at the University of Catania.

Moreover, in recent years, the number of training activities for cultural mediators conducted at regional training centres and voluntary associations, in collaboration with universities or departments of the Sicilian Government, has been continuously increasing. Among these we have:

- Vocational training courses for "Cultural and Linguistic Intermediaries", organized by the Institute for Professional Training - IAL CISL SICILIA (territorial headquarters of Catania) in agreement with the University of Catania, conforming to the Regional Plan of Training in 2006, which were funded by the Sicilian Government.
- Vocational training courses for "Cultural Mediators" specializing in mediation for organizational/employment or promotional/commercial purposes, organized by the Ass.For.SEO srl (promoter), the Regional Province of Palermo, the University of Palermo, the Sicilian Labour Union, the Confindustria (Italian Manufacturers' Association) of Sicily, the Confindustria of Palermo, the "Santa Chiara" Association and the Med. Europe Export Consortium, under the Equal project phase II "Multiethnic Company" (2007).



- Vocational training courses for "Social Secretary, and Social Animator/Educator for children and Socio-Cultural Intermediaries", organized by the Aurora Studies Centre, in collaboration with the Councillorship for Labour, for Social Security, for Education and Professional Training and for Immigration and the Ministry of Labour and Social Policies, with funding from the European Social Fund (2008).
- Other very important projects have been carried out by MSF in Italy ("Mission Italy" project) with the intent of assisting a very vulnerable population, seeking protection, consisting of foreigners - men, women and children - that have arrived in our country. Among these, the Mission Italy carries out training courses for health workers, in order to illustrate the law concerning foreigners' access to health care, underlining the importance of cultural mediation services and how to create a correct approach doctor / foreign patient. The first MSF clinic was opened in January 2003 in Syracuse, and since then similar projects have been implemented in the provinces of Ragusa and Agrigento.
- The Law Studies Association on Immigration (ASGI), dealing with the struggle against discrimination, in 2007 organized a cycle of seminars at the University of Palermo. The themes were: "Work, migrants and denied citizenship: towards a new racism?", "Right of asylum and humanitarian protection, the duty of hospitality", "Maritime borders, contrasting illegal immigration and the safeguarding of human life".

4. Good practices and projects

4.1. Praesidium IV

Over the last few years a number of projects have been carried out in Sicily to improve the reception of immigrants and their social integration.

One of the most important projects currently underway at regional level is the European project "Praesidium IV", co-funded by the Department for Civil Liberties and Immigration (Ministry of the Interior) and the European Commission.

The European Project "Praesidium IV" started in March 2009. It is one of the most important projects now in progress at regional level. The Project is co-ordinated by the Ministry of the Interior and, while during the first three years of activity the projects "Praesidium I" in 2006, "Praesidium II" in 2007 and "Praesidium III" in 2008 were financed by the European Union, the latter came directly under the Ministry of the Interior - Department for Civil Liberties and Immigration.

The project activities are organized following the multi-agency model of action to manage the mixed flows of immigrants, through the collaboration of the United Nations High Commissioner for Refugees (UNHCR), the International Organisation for Migration (IOM), Save the Children Association and the Italian Red Cross (IRC). The project aims at consolidating the capacity of places receiving immigrants, as well as that of the Centres for temporary stay and assistance (CDA, CARA, CIE e CPSA) in Sicily, Puglia, Calabria and Sardinia. At Lampedusa for some years there was also Médecins Sans Frontières association (MSF).



At regional level, the general aim of the project is to strengthen the capacity of reception of illegal immigrants who land at Lampedusa and at other places on the coasts of Sicily. This is done through information activities and legal counselling about rights and duties of immigrants, and the identification of vulnerable groups who need specific assistance (e.g. unaccompanied minors, victims of trafficking, etc.).

Specific aims are:

- to inform immigrants and refugees about risks of illegal immigration, about human trafficking and enslavement, and also about the illegal entering on national territory;
- to inform immigrants about practices for the regular (legal) admission to Italy;
- to monitor the correct development of the reception procedures of Centres in respect to immigrants' rights;
- to help police in identifying vulnerable groups.

The project's activities take place at the First - Aid Station and at the Reception Centre in Lampedusa, just as at other reception centres in Sicily, where immigrants are transferred to after their arrival at Lampedusa.

The project foresees the creation of teams of officers representative of the four humanitarian organizations (two for each organization), supported by mediator - interpreters, in order to respond efficiently to the needs of immigrants who land in Lampedusa and in other places on the Sicilian coasts. In particular:

- The Italian Red Cross (CRI) is involved in:
 - o the supervision of the illegal immigrants' health conditions, promoting humanitarian assistance, before they are transferred to other reception centres or are repatriated;
 - o the identification of minors among illegal immigrants, accompanying them to specific reception structures, if necessary;
 - o the support of health monitoring of immigrants and the identification of vulnerable cases;
 - o the guarantee of information about social and health assistance for immigrant women and minors and the reporting of specific cases to the competent authorities;
 - o the support and improvement of information and counselling services for immigrants about health issues;
 - o the monitoring of the procedures taking place at reception centres in order to respect the rights of immigrants and refugees;
 - o the development of information and training activities, together with the exchange of experiences and good practices regarding specific health and



psycho-social needs of vulnerable groups, under the direction of the Ministry of the Interior and in connection with other organizations;

- the improvement of the exchange of experiences and good practices of reception developed along borderlines, with particular attention to landings along the coasts of the island where major immigration pressure from the Mediterranean Basin is concentrated. All this is to guarantee uniform treatment and assistance to immigrants, with particular attention to those activities regarding vulnerable groups.

The feather in the cap of the project is the publication of brochures for women and minor immigrants in the Italian, French, English, Arabic, Ethiopian, Eritrean, Bengalese and Somalian languages, to give them simple and synthetic information about useful assistance for vulnerable people, in respect of Italian and European laws. All these brochures are published on the Sicilian website of CRI².

As the CRI focuses its attention on women and children, three female teams were organized, each made up of a trained nurse and a cultural mediator: one of these teams is engaged permanently at Lampedusa, one along the Sicilian coasts, where the landings take place (e.g. Pozzallo, Porto Empedocle, etc.) and another works at the Sicilian Reception Centres of Trapani, Caltanissetta and Cassibile.

In 2009 the CRI is going to open a new service at Lampedusa with the aim of giving psychological and emotional support to all people helping immigrants.

- The International Organisation for Migration (IOM) provides information about regular immigration and voluntary repatriation. The organization gives immigrants information about their rights and duties and provides technical assistance to social workers, including the identification and protection of victims of trafficking. When immigrants arrive at Lampedusa, IOM is involved in:
 - legal counselling to immigrants on the consequences of irregular entry (joint information sessions with UNHCR);
 - identification of vulnerable groups such as victims of trafficking, unaccompanied minors and people in need;
 - counselling on family re-unification, if feasible;
 - referral of specific cases (e.g. victims of trafficking) to the competent authorities (police and judicial authority);
 - the monitoring of reception centre conditions and general migrants' treatment.

² <http://cri.it/flex/cm/pages/ServeBLOB.php/L/IT/IDPagina/7265>



In Lampedusa a field officer and a cultural mediator meet immigrants to give them legal and useful information. For the most vulnerable cases IOM tries to offer further assistance and protection, in collaboration with the local authorities and other IOM officers working in Sicily³.

- The United Nations High Commissioner for Refugees (UNHCR) provides immigrants information and assistance regarding asylum procedures. In Lampedusa the team is composed of two people, who give legal counselling to immigrants in conjunction with the IOM teams⁴.
- The Save the Children Association provides:
 - o information and legal support for unaccompanied minors;
 - o help in identifying the exact age of minors;
 - o help in monitoring the standards of reception centres for immigrant minors to assure they are in conformity with the standards of human rights, as established in the ONU Convention on the Rights of Children and Teenagers;
 - o support and collaboration to the other organizations' teams in Lampedusa and Sicily.

The organization monitors the living conditions of minors staying in the reception centres of the Region. CRI and Save the Children association provide support to the local authorities to identify minors⁵.

4.2. Multipurpose Agency for the promotion of the integration and reception of refugees and immigrants

Of the same importance was the project "Multipurpose Agency for the Promotion of the Integration and Reception of Refugees and Immigrants" (January 2008 - January 2009), which was promoted by the Province of Palermo, financed by the National Fund for the Migration Policies of the Regional Department for Labour⁶.

The aim of the project is to support the reception and integration of refugees and minors and adult immigrants living in the Province of Palermo, and to coordinate the network activities of public, private and NGOs. The partners involved were: the Province of Palermo, the NGO "Centro Astalli" for immigrants' assistance, the Centre for the Study and Research on Social Issues "Giuseppina Arnao", the local Public Hospitals of "Villa Sofia" and "V. Cervello", the

³ <http://www.italy.iom.int/index.php?language=eng>

⁴ <http://www.unhcr.it/>

⁵ <http://www.savethechildren.it/>

⁶ <http://politichesociali.provincia.palermo.it>



University Hospital and the Civico "Di Cristina" National Highly Specialized Hospital (ARNAS) in Palermo, where cultural mediation services were opened.

The main activities regarded the starting up of a Multipurpose Agency concerning "Childhood and young people" and "Intercultural" themes, through the opening of two information points, one on legal issues and another on work issues. A website has also been created - into the web portal of the Social Policies Department of the Sicilian Region - to allow people to find out, in real time, which social and health services are offered and which bureaucratic and legislative changes there are in the immigrant field.

The Multipurpose Agency permits the multiethnic exchange of experiences and promotes the link among institutional and non-local services which are involved in immigration (assistance, cultural and recreation activities, etc.). The Multipurpose Agency aims at supporting the social integration of immigrants and placing a cultural mediator, as "facilitator", at the disposal of local public hospitals for 18 hours a week. This is to guarantee and improve access to the services.

Regarding the "Childhood and young people" area, activities focused on the integration of the numerous associations which work at local level, such as those organizing afternoon cultural and sport activities, intercultural narration laboratories, animation activities, film clubs and ethnic art laboratories. The "Intercultural" area had two objectives: the protection of cultural identities and the knowledge and integration among Sicilian and other cultures. For these reasons a fund was constituted to intervene specifically on the following issues:

- "Immigration and Health", through the creation in public hospitals, which participated in the project, a new "Intercultural Department", which was a meeting place which involved social and health personnel, immigrant and refugee communities and Italian citizens, with the support of facilitators, where specific aspects of health and immigration were discussed;
- "Intercultural and interethnic communications", which focused on overcoming the barriers of diversity, through the collaboration among associations which are involved in intercultural activities and public and private institutions specialized in these sectors.

In all thematic areas the participation of refugees and immigrants was an additional value also for Sicilian citizens, because their widespread inclusion had allowed them, especially young people, to experiment how a culture of solidarity could be an occasion to exchange experiences which contributed to develop every person involved humanely and culturally.

Many activities managed by Italian and immigrant women and groups were organized in the Multipurpose Agency. A nursery was organized for children of women who participated in the following training courses: the Italian language course, multiethnic tailoring and a multiethnic choir, which was directed by Matilde Politi.

To develop the project's activities a permanent work group was created. This group evaluated the progress of work and was composed of: a coordinator of the Agency, a few social workers of the Social Policies Department of the Regional Province of Palermo who worked in the immigrants' area, and a few delegates from Public Hospitals. The aim was to organize the Centre's activities and draw up a monthly report to describe these activities, both from the



qualitative and quantitative point of view. Their task was also to specify certain cases followed and the results achieved and achievable.

Four people (together with some volunteers) worked at the project: a social worker coordinator of activities - 10 hours a week; a lawyer, who is an expert on immigration, as a legal counsellor and provided assistance in filling in documents, when necessary, or putting immigrants in touch with other competent services - 8 hours a week; 2 intercultural experts to work in the local public hospitals - 18 hours each a week.

Among the four public hospitals of Palermo, only "V. Cervello" and the local hospital "Di Cristina" of the ARNAS Civico signed the protocol with the Province of Palermo - Social Policies Department. The other two public hospitals did not participate in the project because of organizational problems.

Following are listed some of the main project's results.

A cultural mediator, from Mauritius, worked at the "V. Cervello" Public Hospital in the infection and in the obstetrician/gynaecology departments, while in the ARNAS Civico "Di Cristina" hospital a cultural mediator, from the Ivory Coast, worked in the Migrants' Health Care Department. Access to the former was mainly to women, while access to the latter was mainly to men.

The prevalence of people who accessed these services was mainly from Africa (in particular from Tunisia), followed by Asia (mainly from Bangladesh), Europe (mainly from Rumania) and Latin America.

At the "V. Cervello" Public Hospital services requested for cultural mediation were: 25% for cultural mediation between doctors and patients, 5% for linguistic intermediation between doctors and patients, 62% for other information services, 6% to accompany patients around the hospital, while 2% was for other requests.

At ARNAS Civico "Di Cristina", services requested for cultural mediation were: 8% for linguistic intermediation between doctors and patients, 2% for complex surgeries, 64% for other information services, 11% to accompany patients around the hospital, and 15% was for other requests.

The immigrants asking for information at the legal help desk were in prevalence males (77%), coming mainly from Africa, above all from the Ivory Coast, Ghana and Morocco.

At the legal help desk 32% of the requests were for documents related to claims for asylum, 25% was for information about immigration flows, 25% was to extend the residence permit, 5% was for family reunion and 13% of the requests was for various information.

At the Social Service desk, immigrants asking for information were 56% males and 44% females. Most of these people were between the ages of 20 to 30, followed by the 30 to 40 age group.

Countries of origin of these immigrants were: Africa in first position, followed by Asia; a few from Latin America, while nobody came from Europe.



The various types of requests were: 31% for employment, 22% for commodities' assistance, 16% for legal assistance, 15% for linguistic assistance, 5% for medical assistance and 15% for various other requests.

Project activities allowed the measurement of the percentage incidence of immigrants' needs and were requests related to: economic difficulties (32%); accommodation difficulties (17%); legal counselling (12%); psychological problems (5%); health assistance (3%); the solution of relational difficulties (9%) and 22% for various other problems.

4.3. Cross Cultural Care

The project "Cross Cultural Care" (2000), financed by the EU program Leonardo da Vinci, was realized with collaboration of CEFPAS (Caltanissetta, Italy), AWO (Bielefeld, Germany) and EUFIN (Copenhagen, Denmark). The aim of the project was to improve the cultural and scientific competences of social and health professionals who take care of elderly immigrants. The project's particular aim was to develop both a trans-cultural typology of assistance and training courses in the social and health field. The activities' program was organized in six phases, covering a period of 24 months. For each phase all partners developed different activities related to the specific needs of its local contest. CEFPAS provided the following activities:

- Situation analysis - with the aim of analysing social, health and retirement needs of elderly immigrants in Sicily. This activity, realized in collaboration with regional and national voluntary associations (Caritas, ANFE, AIM), allowed the identification of the training needs of immigrants in this Region.
- Definition of the program - with the aims of identifying a group of experts, within the social and health assistance system, among immigrants and the local population and planning the training activities (program, contents, teachers and location).
- Pre-implementation - in order to develop the evaluation instruments for the training activities: evaluation modules and tests were designed to be administered to trainees and teachers.
- Training courses - two main training activities were developed in this phase:
 - o a "training course" for 18 immigrants living in the provinces of Palermo, Caltanissetta and Ragusa. This was structured in three modules regarding the following contents: laws on immigrants; the organization of services at local level; the protection system in cases of accidents in the work place; social security rights; medical and health aspects related to this sector.
 - o "cascade training" which involved directly those immigrants who were already trained in planning activities and who later became trainers of a group of 30 immigrants, for the realization of training courses located in Palermo and Caltanissetta.



- Supervision and Monitoring - in order to develop, in each partner of the project (Germany, Denmark, Italy), the evaluation of the process, its monitoring and impact, using tests/questionnaires and transnational workshops.
- Propagation of the outcomes - in order to propagate the project's outcomes through: meetings and workshops at national and transnational level, the development of a website dedicated to the project and the publication of a book referring to the project.

4.4. Other projects

ASASI

The experimental project "ASASI" of health services for immigrants, proposed in April 2009 by the Provincial Councillorship for Social Solidarity of the City of Messina, has the target of achieving a "Health Point" at the Department of Infectious Diseases of the University General Hospital of Messina. This "Health Point" is an ambulatory that, in specific hours and on certain days, provides free health care to those who are temporarily in Sicily and have health problems. In this ambulatory cultural mediators, from the University of Messina, work on the simplification of doctor/patient relationship and to give immigrants information about health services. The Sant'Egidio and the Santa Maria della Strada Communities, which for years have been helping the homeless and immigrants, are realizing a project which will spur immigrants to be come more aware of how to obtain major health care. These communities will also support the Councillorship which will open a provincial office for immigrants.

Liaison Project

The "Liaison Project", implemented in spring 2009, is also very interesting. The project, funded by the Ministry of Labour, Health and Social Policies, provides free courses of the Italian language and culture for foreigners (150 hours) with the aim of acquiring linguistic, cultural and civic-legal skills. The participants are Arabic speaking adult foreigners (men and women) living in Sicily. The activities are carried out by cultural mediators and the courses will be held in Palermo and Agrigento.

Juvenile justice

The Convention for cultural mediation interventions between the Centre for Juvenile Justice in Sicily and the "Apriti Cuore" Association of Palermo has been renewed for 2009. This is to assist young foreigners in custody in Palermo for having committed crimes, to help them to understand why they are in the situation they find themselves and to integrate them in the lawful social context. All the activities will be addressed to the Juvenile Criminal Institute, the Social Services Office for Minors, the First Reception Centre and the Administration Community of the city of Palermo.



Documentation Centre on Migration

In 2008, a protocol between the Sicilian Regional Delegation of ANFE (National Association of Emigrated Families) and the Municipality of Palermo was signed. This regards the activities to be carried out on the "Studies and Documentation Centre on Migration". In particular, the following activities are provided: research and data collection to create a useful portal for an updated knowledge of the migration phenomenon and in favour of the integration of migrants into the local socio-labour context; the opening of a multifunctional office for migrants; research and elaboration of the data and information in order to publish a manual on migrants' rights and their access to services; collaboration in the planning of an Observatory on non-accompanied foreign minors; collection of publications for adults and children in order to create a newspaper and intercultural library; the formation of a research centre dealing with the documentation of Sicilians abroad.

MONDOCULTURA

The Red Cross-Regional Committee of Sicily (CRI Sicilia) has embarked on a new and innovative project for foreigners and their families residing in the Region, thanks to the contribution of the Regional Government and the Ministry of Labour - National Fund for Migration Policies. The project "MONDOCULTURA- open window" consists in opening an information desk for immigrants which offers them advice (on legal issues, protection and enjoyment of civil and political rights, projects for immigrants being realized in the Region, etc.), orientation (the structures in the territory, basic services, opportunities offered by legislation, together with help in the compilation and processing of documents), and promotion (of the agreements and partnership with other organizations, public or private). It is characterized by a model of integrated and multidisciplinary intervention and an ideology based on the principle of legal equality, social and equal opportunities. The project is designed to respond primarily to the needs of global information for immigrants in the regional territory.

Others

Other studies and research conducted in recent years involving individual Sicilian institutions or bodies are the following:

- General Directorate for Research of the Ministry of Health. "Inter-regional experimentations to fight inequalities in accessing to health services". Institutions involved in the project: Department of Clinical Medicine and Emerging Diseases at the "P. Giaccone" University Hospital of Palermo; the Epidemiological Observatory Department of the Sicilian Region. Duration: December 2002 - December 2004.
- European Commission - General Directorate of Justice and External Affairs - Daphne 2002 "Say no to violence". Target population: women and children. Promoter: London borough of Haringey - Local Partners: Clinic for travellers', tourists' and immigrants'



- medical care at the "P. Giaccone" University Hospital of Palermo, the London borough of Croydon - Local Authority, Hackney's Women's Aid - NGO, the AUSL Bologna. Duration: 12 months.
- General Directorate for Research of the Ministry of Health. "Planning and Experimenting of a model of an Epidemiological Observatory on Migration". Partners: Clinic for travellers', tourists' and immigrants' medical care at the "P. Giaccone" University Hospital of Palermo, the Health Department of the Caritas Association in Rome, the Family and Social Solidarity Office of the Lombardy Region, the Inequality Observatory of the Regional Health Agency of the Marche Region, the National Institute of Health, the Public Health Agency of the Lazio Region. Duration: 24 months.
 - General Directorate for Research of the Ministry of Health. "Network for the analysis of health inequalities and for the promotion of the weaker groups of the Italian and immigrant population". Partners: the S. Gallicano Institute IRCCS in Rome, the Clinic for travellers', tourists' and immigrants' medical care at the "P. Giaccone" University Hospital of Palermo, AFAR in Rome, the "Bambino Gesù" Hospital - IRCCS in Rome, the Caritas section in Rome, the "S. Giovanni di Dio Fatebenefratelli" Centre - IRCCS in Rome, the Emergency Children Foundation in Rome, the National Institute for Infectious Diseases L. Spallanzani IRCCS in Rome and the Higher Health Institute in Rome. Duration: 24 months.
 - The "DROP OUT" project, an Operational Program regarding the "Security for the Development of Southern Italy" 2000/2006. The project is coordinated by the Department for civil liberties and immigration of the Minister of the Interior. The goal is to achieve prevention and recovery interventions in regard to the school dropout phenomenon, identifying methods and models of action capable of giving answers to the problems. The persons involved are young people under the age of 15 who still have obligations to attend school and young people who have exceeded the limits of compulsory education (up to 18 years of age). The project was conducted in Cagliari, Syracuse and Vibo Valentia. Duration: November 2002 - July 2004.
 - The "Maghreb" Project (2005), promoted by the National Insurance Institute for Occupational Accidents (INAIL), regards the creation of a cultural mediation service for the Maghreb workers of Trapani and Mazzara del Vallo within INAIL offices, in order to improve accessibility and usability of the INAIL services for injured workers coming from the Maghreb region.
 - The Sicilian Region has also foreseen, in the section III - Social inclusion - of the ESF Regional Operational Program 2007-2013, the overall target to promote an inclusive society by ensuring opportunities and resources necessary for full participation in social, economic and cultural life (See "Stewardship" section).



5. Conclusions

Taking into consideration the data and the information previously showed, it appears very clearly that for many years the Sicilian Region has been committed in reception and accommodation activities for thousand of migrants coming from foreign Countries. Because of its geographical position Sicily is at the centre of various migration flows going from economic disadvantaged Countries to Europe, where migrants hope to find a better future.

The Sicilian Government during the last years has made lot of legislative and organizational efforts to respond to migrants' needs. Nonetheless, the number of persons arriving in the island is so great that what every has been done has not been enough.

The wellbeing and health condition of migrants depend on the efficiency and quality of health systems, and moreover on the implementation of adequate and coordinated policies of social integration, with specific attention to work, accommodation and families' support.

The management of migration flows is really a social problem that can not be managed only at local level. Representing a "gate" to Europe, Sicily is, in fact, primarily an intermediate place and can not take upon itself the responsibility to manage and resolve the problems related to immigrants.

For these reasons it is advised to constitute a permanent technical committee to work out useful strategies to face up and manage in a better way the migration processes at Regional, National and European level.

World Health Organization
Regional Office for Europe
Regions for Health Network



Migrants and Health Care: Responses by European Regions (MIGHRER)

Complete reference material

VII. Regional report Szabolcs-Szatmár-Bereg County

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Summary

Immigration increased with the political changes in the Central and Eastern European countries at the beginning of the 1990s, we especially have to mention the refugee flow from the former Yugoslavia. Some 43% of foreigners were Romanian citizens, followed by Yugoslavians (11%) and Ukrainians (8%), most of them ethnic Hungarians. Around 10% arrived from the EU, while 6% were Chinese. Since 1990 the border guards have recorded 152,000 cases of foreigners attempting to enter illegally, and 80,000 efforts to leave Hungary illegally.

In 1989 a law was passed on emigration that abolished all administrative obstacles to the right of Hungarians to freely enter and leave their country. The Aliens act and associated decrees (1993-1994) cover on requirements of lawful entry and residence in Hungary, issuing the visa and identity documents of various groups of foreigners. The 1998 Act on Asylum lifted the geographical limitation and established three categories for refugees, with different decision-making procedures and rights. In 2002 a new legislative package entered into force, aimed primarily at harmonizing Hungarian regulations with those of the European Union. A minimum of three years working and living in Hungary with a residence permit needs to obtain a settlement permit.

Hungary, like most receiving countries, tends to treat the inflow of immigrants not as a complex social and economic issue, but more as a deviant phenomenon with potential impact on public order. This approach aims at the short-term treatment of problems through defensive measures. The underlying idea is that migration can be kept in check with the means at the disposal of the authorities, particularly border control and strict residency rules. No comprehensive social, economic, or political strategy has been developed concerning migration in Hungary. Indeed, the policy is still characterized by ad hoc regulations.

An act granting special status to Hungarian minorities living in neighbouring countries was passed in 2001. Its declared goal is to help ethnic Hungarians remain in their countries of residence and support their existing communities. It provides special benefits for ethnic Hungarians in the fields of education, employment, travel, and culture. In addition, it furnishes them with financial aid and grants them easier procedures if they wish to enter Hungary for work or study.

The entry to Hungary from a third country is regulated by a separate law. The law covers those foreigners who do not have the community right of free movement and of free staying. The Act on entry and stay of third country nationals was passed in 2007.

A project on Labour market orientation for asylum seekers aims to develop and implement innovative approaches and methods which contribute to the elimination discrimination and inequities related to the labour market.

The EUGATE project aims to improve health and prevent illness of citizens in Member States, to reduce inequalities, and to exchange models of best practice.



1. General characteristics

1.1. Historical background

International migration has played a crucial role in Hungary's history since its foundation as a state in the 10th century.

From the 16th century onward, the present-day central and eastern European countries, along with some western European territories, were parts of the Habsburg Empire. The empire functioned as a single political and administrative entity, making population movements among areas of the empire routine. Deliberate settlement campaigns were also implemented within the empire, mainly in the 18th century. Later in history, migration was also a matter of course within the Austro-Hungarian monarchy.

While previous population movements in Hungary were mainly immigration flows, between the 1880s and World War I emigration reached such proportions that it has often been described as a "calamity" or "bitter Hungarian tradition". In this period, two million people left the country, primarily for economic reasons.

The start of World War I cut short these migratory movements, and at its end, the Peace Treaty of Versailles lent a special substance to questions of migration and national minorities. Hungarian minorities became stranded outside the borders of their ancestral homeland. As a consequence, new - and to a considerable extent, forced - migratory movements took place. Between 1919 and 1923, some 200,000 ethnic Hungarians resettled in Hungary.

World War II, subsequent peace treaties, evictions, and forced settlements resulted in further migration flows, significantly modifying the ethnic map in Central and Eastern Europe. Some 200,000 ethnic Germans were evicted from Hungary, and 73,000 Slovaks left Hungary as part of an "exchange of population". The number of those leaving Hungary in the three years following the end of the war is estimated to have exceeded 100,000. At the same time, 113,000 ethnic Hungarians were resettled in Hungary from Czechoslovakia, 125,000 from Transylvania, 45,500 from Yugoslavia, and 25,000 from the Soviet Union.

Following the Communist takeover in 1947, the borders were closed. The state prohibited migration; illegal departure from the country and failure to return home from abroad became a crime.

The borders opened briefly in 1956 as part of that year's uprising against the Communist government. Over a period of just three months, nearly 200,000 people fled the country and made their way through Austria. Most eventually settled in the US, but the rest scattered across some 50 other countries.

In the four decades that followed, emigration was only permitted in exceptional cases. Immigration was also limited, and tended to be restricted to intergovernmental agreements, family reunification (often with false marriages to obtain immigration papers), and admissions based on political decisions. The latter involved cases such as workers from Cuba and students from friendly East Block countries. The few cases of admission of asylum seekers-for example, those fleeing from the Greek civil war or the 1973 US-backed coup in Chile-were given little publicity.



The strictly guarded borders, stringent visa requirements, readmission agreements, and travel restrictions in surrounding countries meant that Hungary was not even a transit country for migrants during this period.

Since the radical political and social transformation of Eastern Europe around 1990, the extent and character of population movements into and through Hungarian territory has changed. By the mid-1990s, the country had become a transit country to the West, and also a destination country for immigrants.

1.2. Recent migration stocks and flows

Immigration increased with the political changes in the central and eastern European countries at the beginning of the 1990s, especially the refugee flows from the former Yugoslavia. In 1990, almost 40,000 legal immigrants arrived in the country. Their number fell steeply thereafter, dropping to 20,000 in 1992. The figures for more recent years show that the annual number of legal immigrants has stabilized at around 14,000-15,000.

Most immigrants arrive from neighbouring countries and are of Hungarian ethnicity. Eighty percent of those who entered in 1989-1990 were Romanian citizens, mostly of Hungarian ancestry. In the following years their proportion declined, reaching less than 40% between 1994 and 2002. A common explanation for this decline is that by 2002, those who had the inclination and means had already settled and naturalized in Hungary.

As of 2002, some 115,000 foreign citizens with a valid long-term permit (i.e., good for at least one year) or permanent residence permit were residing in Hungary. This population amounted to 1.13% of Hungary's total population of 10.1 million, with a quarter residing there on a temporary basis. For those coming from EU countries and North America, this rate was above 80%.

About 43% of these foreigners were Romanian citizens, followed by Yugoslavians (11%) and Ukrainians (8%), most of them ethnic Hungarians. Around 10% arrived from the EU, while 6% were Chinese.

In addition to the foreign residents, another 115,000 immigrants have acquired Hungarian citizenship since 1990. Hungarian citizenship has been granted almost exclusively to ethnic Hungarians from neighbouring countries.

At the end of 2000, 3% (294,000) of Hungary's population were foreign-born. It is not clear, however, that actual international migration took place in their life: there are immigrants in this group as well as people who became foreign residents as a consequence of historic events such as border changes or citizenship agreements.



1.3. Labour migration

More than 100,000 foreigners work legally in Hungary. Immigrants with permanent residence permits can take up employment under almost the same conditions as Hungarian nationals, with a few exceptions such as jobs in the civil service. No exact statistics show the number of employed permanent residents, but considering their age composition and the overall employment rate, 40,000 is a fair estimate.

Temporary immigrants, apart from some exceptions, can take up legal employment only if they hold a work permit. The most important exception is that senior executives of foreign companies do not need a permit. Many small family-run enterprises and a considerable number of self-employed foreigners fall into this category, because establishing a company to facilitate living and working in Hungary is often easier than obtaining a work permit. Based on the residence permit data, about 5,000 foreigners belong in this category.

The number of temporary work permits-valid for up to one year-is limited. The quota was 81,320 in 2002, in line with the number of vacancies. The quota was far from filled. The number of valid work permits was 42,000 in 2002.

According to work permit data, the construction, agriculture, textile, clothing, retail, catering, and entertainment sectors are most affected by foreign labour. The majority of the employees are Romanian citizens. Many come from the former Soviet Union, mainly from the Ukraine. Since 1997, the Chinese have made up the third-largest group.

Work permit figures are sometimes misleading. In the case of neighbouring Austria, the 246 valid permits on record as of the end of 2002 are probably not an accurate reflection of reality. It is more probable that Austrians working in Hungary can easily travel home, often do not live in Hungary at all, or legally commute each week as "tourists".

This type of commuting is not exceptional. Most illegal foreign workers are from neighbouring countries. These workers enter legally as tourists and acquire regular or occasional work.

Temporary migrants often work illegally, mostly in the construction, agriculture, catering, entertainment, and clothing and textiles sectors. The chances of temporary immigrants obtaining regular, formal employment are slim. An employer must obtain a work permit for the immigrant through a complicated and lengthy procedure.

Despite the broad media exposure of the illegal employment of foreign workers, there are no reliable data on the scale and extent of this type of work. However, most analysts believe that illegally employed foreign workers greatly outnumber those with work permits. In the high season, many experts estimate that the number of illegal foreign workers may be double that of foreign workers with permits.

In recent years, there have been considerable changes in the scale, forms, and organization of the illegal work of foreign nationals. The supply and demand for such workers is now more balanced, and recruitment is mostly organized through various go-betweens.



One category of legally and illegally employed foreign workers that is rarely mentioned consists of professionals, language teachers, experts, and self-employed intellectuals such as journalists from industrialized countries.

Contrary to stereotypes, foreign residents with long-term permits on average have higher occupational status than Hungarian citizens, and permanent residents (who are mostly returning "ethnic" Hungarians) are less qualified than temporary immigrants. This is reflected primarily in the proportion of highly qualified individuals, which makes up one-third of the total immigrant population and more than 40% of temporary migrants. The proportion of non-manual workers is around 50% of the active foreign population.

The majority of foreigners, both legal and illegal, work in the capital, Budapest, and its metropolitan area. Many others work in the counties to the south, south-east, and east of the country, near the borders with the Ukraine, Romania, the former Yugoslavia, and Croatia. Increasing numbers of foreigners are employed - mostly legally - in the western, more developed regions of Hungary.

1.4. Illegal migration

Since 1990, the border guards have recorded 152,000 cases of foreigners attempting to enter illegally, and 80,000 efforts to leave Hungary illegally. This difference can be explained by the visa regime: migrants from Romania, the successor states of Yugoslavia, and the former Soviet Union could legally enter Hungary, but not western European countries. In 2002, when Romanians were first allowed to enter the EU without a visa, the number of illegal entries and exits were about the same in number (around 6,000). These figures indicate Hungary's transit role in illegal migration.

According to border guard officials, 75% of those trying to leave the country are former inhabitants of refugee camps who wanted to leave the country for the West with the help of human smugglers. Since 1990, migrants have been assisted in illegal border crossings in 43,000 cases. As the assistance remains mostly undetected, these figures greatly underestimate the role of smugglers.

Of the various forms of human trafficking, that of women is the most visible and frequently discussed. In Hungary, there are organizations that recruit women for prostitution, taking them to France, Austria, and other destinations. They also import women to Hungary from Romania, Moldova, Slovakia, and the Ukraine. The real scale of the phenomenon is unknown.

1.5. Asylum seekers and refugees

Hungary acceded to the 1951 Convention relating to the Status of Refugees in 1989. By the time the convention came into force, more than 30,000 Romanian citizens were staying in Hungary on the basis of temporary residence permits. The vast majority of these people were ethnic Hungarians. Most of them settled in Hungary permanently.



The next largest category came from the former Yugoslavia, arriving in several waves that rose and fell in rhythm with various armed conflicts.

Until 1997 Hungary accepted refugees only from European countries. Immediately after lifting this limitation, nearly half of the asylum applications were submitted by non-European citizens (mostly from Afghanistan, Bangladesh, and Iraq). The other half came from Yugoslavs fleeing from the Kosovo crisis. In 1999 there were 11,500 applications, with 5,100 submitted by Yugoslavians and 6,000 by non-European citizens. Since then, there have been hardly any European applicants; in 2002 they amounted to only 7% of all applicants.

Hungary is primarily a transit country for asylum seekers. Economic forces are only part of the reason for this phenomenon. Equally important factors include lengthy asylum procedures, low chances for long-term and effective protection, and scarce opportunities for integration. For these reasons, asylum seekers generally seek protection elsewhere, mainly in member countries of the European Union. Therefore, the most common reason for terminating an asylum procedure is that the applicant "disappears".

During the period from March 1, 1998 to August 31, 2000, protection was granted to 3,355 asylum applicants (15.7% of all applicants). This rate of approval is higher if the number of those who "disappeared" is subtracted (28.8%). This includes those who received refugee status and those who were authorized to stay in the separate category of "accepted refugees". Out of the 3,355 applicants, refugee status was granted under the Geneva Convention in 809 cases (3.8% of all asylum seekers).

1.6. The regional situation²

Based on the 2007 Act:

- with an EEA³ residence permit: 1,286 persons
- with registration certification: 3,316 persons
- as a relative of a Hungarian citizen received residence card: 872 persons
- as a relative of an EEA citizen received residence card: 6 persons
- with permanent residence card: 779 persons

Residence permit was made out for 2,287 persons, because of: family living together, treatment, official visit, earning, research, visit, voluntary activities, studying and other reasons.

Humanitarian residence permit was made out for 1382 persons:

- permit for asylum seekers: 539 persons
- temporary residence permit: 529 persons

² As in February 2009, for the responsible area of North-Plain Regional Directorate of Immigration and Nationality Office. Szabolcs-Szatmár-Bereg County is one of the 3 counties in this region.

³ The European Economic Area.



- settling permit for 107 foreigners
- state/national residence permit for 207 foreigners

Because of data protection no information is registered regarding nationality, employing or marital status.

The National Strategic Research Institute as a background institute of Ministry of Health carries out official data collection about the health status of the Hungarian population. The Hungarian On-line Health Data Base as a part of this Institute doesn't have information regarding to the health status of minorities or immigrants. Although there are some initiatives which focus on this field, mainly they give insight into the health of minorities.

At regional or county level, there is not enough information on health service delivery, from the immigration point of view. Some personal experiences are available, which need confirmation.

There is little special immigration-focused health policy in Szabolcs-Szatmár-Bereg county. (That is the reason why it initiated its EU-funded project, which aims to collect good practice and information and plans training on social integration, mainly on the labour market of immigrants.

2. Regulations and legal framework

2.1. Migration policy and legislation

In recent decades, Hungary's legal framework for regulating migration has developed gradually. At the end of the 1980s, the need to establish a new administrative and legislative system to cope with migration became clear. This resulted in a series of legislative measures.

In 1989, a law was passed on emigration that abolished all administrative obstacles to the right of Hungarians to freely enter and leave their country.

In 1993-1994, two immigration regulation acts entered into force: the Act on Hungarian Citizenship and the Act on the Entry, Stay, and Immigration of Foreigners in Hungary. Both acts tightened regulations governing immigration. The Citizenship Act stipulates that eight years of residence in Hungary are a necessary prerequisite for naturalization. The second act, known as the Aliens Act, requires an individual to spend a minimum of three years working and living in Hungary with a residence permit in order to obtain immigrant status.

In 1991, strict rules were put into effect to regulate the employment of foreigners.

In 1997, the issue of illegal border crossings was extensively addressed by the Act on Borders and the Border Guards, which gave the border guards more power and resources.

The last piece of the migration "package" - regulation of the refugee issue - was postponed until March 1998, when the Act on Asylum entered into force. This measure was connected to events in 1989, when Hungary joined the 1951 Geneva Convention relating to the Status of Refugees, but with a geographic reservation limiting its application to European events. The Act on Asylum lifted the geographical limitation and established three categories for refugees, with different decision-making procedures and rights. Besides the traditional category of



"convention" refugee (which entails basically the same rights as citizens), the act allows the entry and stay of "asylum seekers" and "refugees given shelter/accepted refugee".

In 2002, a new legislative package entered into force, aimed primarily at harmonizing Hungarian regulations with those of the European Union. A minimum of three years working and living in Hungary with a residence permit is now needed to obtain a settlement permit; that is, immigrant status. Eight years of residence are a necessary prerequisite for naturalization.

There are, however, exceptions to the rule and groups that receive preferences. Naturalization and acquiring a settlement permit are easier for ethnic Hungarians, in whose cases citizenship derives from a parent's Hungarian citizenship under the principle of "jus sanguinis" and also for those born in Hungary. Furthermore, former Hungarian citizens can re-obtain their citizenship on request, without a waiting period.

Up till now we have spoken about the laws concerning immigrants in general but as we have mentioned until 1997 Hungary accepted refugees only from European countries. As soon as this restriction had been abolished nearly half of the asylum applications were submitted by non-European citizens so enactment of laws regulating the entry and stay of third country nationals were crucial. Fortunately in 2007 an Act on entry and stay of third country nationals was passed.

2.2. Health system

Based on the Constitution every Hungarian citizen and others who live in Hungary have a right to the highest possible level of physical and mental health. Moreover there is right to social security guaranteeing income for old people, widows, orphans, and unemployed who lost their job due to ill health or disability, or reasons other than their own fault). The health services are available on an insurance basis.

The framework, services, and provision of health system is regulated by the Health Act. A separate responsibility is mandated to the local government (Act on Local Governments - Act 65 of 1959.)

Primary health care - the Local Government authorities are mandated to arrange for provision of primary health care services.

Hungary is today an originating, transit, and destination country for migration.

2.3. Refugees and asylum seekers

People are considered to be refugees who are either foreigners or who have no home country and who applied for this status and got this status from the refugee authority. The basic prerequisite is that such people are persecuted in their own countries because of their race, religion, national affiliation, or political conviction, or because they belong to a certain social group. It does not have to be actual persecution but there should be a real possibility of that occurring in the given country. These people cannot or do not want to have resort to legal protection.



People cannot be recognized as refugees (or as asylum seekers) who committed war crimes or crimes against peace or humanity or committed other serious but not political crimes, or who are guilty of actions against the aims and principles of the United Nations. . They cannot be recognized as refugees if their staying in Hungary is against national security interests or seriously endangers public safety.

The legal status of being a refugee lasts until the refugee obtains Hungarian citizenship or until the Office for Immigration withdraws recognition as a refugee.

The asylum seeker is a foreigner who belongs to a group of such refugees who want to find asylum as a group on the territory of the Hungarian Republic and this group gets temporary asylum by either the Government or the European Union. They can get this status only if they had to escape from their homeland as there was a civil war or armed conflict or ethnic battles or their human rights are constantly and violently destroyed. This would mainly entail torture and inhuman or humiliating treatment.

The legal status of the asylum seekers ceases if:

- the time of the protection is over or the fact marked by the government has been realized;
- the asylum seeker receives a legal status as a settler in Hungary;
- the Office for Immigration and Nationality recognized the asylum seeker as a refugee;
- the asylum seeker leaves the territory of the Hungarian Republic forever;
- the Office for Immigration and Nationality withdraws the asylum seeker status;
- with the agreement of the asylum seeker, his or her residential place is located in one of the states of the European Union.

The procedure of being recognized as a refugee and an asylum seeker is conducted by that regional directorate of the Office of Immigration and Nationality where the foreign person stays.

Applications for being recognized as refugees or asylum seekers can be handed in to the Office for immigration and Nationality orally or in written form. The applicant has to give in his or her identification and travel documents. The applicants have to justify first of all that the reasons that forced them to escape are real and true.

There is a difference between those who have only requested the recognition as refugees or asylum seekers and those who have already got that status.

It is the fundamental right, that people who apply for the refugee or asylum seeker state or those who have already been recognized as refugees or asylum seekers can stay in the territory of the Hungarian Republic.

Regarding obligations, the international treaty concerning the refugees' situation states in general that each refugee should submit to the legal rules and procedures of the recipient country.



The applicant who applied for being recognized as a refugee has the right to have documents which justify that he stays in Hungary legally, has the right to have accommodation and provision and to get in touch with any refugee organization.

On the other hand the applicants who applied for being recognized as refugees must stay at an obligatory place defined for them, and it is compulsory for them to cooperate with the authorities, and to submit themselves to medical screenings, medical treatments and compulsory vaccinations. There is another additional limitation. Those people who want to be recognized as refugees can work only at the territory of the residential centre within one year from the time of the application. After this time they can work according to the common rules.

The refugee's rights and obligations are basically the same as Hungarian citizens' rights and obligations. The refugees have the right to have IDs - it is compulsory for them to apply for them - and to have bilingual travel documents which are necessary for crossing the border. They have the right to have different provisions and supports.

The refugees do not have to serve in military service, on the other hand their voting rights are restricted compared with the Hungarian citizens' voting rights, since they can vote only in the local municipal representatives' and mayors' elections, and in the local referendum and the local public initiation, but for example they cannot vote for members of parliament. The refugees may not undertake work where it is a condition that such work may be done only they are Hungarian citizens.

Those people who are applying for recognition as asylum seekers have the right to stay and to get provision and accommodation in Hungary. They have to stay in a certain place defined for them to collaborate with the authorities, and to submit themselves to medical screenings, medical treatment and must be up to date with the immunisation. They are allowed to undertake work only at the recipient station.

The asylum seekers have the right to have a residence permit, accommodation and provisions and may undertake work without permission on the territory of the country.

The asylum seekers have to notify their place of residence to the Refugee authority, and to the local authorities, and they have to report if there are significant changes in their financial situations.

The form of the provisions and supplies can be:

- supplies and provisions belonging to the domain of personal care
- financial support
- cash benefits
- grants from donations

In the framework of accommodation in reception stations or other similar accommodation, refugees and asylum seekers can get accommodation, food three times a day, personal things like toiletries and clothes.



In the framework of medical care the refugees, and asylum seekers can get free examinations and treatment relating to medical primary care and they can get medicines and bandages, obligatory vaccinations, urgent out-patient and in-patient care, therapeutic equipment, prenatal care and obstetric provision free.

In the framework of educational provision the refugees and asylum seekers may ask for the reimbursement of kindergarten and primary school expenses and they may take part in a 360-hour long Hungarian language course for beginners free if at the end of the course they pass the examination successfully.

The person recognized as a refugee can also get:

- benefits in the form of sick pay, maternity benefit, child care allowance, accident sick pay or accident annuity;
- benefits in the form of old age, work incapacity annuity, temporary annuity, regular social welfare annuity, disability support;
- benefits for war veterans;
- child care allowance;
- child raising support;
- a pension from churches;
- benefits in the form of regular social welfare assistance;
- unemployed benefit;
- housing maintenance;
- maternity allowance.

As a social support they can get housing maintenance support, temporary support and funeral support.

They can get support helping to meet the requirements of the family, farming aid and professional advice.

The foreign person who needs help and who is involved in the asylum procedure may get a free legal helper who gives legal advice and writes submissions, and other documents. The asylum procedure is free.

There is a special procedure for the Hungarians living outside of the border of Hungary. In case of certain groups of illnesses (e.g. diagnosing tumour-related diseases and its surgical therapy, neurosurgery, orthopaedic interventions, ophthalmologist/ear-nose-throat surgeries) the relatives, family members or the doctors may apply for financing. The application will be sent further by the Information Bureaux or the Helping Right Medical and Humanitarian Foundation which have an agreement with the Office of the Prime Minister but the decision will be made by the evaluating commission.

The Office of Immigration and Nationality is responsible at state level.



Refuge supporting foundations are

- Autonomy Foundation
- For Democratic Rights Foundation
- Hungarian Helsinki Committee
- Hungarian Red Cross
- Shelter Charity Association
- Company for Free Law

3. The policy agenda

Hungary became an EU member state from May 1, 2004. This development has many ramifications for the country's migration policy.

In recent years, migration has drawn political and media attention, most frequently in connection with the EU accession process. This attention has prompted new administrative and legal measures connected to migration. It has also been a determining factor in connection with measures and statements on the issue of illegal migration and tighter border controls.

Since 2004 Hungary's eastern and southern borders have both been with EU states, bringing serious changes in the border regime, such as strict border controls and visa requirements with neighbouring countries. Controlling the border is not only a difficult task, but also an extremely delicate issue, as the new regulations may negatively influence cultural, economic, and family contacts with the large Hungarian communities in Romania, the former Yugoslavia, Ukraine, and Croatia.

After serious debates on these issues, an act granting special status to Hungarian minorities living in neighbouring countries was passed in 2001. Its declared goal is to help ethnic Hungarians remain in their countries of residence and support their existing communities. It provides special benefits for ethnic Hungarians in the fields of education, employment, travel, and culture. In addition, it furnishes them with financial aid and grants them easier procedures if they wish to enter Hungary for work or study.

In spite of widespread agreement with the act's general aims, it has still been heavily criticized. Some feel the benefits provided are limited and not appropriate, while others are afraid that it costs too much with limited results. From one side, nationalistic sentiments are emphasized, while from the other, the alleged "abuse" of nationalistic sentiments for domestic political gain draw fire.

The main problem, however, has been the reaction of the relevant neighbouring governments and their majority populations. Some provisions are looked on as discriminatory, and have sparked anti-Hungarian sentiment. Some of Hungary's neighbours, and the EU as well, expressed official concern over the proposed law. In response, Hungarian lawmakers modified the act, and the government now considers it entirely in line with EU norms. With the accession to the EU of Hungary and other key countries, this legislation will lose much of its importance.



Some EU states, uneasy with the union's ongoing enlargement, have voiced fears that equate potential migration from central and Eastern Europe with the immigration of undesired masses from the East. This is behind the derogation requested by the EU for the free movement of labour, which will not take effect until 2011. In fact, the free movement in the EU may be a strong factor pulling in migrants. Some current EU countries have different answers. The United Kingdom, Ireland, the Netherlands, Denmark, Sweden, Spain, and Greece planned to grant working rights to people from Hungary and citizens of the new EU countries. However, Germany, France, and Italy were planning to delay that right for up to seven years.

The free movement of labour from eastern countries would primarily alter the border regions of Austria and Germany. At the same time, the growth of the Hungarian economy seemed sustainable, and according to economic forecasts, it would maintain a growth rate above the EU average. Furthermore, according to survey results, a negligible 2.7% of Hungarian workers would take advantage of free movement of labour to work abroad for a longer period of time. No more than 1.5% aspired to permanent emigration

Hungary, like most receiving countries, treats the inflow of immigrants not as a complex social and economic issue, but as a deviant phenomenon affecting public order. This approach aims at the short-term treatment of problems through defensive measures. The underlying idea is that migration can be kept in check with the means at the disposal of the authorities, particularly border control and strict residency rules. No comprehensive social, economic, or political strategy has been developed concerning migration in Hungary. Indeed, the policy is still characterized by ad hoc regulations.

It is frequently argued that the adoption of more liberal rules for the employment of foreigners would jeopardise the jobs of Hungarians. Illegal employment is often referred to in this context by the press and in political debates.

The number of foreign nationals working illegally in Hungary (estimates stand at 70,000-140,000) is not particularly great. The number of legally employed foreigners (around 100,000) is low not only in comparison with the total number of employed persons (3,870,000), but also with the total number of unemployed, who by official counts reach 234,000. But by virtue of its illegality, it has the potential to severely harm both migrants and the host society. The opinion that immigrants take jobs from Hungarians, raising the unemployment rate, appears not to be a convincing reason for further restricting immigration. In view of the structural differences between the sectors of the labour market and the flexible nature of the foreign labour force, it is unlikely that migration could seriously endanger the labour market position of native Hungarians.

Hungarian regulations strive to follow European standards, which are designed to secure the outer borders of Western Europe. The question is whether this is the proper course to follow. Restrictions cannot remove the causes of migration. Experience tends to show that measures aimed at restricting the influx of foreign workers do not greatly reduce the level of migration, but do have the effect of increasing illegality

It is important to note that the various forms of temporary migration for employment have encouraged economic development on both sides of the border, which is a prerequisite for



order and security. For many years, several regions were unable to develop because of their isolation and the strictness of border controls. Work abroad and commuter migration have therefore made an important contribution to economic development in labour-sending countries.

4. Projects and experiences

4.1. Labour market orientation for asylum seekers

Action has been taken funded by European Social Fund and the Hungarian Government and within the framework of the EQUAL programme. The aim of the EQUAL Community Initiative is to develop and implement innovative approaches and methods which contribute to the elimination of discrimination and inequities related to the labour market.

Innovations supported by EQUAL fit into the political frameworks defined by European Employment strategy and the Community Strategy against Social Exclusion. The Hungarian EQUAL programme supports pilot initiatives which foster education, job finding and employing people in disadvantageous situation. The programme realised in the framework of the "Esély" (Chance) Development Partnership started in 2005, provided education modules for asylum seekers: simultaneous and coordinated labour market orientation and skills measuring; cultural orientation; psychosocial support and communication/lingual education.

The objectives of cooperation:

- elaboration of methods connected to the labour market orientation of asylum seekers,
- trial of simultaneous application of integrated professional services.

The objectives of the programme

- changing the political (professional) environment with an extension of existing labour services for new, until now unsupported target groups, and expansion of the services of the migration institutional system with employment policy tools, and with supervising the recently updated regulation for employees;
- diminishing social prejudice;
- with all those contributing to the final aim of the social integration of asylum seekers and refugees.

Service packages which were developed and tried during this project are unique because:

- this target group could not take part on similar programme until now,
- organizations taking part in this development partnership did not collaborate in this organized form until now.



The programme was implemented in 2 places, in Debrecen and Békéscsaba, in the camps for refugees. The 6-month training programmes had three parts including recruitment, education and training, and follow up with evaluation. All those activities were realised with psychosocial support. Two models were tested "indoor" and "outdoor" education, the latter seemed more effective.

This programme did not include directly health-related themes, yet the inclusion of communications skills, social participation, networking as elements of training for asylum seekers and enhancing cooperation between services which could have competencies concerning migration-social integration meant that it contributes to the equity in health of these people.

4.2. EUGATE project

The EUGATE -project will be arranged in co-operation with 16 EU partners. The funding for the project has been granted by the EU Health Programme for 2008 - 2010. The project lead institution is the Queen Mary and Westfield College of University of London in the United Kingdom. The main objective of the project is to identify, develop and distribute best practice and recommendations on health care for immigrants in the European countries

Project overview

- multidisciplinary consortium will to consolidate the currently fragmented knowledge in the field and identify best practice of health care for different immigrant populations;
- review legislation, policies, and funding arrangements, assess systems of health care services, and compare models of best practice across European countries for the people concerned;
- EUGATE will define guidelines for best practice and disseminate the findings widely among the relevant stakeholder groups in Europe;

Project questions

- What are the legislation and directives in European countries regulating health care for immigrants?
- What are the views of experts on what constitutes best practice of health care for immigrants?
- What are the experiences of practitioners of best practice of health care for immigrants?
- What recommendations can be drawn on the findings for best practice of health care for immigrants in Europe?



General objectives

- To improve health and prevent illness of citizens in Member States, especially among immigrants and minorities;
- To reduce inequalities in provision of care and referral practices for migrants and minority populations by contributing to mainstreaming health and consumer policies across the EU;
- To exchange models of best practice among member states and learn from each other by building a network of experts among the participating EU countries;
- To contribute to the goal of the EC regarding providing quality, relevant and timely data of services for immigrants and minorities;
- To contribute to a harmonized European strategy in providing responsive health and social services for immigrants and minorities, disseminating best practices;
- To contribute to the further improvement of services by defining measures of quality and by facilitating a discussion on the issues, leading to policy decisions on both national and European levels;
- To publish and disseminate best practice examples in a coherent way, for service improvement for immigrants and minorities.

Methods

- Document research of legislation and directives in the participating European countries
- Delphi process of expert opinion on what constitutes best health care for immigrants in Europe
- Interviews with practitioners in health services

Delphi process of expert opinion on what constitutes best health care for immigrants in Europe:

- In each participating country, in total 8 experts from academia, NGOs, policy makers and practitioners (at least 3 groups represented in each country) will be identified and recruited to participate in the process
- Interviews with practitioners in health services

Three types of services will be identified:

- accident and emergency department
- service providing long-term care for patients with chronic and severe mental illness
- primary care services (e.g. GP practices)

The interviews have three parts:

- general information
- general experiences



- scenarios based on case vignettes

General information

- Percentage of immigrants of the total clientele
- Typical characteristics in terms of gender, age, nationality, length of stay in the host country, and command of language of the host country
- Most frequent diseases among immigrants in the service
- Existence of specific departments, programmes and staff for immigrants
- Existence of specific policies and guidelines for dealing with immigrants
- Training of staff for dealing with immigrants
- Availability of interpreters
- Specific consideration of immigrants in evaluation and/or quality management

World Health Organization
Regional Office for Europe
Regions for Health Network



Migrants and Health Care: Responses by European Regions (MIGHRER)

Complete reference material

VIII. Regional report Ticino

Annamaria Fahrländer¹



¹ UPVS - Direzione salute pubblica - Dipartimento della sanità e della socialità. Cantone Ticino. Switzerland.



Summary

Switzerland has been dealing with the phenomenon of migration for many years; most people come from European countries and have immigrated to Switzerland for economic reasons, to rejoin their families or because of political problems.

The challenges connected to the integration of the migrants and their chance of finding a new placement and identity in a foreign country, as well as the topic of access to the health system linked to these factors, in particular bring to light the cases of recent migrants and/or those with precarious status (including asylum seekers) or without resident permits, that is those groups who have difficulty in expressing their rights of citizenship.

In 2002 the Federal Government approved a first five-year programme of "Migration and Public Health Strategy", extended till 2013, whose main characteristic is an approach favouring socio-economic determinants, along with environmental, social and cultural ones and their impact on health; it proposes instruments and interventions which make access to health services easier for those with problems and it focuses attention on the factors which determine situations of vulnerability and exclusion. A "Monitoring of Health Status in the Migrant Population in Switzerland" accompanied the first years of the execution of the federal strategy. Some of the findings of the Monitoring are mentioned in the present report.

The guidelines contained in the Federal Strategy direct the political health agendas of the 26 cantonal governments, who are responsible for organizing, planning and managing the supply of health care. The methods to be used to face the themes relating to migration vary and depend on the local geographic, linguistic and economic and social characteristics.

In Canton Ticino 26% of the resident population are foreign nationals, of whom, however, 57% are Italian.

The approach to people of different languages and cultures has become an integral part of professional training in the health sector, thanks also to the contribution of the children of second and third generations of migrants who have helped bring about the changes in a society which would like to be multi-ethnic but which is afraid of losing its cultural identity, which is changing.

The health care structures which mainly face the problems connected to migration, that is those specifically tied to forced integration, are hospitals, casualty services and the low threshold community services in the area which in their turn enable easier access and also provide information on legal and social as well as health topics. The linguistic-cultural mediators represent an essential bridge between the immigrant population and the social/health care operators.

The comparison of health care policies linked to migration at local, national and international level is important, not only because of the global nature of our age, but especially in order to respond to the necessities of comparison and lesson-learning and to find sustainable methods to meet the needs of the different ethnic, institutional and professional groups who make up our society.



1. Health system overview, national and regional situation

In the first part of this chapter the elements of structure and organization of the health care system at federal and cantonal level are developed in a general way. The specific aspects linked to migration will be dealt with in more depth in the second part of the chapter (1.3 and following) and in chapters 2 and 3.

1.1. Structural organization at federal level

Switzerland is a federal state with three institutional levels:

- the Confederation (the central state),
- 26 Cantons,
- 2,740 Municipalities.

At each level specific tasks and responsibilities are allocated, financed by taxation at the federal, cantonal and municipal levels². The allocation of responsibilities between the Confederation and the cantons is defined by the federal constitution, which confers upon the cantons full sovereignty in all fields not specifically within the ambit of the Confederation (the subsidiarity principle).

The federal constitution explicitly allocates to the central state only very few responsibilities in the field of health, which are limited to:

- organizing and regulating health insurance;
- control and eradication of communicable diseases as well as health protection (drug addiction incl.);
- regulating reproductive medicine, genetics and medical research;
- defining study programmes for most health professionals.

As a result, it is the Cantons who are responsible for organizing and managing the supply of health care. Due to the sovereignty that the 26 Cantons enjoy in this field, it may be argued that in Switzerland 26 different models exist where the planning, organization and management of the health care sector is concerned. The various cantonal systems are however interlinked, like communicating vessels, by the Federal Law on Health Insurance, called LAMal.

At the heart of the Swiss health care system is a health insurance model (LAMal) that is a halfway-house between a social insurance and a private insurance system. Although insurance is compulsory, it is managed by several private non-profit health insurance companies, which officially compete with each other and provide an identical benefit package at prices (premiums) varying according to the average risk of each health insurer's clientele within the 26 Cantons (Figure 1).

² Depending on the allocation of the responsibility, as defined by the federal constitution, the various functions to be carried out are financed by national, cantonal or municipal taxes (tax federalism).



The features that distinguish this model from a public insurance system are, especially, the premiums, which are not income-related, and the fact that insurers (whose business in the mandatory health insurance sector is framed by social law) may simultaneously offer a range of complementary health insurance policies governed by private law. It is therefore not surprising that the dynamics triggered by this model over the last ten years were not able to effectively counter rising health care costs. Such a development weighs heavily from a social viewpoint, given the fact that the financing of the Swiss health care system is one of the most unfair in Europe.

In Switzerland two thirds of health expenditure is financed independently of income, which leads to an increasingly intolerable financial burden for a growing proportion of the population (Bolgiani *et al.*, 2006).

In 2007 health costs in Switzerland overshot 10.8% of GDP (CHF 55.3 billion). The comparison among OECD countries (latest figures from 2006) shows that it is the USA who use the most resources for their health care system, with a proportion of 15.3% of GDP, ahead of France (11%) and Switzerland. Germany ranks 4th with 10.6% (Federal Statistical Office 2009).

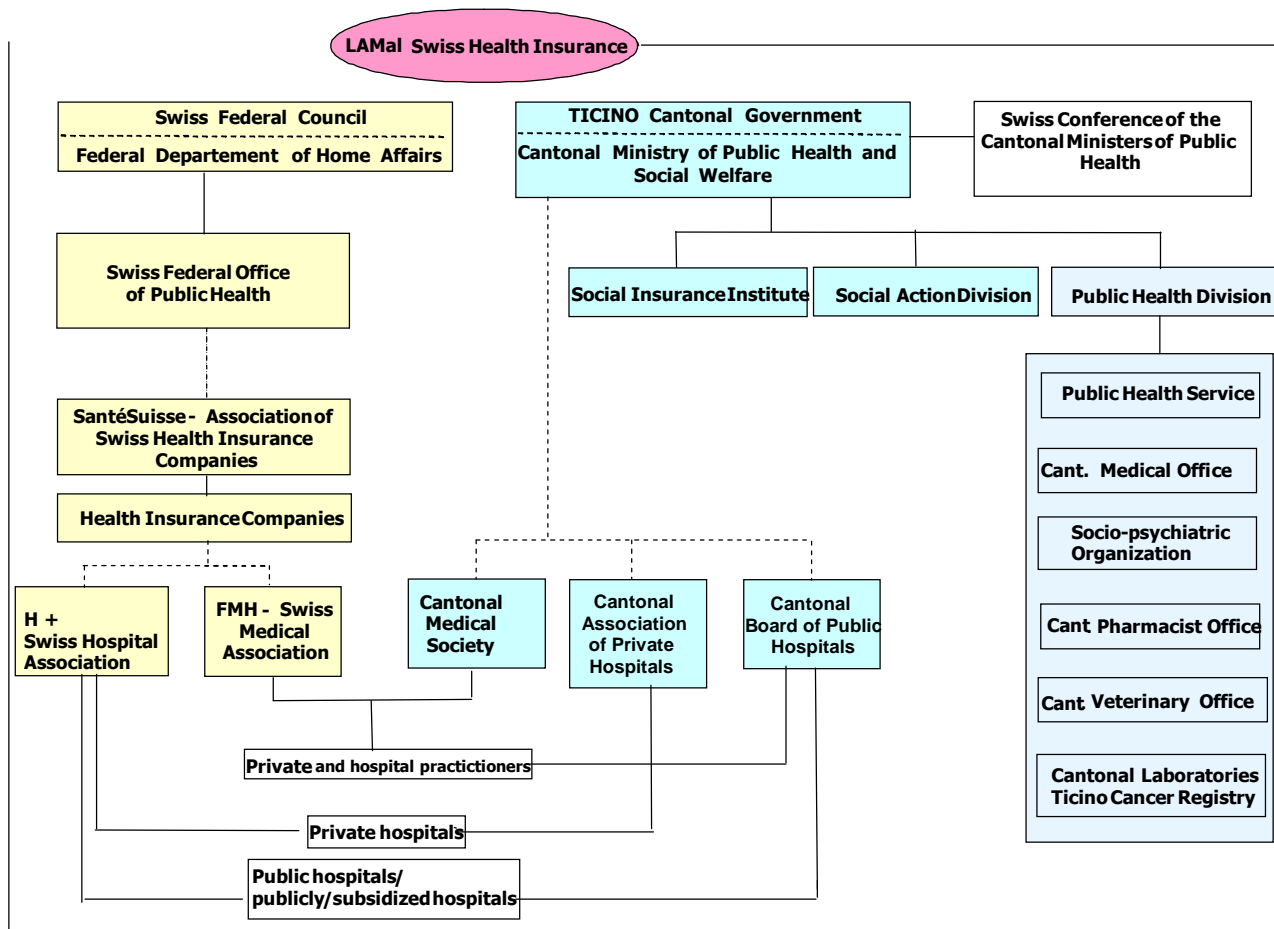
A rough sketch of the Swiss Health Care System is drawn based on the national law of Health Insurance, LAMal (Figure 1).

It is a very simplified sketch and does not represent the complexity of the system. For more details it is necessary to consult further specific documents and literature (Kocher, Oggier 2007, Achtermann, Berset 2006).

As mentioned above, every Swiss Canton has its own health care system. The cantonal part of this organizational chart is focused on the Ticino health care system. The next chapter describes the organizational details at cantonal level.



Figure 1. Swiss Health Care System



Legend: _____ hierarchic link

----- functional link, based on the Swiss Health Insurance LAMal

1.2. Structural organization at regional level

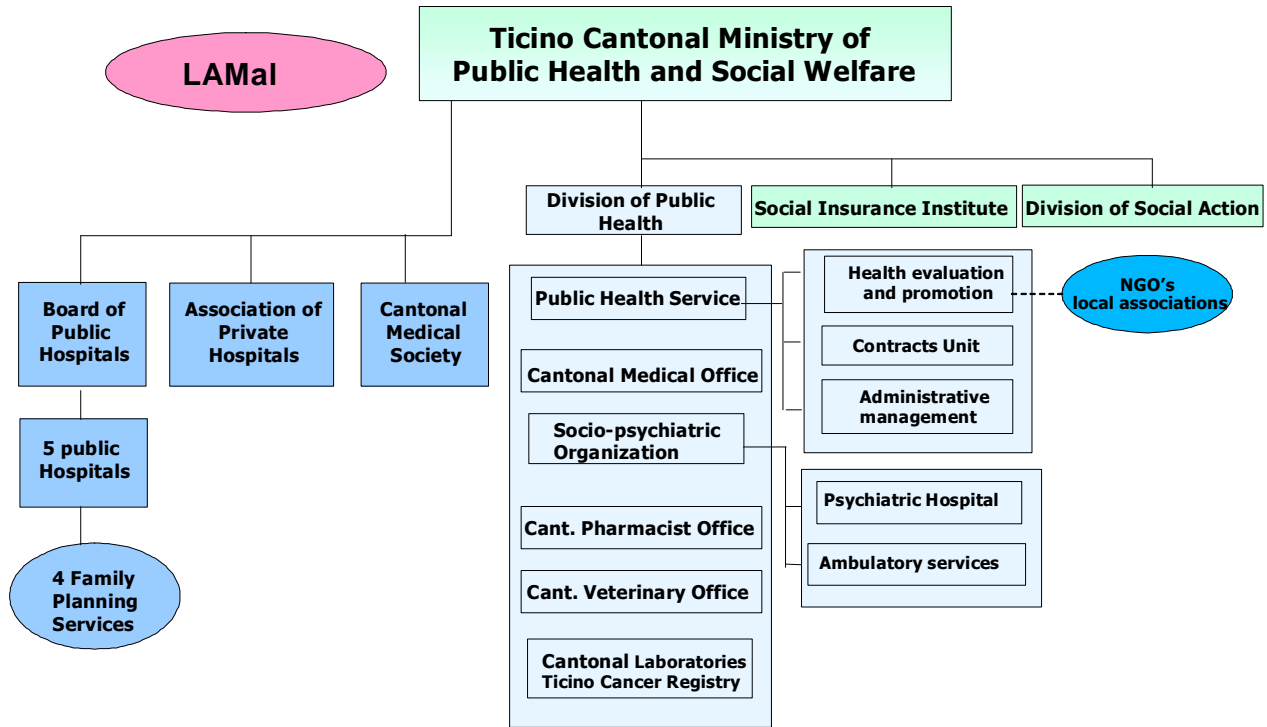
Ticino is one of the 26 Swiss Cantons, the only Italian-speaking region in Switzerland with 327,600 inhabitants, on the southern side of the Alps and bordering on Italy.

The five ministers of the cantonal government are elected directly by the voters; there is no coalition but a government based on consent. The collaboration between the five ministries within the framework of health determinants is one of the important challenges at present (Frei, Casabianca 2006).

Legislation, health policy and planning, within the framework of the LAMal, are the competence of the cantonal Ministry of Public Health and Social Welfare and are decreed by the Cantonal Health Act.



Figure 2. Health Care System of the Canton of Ticino



Health Care - hospitals

Inpatient care (public hospitals, private clinics): acting in accordance with the Health Insurance Law, LAMal, the Canton is explicitly responsible for hospital planning, therefore for the organization of the capacity and structure of hospital supply on the basis of the population's needs and cost-control targets (Figure 2. Cantonal Board of Public Hospitals, Cantonal Association of Private Clinics, Cantonal Public Health Division).

Health Care - ambulatory sector

The ambulatory sector provides general medical care, diagnostic services, obstetric care, perinatal care, care for children, family planning, rehabilitation, dental care and home-based care. Ambulatory services are largely provided by physicians in independent/single-person practices. In addition to independent practices, ambulatory services are also provided by outpatient departments of public and private hospitals (Figure 2. Cantonal Board of Public Hospitals, Cantonal Association of Private Clinics, Cantonal Medical Association).

Family planning, an ambulatory service, depends on hospitals.

Psychiatric care and ambulatory services

Psychiatric care and ambulatory services are managed by the Cantonal Division of Public Health and by private practitioners and hospitals.



Public health

The Cantonal Division of Public Health is responsible for both sectors of primary prevention and health promotion.

Primary prevention activities, such as the implementation of immunization programmes and vaccination-coverage surveys (OECD and World Health Organization 2006), both secondary and tertiary prevention, quality assurance and care of the elderly fall under the responsibilities of the Cantonal Medical Office.

The same institution is responsible for setting up screening programmes and for implementing disease-control intervention as decided and co-ordinated by the federal authorities.

Important cantonal programmes of health promotion are supported by "Health Promotion Switzerland"³ and the cantonal Public Health Service, emphasizing community participation and social empowerment (World Health Organization 2008), within four priority programmes:

- Physical activity, nutrition: the objective of this programme is to stimulate population groups (schoolchildren, young people, the elderly etc.) to take the initiative in promoting their own health in these areas and to consider social implications as part of public health policy.
- Health and work: the principal areas of attention of this programme are workplace safety, the prevention of occupational diseases, fear of losing work, health promotion of the unemployed.
- Adolescents and young adults: the aim of this programme is to strengthen young people's sense of individual worth. A cantonal network of state-subsidised associations and local communities deals with issues such as prevention of the consumption of alcohol, hard and soft drugs. The programmes cover age-targeted groups in the communities with special attention paid to high-risk groups in high-risk environments.
- Mental health: in the light of the growing importance of mental health problems, greater attention is given to prevention, particularly of those problems related to stress and socioeconomic determinants.

To a significant degree the implementation of health promotion projects is left to numerous cantonal and national non-profit associations and is partially supported by institutions at both levels.

³ Health Promotion Switzerland is a foundation financed by the Swiss cantons and insurance companies, and supervised by the Swiss government. The Foundation initiates, coordinates and evaluates policies for the promotion of public health on behalf of the Swiss government (articles 19/20, Federal Health Insurance Act). The Foundation Council is its highest instance. Each person resident in Switzerland currently contributes CHF 2.40 per year to Health Promotion Switzerland - a small investment by each individual towards everyone's health. It is collected by the health insurance providers on behalf of the Foundation.



Some relationships at institutional level in Canton Ticino with other federal and cantonal organs will now be highlighted; their aim is to improve the organization of health care structures, guaranteeing care for patients and migrants.

1.3. Intersectorial actions in the Canton of Ticino

The intersectorial actions concerning Ticino are presented at federal, cantonal and intercanton level. In this chapter a more detailed analysis of the migration phenomenon is started; it will be dealt with further in chapter 2.

Actions at national level

Swiss Federal Office of Public Health, Ticino Ministry of Health and Social Welfare - The Cantonal Public Health Service is collaborating within the national multilingual information and documentation platform Migesplus⁴, aimed at migrants and at professionals of the health and welfare sectors. This platform is supported by the Swiss Red Cross, the Swiss Federal Office of Public Health, the Cantonal Public Health Service and other national and local NGO's.

Information (translated into more than 25 languages) is provided on specific health-related issues, including substance dependence and sexual and reproductive health. The aims of the platform Migesplus are:

- guaranteeing immigrants who live in Switzerland equal opportunities for access to information regarding health care matters
- offering an overview of the main brochures, videos and other multilingual information support material dedicated to this topic;
- encouraging immigrants to take responsibility for their own health and helping them to find their way around the Swiss health care system;
- promoting the production of high-quality information brochures, translating them into the languages of the migrant groups interested and guaranteeing that they take the special features of the migratory context and daily life of the immigrants into account;
- identifying possible information gaps and filling them.

The National working group on Migration and HIV/AIDS Prevention, supported by several cantonal public health services, associations and NGO's, is elaborating a framework concerning aims, indicators and tools in HIV/AIDS prevention and its application at local level. Special attention is given to migrants with precarious status or without resident permits.

Swiss School of Public Health and University of Lugano (Ticino) - An important task concerns the training project for health professionals of Central and Eastern European countries within the Summer School in Public Health Policy, Economics and Management, organized by the

⁴ <http://www.migesplus.ch>



Foundation Swiss School of Public Healthplus (SSPH+), the Institute of Microeconomics and Economics of the Public Sector (MecoP) of the University of Lugano and the Swiss Tropical and Public Health Institute (SwissTPH).

Since 1996 the Swiss Agency for Development and Cooperation (SDC) has supported a four-phase cooperation project within the Summer School which has enabled about 350 health professionals from Eastern European countries (Romania, Bulgaria, Albania, Bosnia, Belarus, Moldavia, Ukraine, Tajikistan, North Caucasus) to be invited to the Summer School. The project contributed to transferring and sharing the knowledge and skills needed for managing health care systems and health service facilities in transition countries.

The focus of the offered courses is on the transfer of practical experiences and new concepts, based on scientific evidence, which enables participants to use the new concepts in their daily work. The participation of health workers (most of them working at highly exposed positions in health institutions in their countries) from different countries, with different cultural and professional backgrounds, creates an unique learning environment, a platform for mutual learning. Concerning the challenges in global health, such a platform is necessary and bears also the opportunity of integrating new concepts into the Swiss Health System.

Actions at cantonal level

All Cantonal Ministries: Education-Culture-Sport, Home Affairs-Justice-Police, Territory, Finance and Public Health and Social Welfare of the Canton of Ticino.

A Health Impact Assessment procedure for the systematic assessment on health of non-health-related public policies has been projected, in accordance with the principles of the cantonal policy based on sustainability. The procedure focuses on the evaluation of measures (laws, projects and directives) and is in accordance with the principles of equity. The HIA procedure intends to improve the quality of governmental decisions, through recommendations to enhance predicted positive health impacts and minimize negative ones.

Ministries of Education, Culture, Sport and of Public Health and Social Welfare of the Canton of Ticino

Secondary schools: interventions on the topics of tobacco, alcohol, drugs, sexuality, violence for all adolescents supervised by the forum "Health Promoting School", with the aim of spreading the culture of health and prevention of risk behaviour within schools and to enhance the already existing specific projects in the Canton.

This Forum is provided with a permanent advisory board. It aims to regularly bring together public and private institutions that work in close contact with schools and deal with health-related issues (health promotion and prevention).



The higher education institution specializing in nursing care lasting 3 years offers a module every year on topics relating to migration and intercultural communication. Another aim concerns the elaboration of the migrant background of many of the students (second and third generations of migrants) and their comprehension within the professional field.

Ministry of Territory and of Public Health and Social Welfare of the Canton of Ticino

Slow mobility - Sustainable development of healthy cities: promotion of physical activity and slow mobility (walking and riding) and encouraging people to use these activities for getting to work and to school and also for pleasure.

The project aims to provide information, to educate people of local communities (towns and neighbouring villages) and to create and strengthen existing local networks formed by politicians, professionals, and citizen associations.

A cantonal information network for asbestos and domestic health issues formed by professionals coming from public administration and private services answers to people's information needs, to professionals working in the building sector and to find effective solutions for the correct management of this problem.

A cantonal workgroup aims to manage and reduce health risks during specific and recurring environmental crisis (heat-waves and air pollution).

Ministries of Home Affairs, Justice and Police and of Public Health and Social Welfare of the Canton of Ticino

Information service on social, health and legal matters

The information service, MayDay, is aimed at migrants with precarious status or without a resident permit and offers advice and intervention on matters regarding health, legal and social problems. A network of professionals in all the above-mentioned matters supported by intercultural interpreters is available for migrants who have lost their rights. Health promotion initiatives involve sex workers, many of them are without resident permit.

Many local NGO's, some of them supported by the Canton, provide for the most vulnerable groups of migrants.

Ministries of Finance and of Public Health and Social Welfare of the Canton of Ticino

Psychopathologies due to work conditions, contracts and economic constrains

This service is aimed at all people, Swiss and migrants, with troubles related to higher risk in work, social and economic conditions like stress, psychopathologies, muscular-skeletal troubles and other diseases caused by work conditions. One of the aims is to form a network between the cantonal Departments of health and social welfare and of economy, the trade unions and the industrial association.



The proposed new phase of the project aims at a further contribution to health development with a special focus on creating partnerships between health professionals in Eastern and South-East European countries and partners in Switzerland and other European countries. This corresponds with several initiatives aiming at building individual and institutional capacity in the field of postgraduate education in the health care sector.

Actions at intercantonal level

Health ministers, directors of public health services and those in charge of prevention and health promotion in the French and Italian speaking Swiss Cantons are grouped as following:

Swiss Conference of the Cantonal Ministers of Public Health

The tasks of the Swiss Conference of the Cantonal Ministers of Public Health include the collaboration between the 26 Cantons, that between the cantons and the Swiss federal Council and with other important organisations within the Health Sector. The Conference is an advisory body and represents an important political power within the Federal Health Policy.

Conférence Latine des Affaires sanitaires et sociales (CLASS) Groupement romand des services de santé publique (GRSP)

The aim of the "Conférence Romande des Affaires sanitaires et sociales" (CLASS) and "Groupement romand des services de santé publique" (GRSP) is to integrate health and cantonal policies, in order to create policies that work in accordance with the WHO's "health for all" scheme. The CLASS brings together health ministries from the French and Italian cantons of Switzerland calling regular meetings six to eight times per year. The GRSP organizes meetings between directors of all public health services.

The working areas are as following:

- Comparing cantonal health care systems
- Solutions for financing health care systems
- Environment and health
- Efficiency and efficacy of health care systems
- Promotion of health and prevention
- Development and management of health and social projects



Intercantonal Group for Prevention and Health Promotion (CPPS)

The aim of the group is to co-ordinate activities for the promotion of health and prevention within the public health services of the French and Italian cantons of Switzerland.

A national and regional framework of data collection, reports, health surveys and webliography is believed to be useful in this context. Some web sites of institutions which do not have specific health care competence are mentioned, but they are useful considering the determinants of health.

1.3. Health Information System

Switzerland lacks systematic statistical data on the health status of migrants. The various existing standard databases do not enable distinctions to be made between different groups systematically, for example, by residence status or country of origin.

The following statistical and documentary sources on health and migration are available.

National statistical framework - health indicators

- Swiss Federal Statistical Office
<http://www.bfs.admin.ch/bfs/portal/en/index.html>
- Swiss Federal Office of Public Health
<http://www.bag.admin.ch/aktuell/index.html?lang=en>

Swiss Federal Office of Public Health. Federal Strategy "Migration and Public Health"

- Swiss Federal Office of Public Health, National Migration and Health Programme
Presentation of the national Migration and Health programme. Its aim is to improve the health-related behaviour and the overall health of the migrant population in Switzerland
<http://www.bag.admin.ch/themen/gesundheitspolitik/07685/index.html?lang=en>
- Federal Strategy "Migration and Public Health 2008-2013", Berne, Swiss Federal Office of Public Health
View of the past and present federal strategy - with facts on Switzerland as a country of immigration and on the health of the migrant population
<http://www.bag.admin.ch/themen/gesundheitspolitik/07685/index.html?lang=en>
- Federal Strategy "Migration and Public Health 2002-2007", Berne, Swiss Federal Office of Public Health
Information about the first stage of the Federal Strategy "Migration and Public Health 2002-2007" and the projects which have already been implemented
<http://www.bag.admin.ch/themen/gesundheitspolitik/07685/11558/index.html?lang=en>
- Migration and Public Health. The Confederation's strategic orientation 2002-2006. Summary. Berne, Swiss Federal Office of Public Health, 2002



- Federal Strategy "Migration and Public Health Strategy, 2002-2007". Research (basic research, evaluation, monitoring), Berne, Swiss Federal Office of Public Health
<http://www.bag.admin.ch/themen/gesundheitspolitik/07685/11558/index.html?lang=de>

Webliography

This section contains a list of links to institutions, external agencies and platforms on health and migration

- Caritas Switzerland
<http://web.caritas.ch/page2.php?lang=en>
 Analysis focuses on improving the legal status and the living conditions for the socially disadvantaged: asylum seekers and refugees, poorly qualified labour migrants from outside the European Union, sans-papiers and individuals with a migration background in general.
- MIGESPLUS
<http://www.migesplus.ch>
 This Internet platform provides health information for health professionals and for migrants, given in various foreign languages.
- National platform for medical care for the sans-papiers
<http://www.sante-sans-papiers.ch/index-fr.php>
- Swiss Federal Office for Migration
<http://www.bfm.admin.ch/bfm/en/home.html>
 The Federal Office for Migration is responsible for all concerns related to aliens and asylum seekers in Switzerland.
- Swiss Forum for Migration and Population Studies
http://www.migration-population.ch/About_the_SFM.405.0.html?&L=0
 The institute of the University of Neuchâtel is active in teaching and research. It conducts scientific research in the fields of migration and demographic issues with the aim of contributing towards a pragmatic discussion on topics associated with migration.
- Swiss Labour Assistance (SLA)
<http://www.sah.ch/index.cfm?ID=4FFFA6E8-C08A-AB77-1480DDB3F5ADB6E7>
 In Switzerland 10 regional associations offer training and work programmes aimed at the unemployed and outcasts and offer support to asylum seekers, refugees and migrants. Through political campaigns the SLA is committed to building a society based on solidarity.
- Swiss network of health promoting hospitals and health services HPH/migrant-friendly Hospitals MFH
<http://www.healthhospitals.ch/>
 The network of Migrant-Friendly Hospitals has adhered to the Swiss Network of Health Promoting Hospitals, a network of the WHO. The site is only in German and French



- Swiss Red Cross
<http://www.redcross.ch/e/index-fr.php>
http://redcross.ch/data/info/pubs/pdf/redcross_138_en.pdf (pdf, 61 Kb)
 The Swiss Red Cross (member of the International Federation of Red Cross and Red Crescent Societies) carries out public tasks on a mandate from the Swiss government or the cantonal authorities. The SRC has been commissioned by some cantons to work in the asylum sector. The SRC provides social assistance to asylum seekers, those temporarily granted asylum and recognized refugees. The SRC is also involved in a few returnee projects.

Health survey and other reports

- Monitoring of Health Status in the Migrant Population in Switzerland (GMM).
 The full report of the "Monitoring of Health Status in the Migrant Population in Switzerland (GMM)" is published in German by: Rommel A, Weilandt C, Eckert J. Gesundheitsmonitoring der schweizerischen Migrationsbevölkerung. Endbericht. Bonn, Wissenschaftliches Institut der Ärzte Deutschlands gem. e.V., 2006.
- Part of the analyzed data by the "Monitoring of Health Status in the Migrant Population in Switzerland (GMM)" are taken from:
 Swiss Health Survey, Berne, Swiss federal Statistical Office,
http://www.bfs.admin.ch/bfs/portal/en/index/infothek/erhebungen__quellen.html
 Every 4 years a national survey on health offers a data collection at national and cantonal level.
 In English, the most important results of the "Monitoring on the migrant population's state of health in Switzerland 2007", published by the Swiss Federal Office of Public Health, are available on the website
<http://www.bag.admin.ch/shop/00038/00242/index.html?lang=en>
- Aspects of the "Monitoring of Health Status in the Migrant Population in Switzerland (GMM)" are considered by:
 Gabadinho A, Wanner P. Analyse des données de l'enquête GMM, projet de rapport final. Neuchâtel, Swiss Forum for Migration and Population Studies, 2006.
 Gabadinho A, Wanner P. Deuxième analyse de l'enquête GMM. Genève: Université de Genève, Laboratoire de démographie et d'études familiales, 2007.

Other reports:

- Bericht Integrationsmassnahmen: Bericht über den Handlungsbedarf und die Massnahmenvorschläge der zuständigen Bundesstellen im Bereich der Integration von Ausländerinnen und Ausländern per 30. Juni 2007. Berne, Swiss Federal Office for Migration, 2007.
<http://www.bfm.admin.ch/content/dam/data/migration/integration/berichte/ber-integrmassn-d.pdf> (pdf, 606 Kb)



- Legal report on the right to intercultural translations and on funding this in the area of health
<http://www.bag.admin.ch/themen/gesundheitspolitik/07685/07692/index.html?lang=en>
- Probleme der Integration von Ausländerinnen und Ausländern in der Schweiz: Bestandesaufnahme der Fakten, Ursachen, Risikogruppen, Massnahmen und des integrationspolitischen Handlungsbedarfs. Berne, Federal Office for Migration, 2006
<http://www.bwo.admin.ch/themen/00235/00237/index.html?lang=de&download=NHZLpZig7t,lnp6I0NTU042I2Z6ln1acy4Zn4Z2qZpnO2Yuq2Z6gpJCDdYN3fmym162dpYbUzd,Gpd6emK2Oz9aGodetmqaN19XI2IdvoaCVZ,s-> (pdf, 1.4 Mb)

Canton of Ticino

At cantonal level there is no specific data collection on migrant health issues. Data on migrants are included in general data collections and surveys distinguishing between Swiss and foreigners or between Swiss, Italians and others. Cantonal databases do not enable a distinction to be made between different nationalities in a systematic way. As an example, cantonal data taken from the Swiss Health Survey allow only the above-mentioned distinction.

- Demographic and socio-economic data are available at the Cantonal Office of Statistics
<http://www.ti.ch/ustat>
- Data about health indicators are available from the Public Health Service of the Canton of Ticino
<http://www4.ti.ch/dss/dsp/upvs/dati-studi-e-pubblicazioni/dati-e-statistiche/indicatori-della-salute-dei-ticinesi/>
- Data about the work market within the Schengen and Dublin association agreements are available from the Service for economic promotion, Office for Surveillance of the Work Market
<http://www.ti.ch/DFE/DE/SPE/USML/>
- Treaty on the free movement of persons from EU15/EFTA countries
<http://www.ti.ch/accordi-bilaterali>
- Soccorso Operaio Svizzero (SOS) Swiss Labour Assistance - Ticino
<http://www.sos-ti.ch>
 The main activities are: insertion and integration of asylum seekers, legal support for migrants and aliens, training and employment of intercultural mediators. Organization of occupational programmes and training for the unemployed, food support for people in difficulty.

Report on health service access in Ticino by migrants without resident permit:

- Médecins Sans Frontières Suisse (2007)
 Accessibilité aux services de santé dans la partie italophone de la Suisse pour les personnes en détresse et les sans-papiers. Genève.



2. Regulations and legal framework

In this chapter the regulations at national level are first highlighted, then those at cantonal level, concerning the health care system and the assumption of care for migrants.

At cantonal level there is not a specific law of application on migrants; the canton has to apply federal norms. Nevertheless we considered it pertinent to illustrate the content of the cantonal health law inasmuch as it guarantees all citizens the rights to health and access to treatment.

2.1. Regulations at national level (most important laws and acts)

Federal Law on Health Insurance (LAMal)

On 1 January 1996 the Swiss Federal Law on Compulsory Health Care (LAMal) of 18 March 1994 entered into force. This law instituted mandatory health care insurance and an optional insurance scheme to compensate for the loss of daily earnings. Health insurance covers the insured person's medical costs and hospitalization and provides for payments in case of sickness, accidents (unless covered by a separate accident insurance policy) and maternity.

All persons domiciled⁵ in Switzerland must be insured for sickness and accidents within three months of taking up residence, or from the time of birth in Switzerland.

However, those insured must pay a share of the costs incurred each year. These consist of a "deductible", a basic amount for which they have chosen to be responsible and which covers initial costs and 10% of any costs in excess of the deductible.

"The new Alien Act came into force on 1 January 2008. For the first time the main objectives of policies concerning admission and labour market integration have been included in the legislation. Among its other provisions the new act limits the labour migration of nationals of countries outside the European Economic Area to skilled workers, eliminates certain barriers to professional and geographic mobility inside Switzerland and introduces stricter measures against illegal immigration, undeclared work and marriages of convenience. It also provides for the granting of residence permits and short stay permits with participation in a language or integration course through an integration agreement signed between the authorities and the migrant." (OECD 2008)

The new Asylum Act, which entered into force in 1999, was partially amended between 2007 and 2008. Since January 2008 the asylum procedure has been streamlined and accelerated and the full asylum procedure similar to that practised inside the country can now be conducted at airports. In addition, a flat-rate integration allowance is granted to recognized refugees and persons admitted on a provisional basis, new models of financing between the cantons and the Confederation have been established and return assistance programmes have been developed. In parallel with these legislative amendments, pilot projects - such as the "learning programme for refugees" - have been promoted.

⁵ Domiciled persons also include asylum seekers, migrants with precarious status and those who became "sans papiers" if they continue to pay the premiums.



“The Schengen and Dublin association agreements, which, among other provisions, include the removal of checks on persons at borders within the Schengen area and co-operation in determining the State responsible for examining an asylum application, are scheduled for implementation in autumn 2008. Since these agreements were signed in 2004, Switzerland has participated on a provisional basis in all working groups and committees dealing with these issues in the European Union.” (OECD 2008)

The legislation on labour and the protection of workers (Federal Law on Labour in Industry and Trade (13 March 1964) empowers the federal government to compel employers to take the necessary measures to protect the health and safety of the workforce.

The statistics law (Federal Statistics Law 9 October 1992) requires the federal government to compile data on health and the health care system. The health insurance law contains additional regulations that empower the Federal Council to collect the statistical data necessary to implement the law such as expenditure data, utilization data, etc.

2.2. Regulations at cantonal level

The cantonal competences are to apply the norms decreed at federal level. Therefore there is no specific law which enables the methods for assuming the responsibility for migrants to be highlighted, although the health law guarantees rights and duties through some of its specific articles, such as access to treatment to all citizens resident in its territory.

The health service is one of the areas of government activity in which the cantons have a declining but still relatively high degree of independence. Competences of the cantonal health authority are fixed by the Cantonal Health Act (Legge sanitaria del Cantone Ticino)⁶ and concerns four areas:

- Regulation of health matters
- Patients rights
- Provision of health care. The cantons' activities in disease prevention, health promotion and health education vary widely both in scope and nature. Numerous diverse projects and activities aim primarily at preventing disease.
- Disease prevention and health education
- Implementation of federal laws.

The Cantonal Health Act represents the following principles in explicit form:

- The State promotes and safeguards the population's health as a fundamental asset of the individual and interest of the community with due regard for the freedom, dignity and integrity of the human being.

⁶ Law on the promotion of health and health coordination of Canton Ticino (Health Act) of 18 April 1989.



- In particular, in a coordinated way it promotes prevention, health maintenance and recovery for all citizens without distinction for their individual and social condition. It creates the premises so that quality services and interventions are guaranteed at economic costs which are financially sustainable.
- In putting these aims into practice the State avails itself of the collaboration of the Municipalities, other public bodies and natural and legal persons governed by private law, especially health care providers and people of the Orders of health arts, promoting solidarity at cantonal level.
- In order to achieve the aims of this law the State ensures the coordination of the instruments and resources available.

Three of the nine rights guaranteed by the law⁷ are especially relevant for migrants, above all if their status is precarious or they have no resident permit:

- The right to be treated (the right to scientifically based health services) (art. 5 LS)
- The right to adequate information (art. 6 LS)
- The right to confidentiality (art. 6 LS)

2.3. Service delivery

Migration often highlights the great difference that exists between the culture and the social networks of the places of origin and those prevalent in the host country. Socio-cultural aspects in the understanding of the illness and the use of the health services are factors which determine a powerful impact on the ways of making use of the health care system in the host country.

Introduction of the topic of migration in the context described

“Whether or not a person has an immigrant background is not considered to have a direct influence on their health status, but this factor is relevant when combined with other factors.

In Swiss immigration policy, for example, the country of origin is a determining factor for residence status and thus has a direct effect on the general conditions for integration and, consequently, on socioeconomic status and an individual’s life circumstances. Not all immigrants in Switzerland, therefore, are equally affected by health-related inequalities. However, aspects of the health care system expose certain groups of immigrants to higher health risks and increase their vulnerability, causing health-related inequities” (Spang, Zuppinger 2009).

⁷ The rights to: treatment, adequate information, a second medical opinion, consult one’s own medical file and receive a copy of it, give or refuse consent, interrupt treatment, be informed on an early diagnosis, confidentiality, give advance instructions.



Socioeconomic factors and problems related to the poor work and living conditions to which migrants are often exposed often go hand in hand with questions of accessibility to and adequacy of health care and prevention services in Switzerland and in the Canton of Ticino.

As mentioned above,

“every person living in Switzerland has mandatory health care insurance, with basic services open to everybody. This also applies to asylum seekers (although their access to health care services is often limited by gatekeeping practices) and to people living in Switzerland without legal status (*sans papiers*). In reality, however, *sans papiers* are often without insurance for economic and legal reasons. Also, people whose applications for asylum are rejected and who remain in Switzerland illegally are not covered by insurance; they are covered only in emergency situations” (Spang, Zuppinger 2009).

Health literacy is linked to the improvement of health information and its quality and to professionals’ education concerning health literacy as a health risk factor.

Health literacy also is a cultural issue to be considered as a whole of the knowledge and practices shared and transmitted within a given group; it is not a genetic heritage (Therianos-Abdelmoumène 2009).

Access to (and adequacy of) health care services are also affected by language and cultural barriers. Personnel in health care institutions and in organizations active in health promotion and prevention often lack transcultural skills, and the use of intercultural translation services is hindered by institutional, financial and administrative barriers. “Moreover, health promotion and prevention programmes and campaigns are rarely designed in ways that adequately address the needs of the immigrant population” (Spang, Zuppinger 2009).

The use of intercultural interpreters leads to an improvement in the quality of treatment and care. In the framework of the Migration and Public Health Strategy 500 persons have so far been certified as intercultural interpreters in Switzerland.

Availability of services to migrants at national level

Federal Strategy on Migration and Health 2002-2007 and 2008-2013

By 2002 the Swiss Federal Office of Public Health in collaboration with the former Swiss Federal Office for Refugees, the former Swiss Federal Aliens Office and the Swiss Federal Commission for Foreigners had elaborated the “Migration and Public Health Strategy”, which was approved by the Swiss federal government in 2001 and implemented in 2002-2007 (Federal Office of Public Health 2002).

In June 2007 the Federal Council approved a refined version of the programme and extended it to 2013 (Federal Office of Public Health 2007a).

“The Federal Council’s decision enabled the programme to be financed through the Federal Office of Public Health’s credit for preventive measures.



The Migration and Public Health Strategy is completely funded by the Federal Office of Public Health, except for therapy for traumatized asylum seekers (financed by the Federal Office for Migration), the agencies for intercultural interpreters (financed by the Federal Commission for Foreigners through its integration promotion programme) and some additional individual contributions from project partners" (Spang, Zuppinger 2009)

The aim of the Federal Strategy on Migration and Public Health is to improve the health of the migrant population in Switzerland and to ensure equal opportunities as far as health care is concerned.

The implementation of the strategy is guided by several principles of action:

- Integrated approach: migration-specific concerns are to be integrated into the existing provision by means of information, coordination and networking.
- Greater use is to be made of the resources already available in the migrant population.
- With respect to equal opportunities it is particularly important to always take the gender aspect into consideration.
- Integrating migration-related considerations into numerous health-related areas involves pursuing a cross-sectoral approach as far as possible.

These principles has to be applied within the four fields of

- health promotion and prevention,
- training and on-going training in health care,
- health care provision,
- research and knowledge management.

Migration Mainstreaming

The cross-sectoral task of Migration Mainstreaming, developed within the Federal Strategy on Migration and Health, introduces an important paradigm shift (Federal Office of Public Health 2007b).

This is a long term strategy including all the activities intended to encourage the players in the fields of politics, administration and society in the health care sector to take the migration dimension into account in their observations and workings, at the planning level as well as when carrying out and assessing the programmes, projects and measures they take part in.

The main objective of Migration Mainstreaming is to guarantee the migrant population the criteria and conditions of equal opportunities in the ambit of health care, that is to pursue equal opportunities for the migrant population in health matters.

Several projects have been realized within the Federal Strategy of Migration and Health 2002-2007; an important aspect is represented by the Migrant-Friendly Hospitals project which deals with important facets of health care delivery and the training of health professionals.



Migrant-friendly hospitals

The network of the Migrant-Friendly Hospitals (MFH) was established in 2003, initially as a project within the Federal strategy on Migration and Health 2002-2007 and carried out by H+ Swiss Hospital Association. MFH has become part of the Swiss Network of Health Promoting Hospitals, a network of WHO⁸. The ideal of equal opportunities for migrants relating to health services is now being perfected further and given a lasting structure.

The project's aims (Saladin 2007) are:

- to create a network of health care institutions with particular skills in the care of members of migrant population groups;
- to transfer knowledge and skills through the exchange of information and experience by the doctors, nurses and administrative staff directly participating in the project;
- to formulate recommendations and best practice standards for cross-cultural competence, to publish these and make them available to a broader audience;
- to promote and support specific measures to be implemented by health care institutions.

The outcomes and results of the project are published by the Swiss Office of Public Health in collaboration with H+ Swiss Hospital Association (Saladin 2007).

Availability of services to migrants at cantonal level

According to the Federal strategy on Migration and Health and to the Recommendations of the European Council concerning health services in multicultural societies (2006), access to health for migrants is facilitated mainly in two sectors of health policy: public hospitals and health promotion. Most of the health promotion initiatives are supported by cantonal funds and realized by local NGO's.

- One of the 5 cantonal public hospitals is part of the migrant-friendly hospital network, corresponding to the criteria of access, information and training.
- Family planning services meet the needs of many migrant women and are available for illegal sex workers.
- Mayday is a very easily accessible information service on social, health and legal matters referring to migrants who find it difficult to have access to other institutions. This service is free of charge and has become a reference point for the local government on health matters of migrants.

For migrants without health insurance or access to health services who apply to MayDay, a network which includes physicians with different specializations and pharmacists is available; for those without resident permits this network is expanded to include other professionals like jurists and social workers.

⁸ <http://www.healthhospitals.ch>



MayDay is part of Soccorso Operaio Svizzero (Swiss Labour Assistance), a social oriented service which main activities are: insertion and integration of asylum seekers, legal support for migrants and aliens, training for the unemployed, food support for people in difficulty, training and employment of intercultural mediators.

- Primis, a health promotion project on sexually transmitted diseases of "Aiuto Aids Ticino", aimed at sex workers, involves intercultural interpreters and professionals and makes health information accessible.
- Training of health care professionals (nurses) includes migration as an integrated issue. In this context health care professionals with a migration background have the chance to improve their intercultural skills and competences, thus enhancing communication regarding the diagnosis and increasing the quality of health care.
- Projects on health promotion developed at the secondary school level involving all students about tobacco, alcohol, drugs, sexuality and violence help to improve the integration of students with a migration background, who often belong to the second and third generations.
- Local health services participate in developing the national Internet platform "Migesplus" on health promotion and prevention.
- As an effect of the migration mainstreaming approach, cantonal health promotion projects of nutrition and movement are now better targeted at migrants.

In order to better understand the migratory phenomenon some socio-demographic and economic data of the migrant populations in Switzerland and in the Canton of Ticino compared with similar data for the Swiss population will be presented.

3. The migration phenomenon

Switzerland is a country of 7.6 million inhabitants with migrants making up 21% of its population and naturalized migrants another 7%.

In the Canton of Ticino about 26% of the 327,000 inhabitants have a migrant background.

Overall, migrants or people with a migrant background comprise almost a third of Switzerland's inhabitants, their demographic, social, economic and individual characteristics vary considerably.⁹

In comparison with the Swiss population, the migrant population is younger and has more men (54%) than women, although in recent years the immigration of women has increased.

"Until the beginning of the last century Switzerland was a country with net emigration. As industrialization progressed, demand of workers grew and was increasingly met by foreigners from the second half of the 19th century onwards.

⁹ The following definition of "migrants" is used: "Migrants are persons with a migration background who had another citizenship at birth, independent of the fact if they were born in Switzerland".



The quota of foreigners in Switzerland's total population declined during the First World War, but by the end of the Second World War Switzerland's economy was again short of workers and they were again recruited abroad, a practice which continued well into the 1980s.

Swiss immigration policy was largely determined by economic needs and was always at least partially governed by the requirements of the labour market" (Dahinden 2007).

The migration background and the duration of people's staying in Switzerland show that the migrant population is very heterogeneous. The longest-established group are the Italians, many of whom were born in Switzerland, with the second and in some cases third generations strongly represented. A similar pattern is found in the groups from Turkey, Portugal and former Yugoslavia¹⁰.

From the 1980s onwards, Switzerland's admission policies for migrants have become increasingly restrictive. The migration which followed the War in the Balkans in the 90s and took place for economic reasons but also as a result of the war (flight, poverty, trauma, persecutions) coincides with that period.

3.1. Some demographic characteristics at national and cantonal level

85% of the migrants in Switzerland are originally from 43 different European countries. In Ticino this percentage is even higher, 92% of them are Europeans. 7% are from Asian countries such as Sri Lanka (Tamils), India, the Philippines and recently also China, while 4% of the Africans come mainly from North African and Sub Saharan countries.

While most migration is associated with employment and the reuniting of families, about 3% of the migrants in Switzerland are asylum seekers. The number of asylum seekers is rising continuously, as one of the consequences of the restrictive admission policy.

At present an estimated 70,000 to 180,000 migrants live in Switzerland illegally (migrants without documents or sans papiers).

The countries of origin of the migrants are represented to a different degree at national and cantonal level. The reasons are mainly economic, occupational and social, but there is also a linguistic reason.

¹⁰ "Former Yugoslavia" is a term used for methodological reasons in the report "Monitoring on the migrant population's state of health in Switzerland" and includes the citizens of Croatia, Serbia, Montenegro, Bosnia-Herzegovina. The Federal Migration Register (ZAR, Zentrales Ausländerregister) has not completely validated the survey of Former Yugoslavia citizenships. Beside their present citizenship many people are still registered under the name Former Yugoslavia, thus making it impossible to subdivide the sample regarding these countries. For this reason the term "Former Yugoslavia" will be used when referring to the report "Monitoring on the migrant population's state of health in Switzerland".

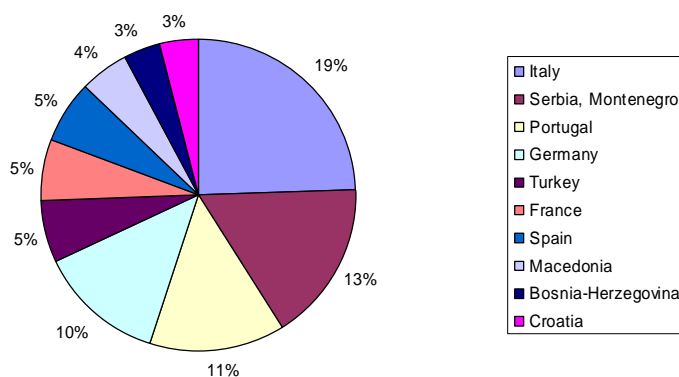


Table 1. Population living in Switzerland and in the Canton of Ticino - distribution by sex

	Switzerland 2007				Ticino 2007			
	N	%	M%	F%	N	%	M%	F%
Total	7.593.500	100	49	51	327.624	100	48	52
Swiss	5.991.400	79	48	52	242.597	74	46	54
Other nationalities	1.602.093	21	53	47	85.027	26	53	47
Migrants without resident permit (sans papiers)	70.000- 180.000; 10% of migrant population							

Source: Statistica dello stato annuale della popolazione (ESPOP), Ufficio federale di statistica, Neuchâtel, Ustat, Bellinzona

Figure 3. Switzerland - Distribution of the most representative nationalities of the migrant population in 2007



Source: Statistica dello stato annuale della popolazione (ESPOP), Ufficio federale di statistica, Neuchâtel

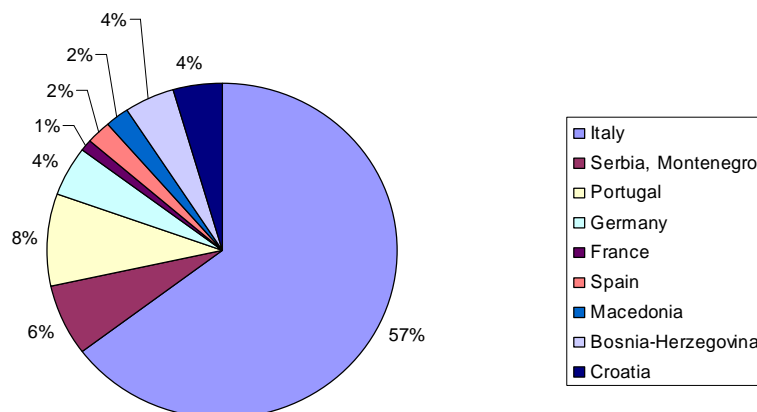
The groups most represented quantitatively at national level come from southern European countries like Italy (19%), Serbia including Kosovo and Montenegro (13%), Portugal (8%), Turkey (5%) and Spain (5%).

Germany (10%) and France (5%) as countries bordering Switzerland represent a more privileged group of migrants, they are not necessarily affected by the same problems.

The Italian-speaking region of Ticino presents a prevalence of Italian migration (57%). Countries like Serbia, Montenegro and Portugal are also represented by 8% to 6%, while Bosnia-Herzegovina, Croatia and Germany are represented by 4% of the migrant population.



Figure 4. Canton of Ticino - Distribution of most representative nationalities of the migrant population in 2007



Source: Annuario statistico ticinese 2008, Ufficio cantonale di statistica

As far as the age structure is concerned, the Swiss and Italian subpopulations are the most similar. Elderly people account for a large proportion of both groups, while the 15 to 38 age band is relatively sparse.

Young adults of other nationalities have a larger representation than Swiss at national and cantonal level. The proportion of migrants in the cohort of 20-39 year-olds is greater than that of the autochthonous population.

Table 2. Switzerland and Canton of Ticino 2007: Distribution by age

	Switzerland 2007						
	N	%	0-19	20-39	40-64	65-79	80+
Total	7.593.494	100%	22%	27%	35%	12%	5%
Swiss	5.991.401	79%	21%	24%	36%	13%	6%
Other nationalities	1.602.093	21%	22%	37%	33%	6%	1%

	Ticino 2007						
	N	%	0-19	20-39	40-64	65-79	80+
Total	328.580	100%	19%	25%	36%	14%	6%
Swiss	245.786	74%	20%	24%	35,7%	15%	6%
Other nationalities	82.784	26%	17%	31%	36,7%	12%	3%

Source: Statistica dello stato annuale della popolazione (ESPOP), Ufficio federale di statistica, Neuchâtel. Annuario statistico ticinese, USTAT.



In Ticino the Swiss and foreign population with a higher prevalence of elderly people than in the rest of Switzerland poses several problems regarding health care.

This prevalence is attributed partly to a flow of pensioners coming from regions geographically further north and also to the ageing of the migrants who arrived in the 60s and 70s and often stay in Ticino for family reasons, although the "migrants' project" provided for their return. The fact is that the relations with their countries of origin diminish over the years thus making a possible return more difficult.

The average total fertility rate is 1.9 children for foreign women and 1.3 for Swiss women.

3.2. Socioeconomic characteristics at national and cantonal level

Education

The level of education among migrants - with the exception of those originating from Germany, France and Austria - tends to be considerably lower overall. Most migrants went to school outside Switzerland. About 50 to 65% of them completed some form of schooling. Women - with the exception of Tamils resident in Switzerland - tend to be less well educated than men when they arrive in Switzerland.

About 20% of resident migrants from former Yugoslavia, Portugal or Turkey go to school or receive vocational training after their arrival in Switzerland.

Employment - work conditions - unemployment in Switzerland and Canton Ticino

With the exception of asylum seekers, most migrants in Switzerland, i.e. about 2/3 to 3/4 of the migrant population are in gainful employment, with a significant majority of them earning a salary.

Migrants from Italy, former Yugoslavia and Turkey are employed predominantly in industry, construction and other trades.

Albanian and Portuguese respondents and both Tamil groups are more commonly employed in the hotel and restaurant industry or provide domestic or consumer-oriented services.

"In Switzerland migrants are overrepresented at both ends of the socioeconomic spectrum. The proportion of the migrant population in the highest income and qualification classes is higher than average for the population as a whole and concerns mainly people coming from Germany, Austria and France. Their socioeconomic position and the fact that their native languages correspond to those spoken in Switzerland make integration easier.

The average level of education and vocational qualification among the migrant population is generally lower than that of the Swiss population. Also, migrants are overrepresented in low status employment sectors and positions. On average wages for migrants are lower, and unemployment and poverty are more common, than among native Swiss. This is particularly the case for migrants from outside the EU" (Spang, Zuppinger 2009).



A large majority of salaried workers have an open-ended employment contract (91.7% in the second quarter of 2008). A larger proportion of foreign nationals than Swiss citizens have a fixed-term contract. Such working conditions are particularly frequent among women (8.5% of foreign women compared to 8.1% of foreign men; 7.0% of Swiss women and 5.4% of Swiss men) (Swiss Federal Statistical Office 2009).

Migrants earn considerably less than Swiss nationals, whose average income is about CHF 4,300. Italians, for example, earn almost CHF 1,000 less, and the monthly income of migrants from Portugal, former Yugoslavia and Turkey is below CHF 3,000.

Albanian asylum seekers are the lowest earners, with an average of CHF 1,160, followed by the Tamil groups with CHF 2,100 and 1,780 respectively.

In Canton Ticino the prevalence of people employed is 47% (N = 153,500), of whom 72% (N = 110,200) are Swiss nationals and 28% (N = 43,300) belong to other nationalities. 41,113 frontier workers resident in the neighbouring Italian area must be added to the 43,300 migrants.

This category of workers is excluded from the statistics surveying data on the resident population in Switzerland, therefore they are also excluded from the data on unemployment.

Table 3. Employment TI

Employment Ticino 2007										
	N=occupied population	Energy, industry, production /distribution	Construction	Hotel/ restaurants	Trade	Health sector	Transport, communication	Insurance, finance, information technology	Education, public Administration	Others
Total	153.500	11%	7%	5%	16%	13%	6%	20%	13%	7%
Swiss	110.200	11%	5%	3%	14%	14%	7%	19%	16%	11%
Other nationalities	43.300	13%	12%	11%	20%	12%	3%	18%	4%	7%
Borderworkers	41.113	33%	14%	5%	16%	5%	4%	14%	1%	8%

Source Statistical Office Ticino, SLFS Federal Statistical Office FSO, Neuchâtel 2008

The rate of unemployment in Switzerland (Swiss Federal Statistical Office 2008) in 2007 is about 3.6% of the active population aged 15 and over. In all age groups the unemployment rate is higher among women.

When split by nationality we can see that the prevalence of migrants is more than double (7.1%) compared with the Swiss (2.7%); migrant women are particularly affected by this phenomenon (9.4%).

The work market and its flexibility are strongly influenced by the migration flow and in turn influence it and its regulation. The health risks caused by work conditions, the chance of keeping the job and the risk of unemployment expose migrants to a greater degree, especially if the person immigrated in the last few years and is a woman, two factors which turn out to be big disadvantages.



Table 4. Unemployment rate 2007 by nationality and sex in Switzerland and Ticino

Switzerland 2007				Canton Ticino 2007			
	Total	Men	Women		Total	Men	Women
Swiss	2.7%	2.1%	3.3%	Swiss	4.4%	4.6%	4.1%
Migrants (1)	7.1%	5.5%	9.4%	Migrants (1)	6.6%	5.2%	8.6%
Total	3.6%	2.9%	4.5%	Total	5.0%	4.8%	5.2%

(1) Migrants with a permanent or yearly residence permit
Source: Swiss Labour Force Survey SLFS, Federal Statistical Office, Unemployment Statistics (ILO-based)

3.3. Composition of migrant flow

The new migratory flows which evolve with the transformation of the work market and international agreements are presented here to complement the previous chapter.

National level

Germans and Portuguese remained the two largest groups, accounting respectively for 24% and 12% of new arrivals (OECD 2008). There was a decline in immigration from Italy (5%), Serbia (5%) and Spain (1.5%), which were formerly the main sending countries of foreign workers (OECD 2008).

This increase in immigration is primarily due to the growth of labour migration, although immigration for family and humanitarian reasons also rose in 2006.

According to the OECD's standardized statistics, slightly more than 38,000 people immigrated to Switzerland for work purposes, a 20% increase over the previous year, accounting for approximately 44% of total permanent immigration in 2006.

In 2006 10,530 asylum applications were filed (500 more than in 2005), reflecting a trend towards levelling off, which, together with 2005, marked the lowest levels since the end of the 1980s. Among asylum seekers some 1,200 were from Eritrea, which was a sharp increase over 2005 when 160 applications from this country were filed.

The number of naturalizations rose significantly (+20%) to approximately 46,700 in 2006 following the legislative amendments that entered into force on 1 January 2006 limiting costs and facilitating the naturalization of certain groups of persons of Swiss ancestry. This is the highest level observed for several decades. Serbian nationals formed the largest group among those granted Swiss citizenship and accounted for over 25% of all naturalizations (roughly 11,700 persons).

In April 2006 the provisions of the treaty on the free movement of persons from EU15/EFTA countries were extended to the ten new EU member States, but these contain transitional arrangements that will apply until 2011 to salaried workers who are nationals of these states, with the exception of Cypriot and Maltese nationals. These transitional arrangements include quotas and give residents priority to labour market access. In addition, a provision is made for



the monitoring of wages and working conditions. Since June 2007 the labour market has been open to EU17 countries (EU15 as well as Cyprus and Malta) and to self-employed workers who are nationals of Central European countries (EU8). The negotiations with the EU aiming to extend the agreement on the free movement of Bulgarian and Romanian nationals ended in February 2008. The protocol on this extension provides for maintaining national restrictions on labour market access for a seven-year period. After these transitional arrangements end, a unilateral safeguard clause would allow Switzerland to reintroduce quotas for three years if there is considerable immigration.

Cantonal level

The restrictions imposed at federal level with the application of quotas limiting the flow of foreigners entering Switzerland led Canton Ticino to draw on the border workforce, as did other frontier cantons, in order to evade these constraints; these workers were excluded from the quota numbers as they resided abroad.

This evolution enabled those branches of the regional (cantonal) economy which were very work-intensive to develop, attributing the capacity of competitive advantage to the workforce.

By controlling the migratory flow in accordance with the economic situation, the aim of these policies was to make the work market flexible, relying on the temporariness of foreigner status. But with the arrival of the Bilateral Agreements in 2002 on the free movement of persons between Switzerland and the European Union (EU15 and EFTA) Switzerland could no longer manage the phenomenon Migration alone, thus losing control of this escape valve which even enabled it to export unemployment over the years.

For its part Ticino fears the consequences of a possible new wave of foreign workers at low cost, who might be attracted by the wage gap and would be able to remove the indigenous workers from the market, with the risk of wage dumping.

On the other hand the process of market liberalization opened new prospects of development, especially on the front of finding resources - first and foremost labour - while it enabled less catastrophic scenarios to be painted concerning the expected ageing of the population and the growing gap between the working population and the retired.

Since 2002 the migratory balance of foreigners has increased thanks mainly to a growth in the net arrivals of citizens from the EU15/EFTA countries, who outranked the migratory balance of foreigners from Third States for the first time in 2002 (Alberton, Gonzales and Guerra 2008).

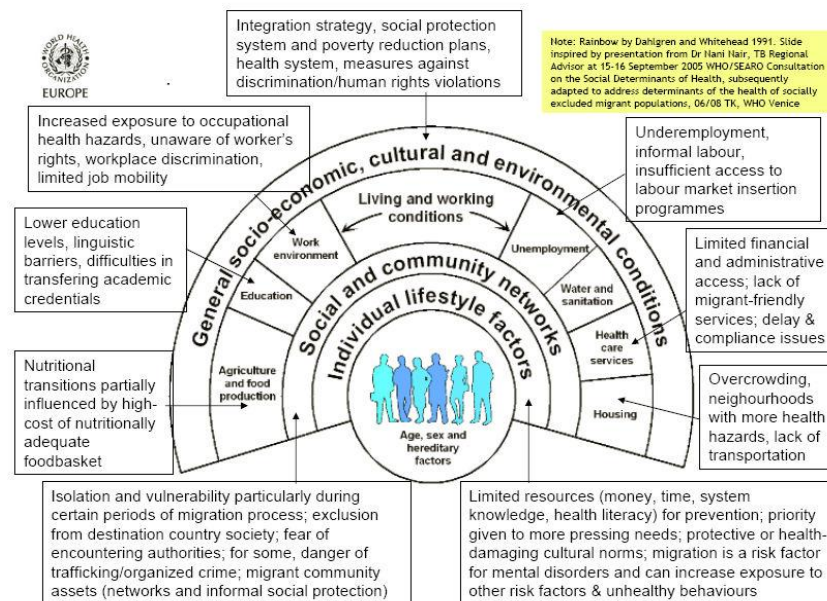
The presence of migrants is indispensable for the national and local economy. It is marked by a high presence of young foreign workers between the ages of 20 and 39. Lower wages (with differences between the groups of migrants), work conditions which are often difficult and lower qualifications make the migrants a less protected, exploitable potential. The results of this situation and the effects on the migrants' state of health are reported in more detail in the following chapter.



3.4. Social determinants of migrants' health and health care needs

The Dahlgren figure of health determinants, adapted by WHO Venice to address determinants of the health of socially excluded migrant populations (Koller 2008), summarizes and represents the impact of the above-mentioned determinants in a effective and useful way.

Figure 5. Health determinants (adapted to migration)



Source: Dahlgren and Whitehead (1991), adapted by Koller (2008)

We shall now mention some facts and observations of the migrants' exposure to risk for their health, compared with the Swiss, taken from the report of "Monitoring of Health Status in the Migrant Population in Switzerland" (Rommel, Weilandt and Eckert 2006), using the adapted Dahlgren figure.

General socioeconomic, cultural and environmental conditions as health determinants

- Migrants working in sectors which depend on the economic situation are more exposed to unemployment and to all the related risk factors.
- They work more often in shift work, on night shift, with irregular working hours; generally the work is physically hard, mainly in industries, the building and hotel sectors.
- In general migrants have lower salaries than the Swiss, there are also differences between migration groups.



- Unemployment among migrants is more than double compared with the Swiss (migrants: 9.4% of women, 5.5 % of men, Swiss 3.3% of women, 2.1% of men in 2007).
- Difficult work, economic and social conditions increase the prevalence of problems like headache, back pain, muscular-skeletal problems, insomnia and stress.
- Those with a temporary permit or without a permit are particularly vulnerable; many of them are women who work in households or in the sex industry, or refugees and asylum seekers.
- Concerning the inability to work, the results of this subjective assessment show that women are considerably worse-off than men in all groups. Tamil asylum seekers: 30% ♀, 15% ♂, Turks: 36% ♀, 23% ♂, Italians: 22% ♀, 16% ♂.
- There is a correlation between work conditions and education. Education is in general lower among migrants coming from the Central and Eastern Balkan countries.
- Health care services are not responsive enough to the specific needs of minorities. There are many challenges facing both service users and providers, especially hospitals which play a particularly important role in serving this segment of the population.
- A research on the migrants' perception of the cantonal public psychiatric services in Ticino (Testa-Mader, Clerici and Degrate 2002) reports that the pharmacy prescription is much more important for foreigners than for the Swiss (82% vs. 53%), especially for those immigrants with less knowledge of Italian. The research shows that among the foreigners interviewed about half considered their language skills to be good and 25% stated they felt it necessary to have an interpreter present during the talks with the therapist.
- There is a lack of information about the hospital and outpatient care services available or about general health matters, both at national and local level, which makes access to health care services more difficult. From the Swiss Health Survey (2007) it can be seen that the migrants in Ticino go to hospital casualty units more often (1 time/year: 15.9% migrants vs. 9% Swiss; 2 or more times/year: migrants 3%, Swiss 1.6%).

Social and community networks as health determinants

- Uncertainties about residence status and legal constraints with the risk of losing resident status increases exposure to risks of health and unhealthy behaviour.
- Migrants ask more often for financial support from the Social Insurance.
- The risk of poverty or of becoming working poor is higher among migrants, especially for women with a low level of education.
- Turkish migrants belong to the long-established groups, many of whom were born in Switzerland, with the second and in some cases third generations represented, but they feel less healthy. Only 70% of Turkish men and 57% of Turkish women feel healthy.

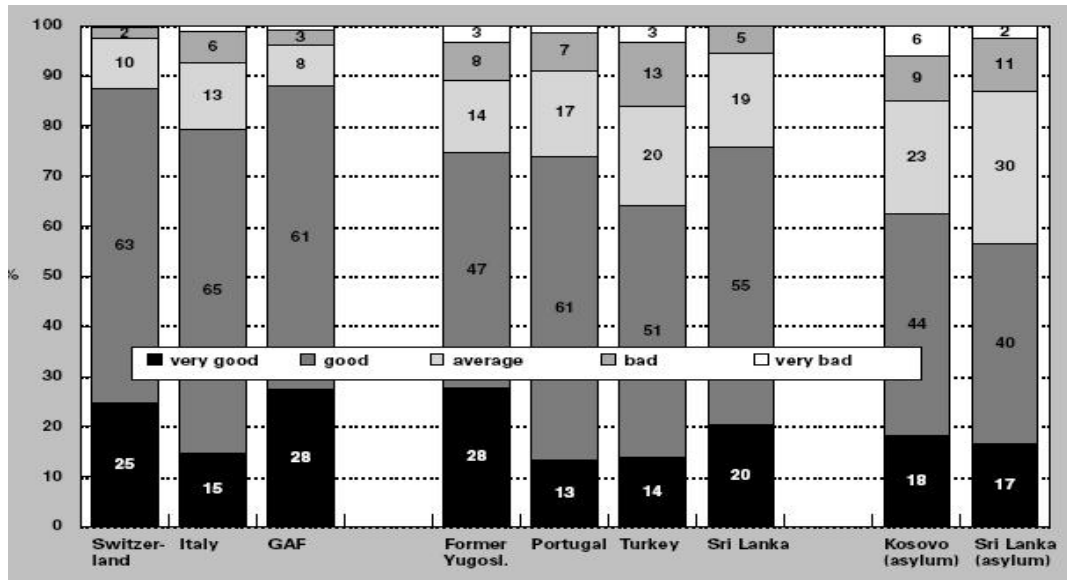


- 30% of Turkish and 26% of Kosovo asylum seekers feel that physical and mental problems are impaired by their everyday activities, compared with 16% of respondents from Switzerland and Italy (10% of those from Germany, France and Austria).
- Migrants' perception of their health status is worse than that of the Swiss. All symptoms like headache, weakness, stomach-ache, diarrhoea, back pain, muscular-skeletal problems, insomnia, thorax pain, troubles which could have psychological causes and are due to increased psycho-social burdens.
- In every age group and concerning all nationalities women complain more frequently about these symptoms than men. These phenomena become more important for women from Portugal, Former Yugoslavia and Turkey with increasing age, till the age of retirement.
- Conditions of violence, suffered in the past or the present, are linked to a higher risk of physical and psychological problems (headache, stomach-ache, insomnia, gynaecological problems).

Individual lifestyle factors as health determinants

The impact of some of the above-mentioned factors is reflected in the self-declared health status (Federal Office of Public Health 2007c).

Figure 6. Perceived state of health



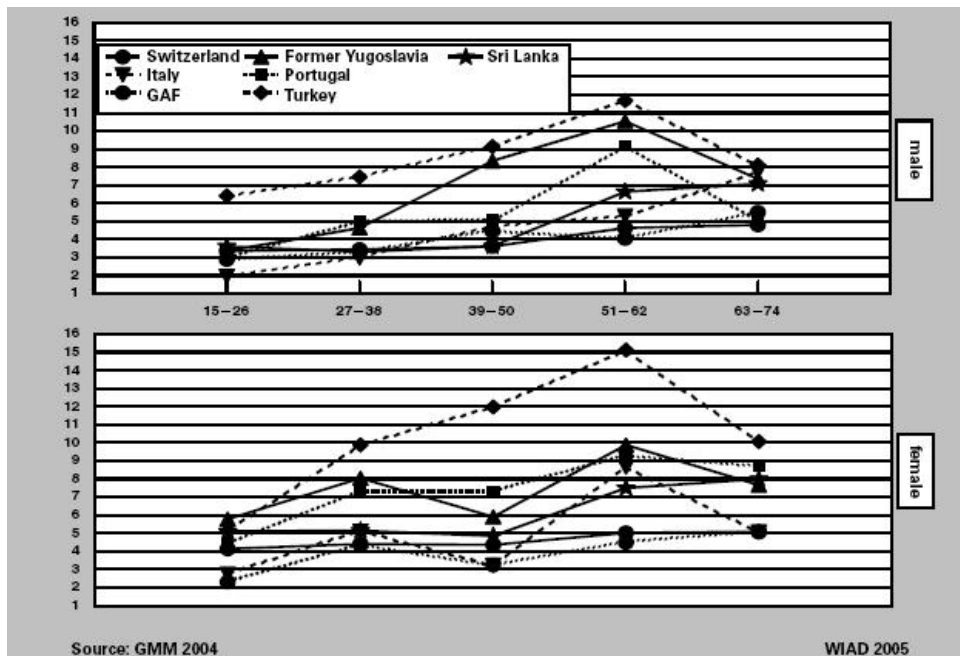
Source: SHS 2002 and GMM 2004

GAF = Germany, Austria, France



- The behaviour concerning the consumption of drugs is different among people who belong to different ethnic groups.
- Obesity or overweight is an important problem among migrants of all nationalities, mostly linked to different nutrition.
- Compared with the Swiss population migrants generally face more health problems, such as parasitic and infectious diseases (for example, malaria, TB and hepatitis) and sexually transmitted diseases (HIV/AIDS, in particular) (Spang, Zuppinger 2009).
- Miscarriages, lack of contraception use and female genital mutilation are more frequent in the migrant population (Therianos-Abdelmoumène 2009).
- The dental/oral health of children and young people with immigration origins is often worse.
- Mortality due to cardio and cardiovascular diseases is lower among migrants. The prevalence of breast cancer among migrant women is lower than among the Swiss.
- Some groups of migrants are more subject than average to certain types of cancer (stomach cancer for South Europeans, rhino-pharynx cancer for the Chinese, liver cancer for Africans and Asians).
- Migrants tend to have a regular family doctor more frequently than Swiss. The figures reflect a similar situation to that of the self-declared health status.

Figure 7. Average number of visits to the doctor by nationality, age and sex



GAF = Germany, Austria, France



The socioeconomic, cultural and environmental health determinants have the most important impact on migrants' health and highlight the aspects which increase their vulnerability.

The health policy agenda has to increase and reinforce migration-oriented knowledge and the skills of health professionals and to empower the migrants' knowledge of the system and their health literacy.

4. Policy agenda

Political issues on migration are the competence of the federal government.

The second Migration and Public Health Strategy 2008-2013 (Federal Office of Public Health 2007a) is the national programme with the long-term objective of establishing a health care system of institutions capable of serving a society and clientele whose nature and needs have changed as a result of migration. It aims to benefit the migrant population in Switzerland, in general, and no specific groups are defined as distinct beneficiaries.

The Equal Opportunities and Health Section of the Swiss Federal Office of Public Health, in collaboration with the Federal Office for Migration and the Federal Commission for Foreigners is responsible for the programme's implementation.

Participation of the migrant population is now better ensured through an enlarged delegation of the Forum for the Integration of Migrants in the Inter-institutional Accompanying Group.

Greater use is to be made of the resources already available in the migrant population.

The measures are to be implemented in four fields of action:

- Health promotion and prevention
 - o Supporting low-threshold health promotion and prevention projects conceived and implemented by migrant networks.
 - o Supporting the promotion of information about the health care system and, specifically, targeted activities in prevention and health promotion.
- Training and ongoing education in health care
 - o Training activities to promote transcultural skills and migrant-specific expertise in health care professionals have to be improved, also at cantonal level.
 - o The existing framework of intercultural interpreters in Switzerland and numerous placement agencies have to be improved. Sustainable provision is to be made for training for intercultural interpreting and has to be integrated into the professional training system.
- Health care provision
 - o Access to health care must not be dependent on language, religion, gender, age or social and economic conditions. This is why a basic aim of the strategy is to ensure that medical care in Switzerland is readily accessible and appropriately designed for the migrant population. "Appropriate" means that



the chances of successful medical treatment are as great for people with a migration background as they are for the native population.

- Projects to facilitate access to health care services are supported in this area.
 - Support of Migrant-friendly Hospitals with projects of their own (Saladin 2006).
 - The Federal Office for Migration supports institutions that specialize in therapy for traumatized asylum seekers and also supports the decentralization of such institutions.
- Research and knowledge management
- Research projects have to integrate migrant mainstreaming issues (Federal Office of Public Health, 2007b).
 - Monitoring of the health status of the migrant population in Switzerland has to be improved, taking into account the lessons learned from previous experience.

The four fields of action are completed by the cross-sectoral task of Mainstreaming Migration, which includes an integrated approach on migration-specific concerns into the existing provision by means of information, coordination and networking.

With respect to equal opportunities it is particularly important to take the gender aspect into consideration.

At cantonal level

The elaboration of further health indicators, statistical data and the improvement of skills will facilitate the cross-sectoral approach of migration mainstreaming within health policy and planning, avoiding an added financial burden.

The diffusion of multilingual health information and documentation aimed at health workers and migrants has to be reinforced.

Low threshold services and the availability of a local network of health services accessible to vulnerable groups of migrants have to be improved.

Migration mainstreaming as a cultural issue of health helps to enhance the sensitiveness, comprehension and knowledge of migrant issues as a further health competence of health professionals.

The University of Lugano, through the Swiss School of Public Health H+¹¹ and its Summer School in Public Health Policy, Economics and Management, invests in capacity building of the health professionals in order to improve the conditions, effectiveness and efficiency of their health care systems and services and contributes to the improvement of the skills of health professionals and administrators (senior executives and middle managers).

¹¹ National coordinating body for the promotion of postgraduate university education and research in the fields of public health and health economics.



The possibility to create partnerships between health professionals and administrators (senior executives and mid-level managers) in health service administrations, hospitals and other health care delivery services of Eastern European countries, Switzerland and other European countries is a further contribution to health development.

The Regions for Health Network (RHN) of WHO and its project concerning "Migrants and Healthcare: Responses by European Regions (MIGHRER)" is an important opportunity for the Ticino Region to contribute to the aim of describing strategies and actions adopted at national and regional level concerning health of migrants and health services provided in order to compare them, to study their complexity, to identify solutions and to help making decisions.

5. Good practices

One example of good practices in Canton Ticino is the "MayDay" service, which deals with immigrants' questions on health care, social, legal and economic issues. It is a low threshold service, aimed especially at migrants with precarious status or without a residence permit.

It is a listening service not one of treatment, and refers the migrants to the relevant institutions and professionals; it relies on a network of professionals who can look after them. The office is in Lugano, the largest city in the Canton.

No document is necessary to gain access to MayDay.

It is a private structure, supported at present by cantonal public financing and has been working since 1996.

Its main activities are:

- information and consultancy on health care, social and legal issues for people with precarious status, those without documents, sans papiers and political asylum seekers who are waiting for a response or have received a negative response. The access to the service is free of charge and anonymous
- coordinating the network of professionals who respond to the health care requirements of those who have no access to the services, excluding hospital casualty services.
- coordinating the consultancy for health care, social and legal matters and the health promotion activities for people who work in the sex industry in Ticino; activating a project concerning the rights of prostitutes in case of sexual harassment
- coordinating projects in the field of migration, in collaboration with national institutions and those of other cantons
- participation in the professional training of intercultural interpreters
- projects concerning information and awareness about HIV, AIDS and sexually transmitted diseases involving about 200 men and women in the migrant communities from: the Congo, Ethiopia, Somalia, Tunisia, Algeria, Kosovo, Serbia, Turkey. The project is realised by eight linguistic-cultural mediators, who have been specially trained



- point of reference for the social and health care workers of institutions, services and associations like Amnesty International, the Federal Office of Public Health, the Red Cross, Caritas, national and cantonal Commissions, Aiuto AIDS, the Department of Public Health and Welfare in Canton Ticino and social/health care services in the area
- organisation of seminars and workshops aimed at all the social and health care workers in the Canton.

MayDay is inserted as an autonomous structure in the Swiss Labour Assistance service¹².

It has an operator employed at 50% who can refer to a network of professionals from various disciplines who respond to the users' needs or who are involved in the projects coordinated by MayDay.

The MayDay activities take place mainly at the migrants' meeting place, whereas the consultancy is offered in the MayDay office. The systematic involvement of the linguistic-cultural mediators highlights the importance of their function as a bridge between cultures.

The flexible work methodology manages to adapt to the continuous changes in the nature of the migrants with precarious status who are often in a legal grey zone or clandestine.

The migrants who make use of the MayDay services differ between those who primarily require social or health care and legal advice and those who are mainly faced with existential and social problems.

The largest group asking for advice is made up of women coming from Latin America, from East European countries belonging to the EU and non-EU countries. Although a timely intervention is sufficient for 2/3 of them, another one third requires more support or has to be accompanied for a longer period.

There are more men among the sans papiers and political asylum seekers. Their requests for help are often a result of difficult life situations and precariousness in social and economic spheres. The latter situation is increasing due to the restrictions in national policy concerning asylum (from January 2008).

MayDay's strength lies in the easy access to the service, in its ability to listen and in the speed with which it responds and the subsequent use of the informal network of collaboration with doctors, chemists, hospitals and other social and health care services.

The qualitative and quantitative relation between requests for assistance, functional efficiency of the network of professionals and the limited human resources available requires careful management when faced with somewhat scarce or partial political, health care attention towards these population groups.

MayDay operates as an observatory in the field of migration - precariousness - health.

¹² Soccorso Operaio Svizzero (SOS) Swiss Labour Assistance - Ticino. The main activities of this institution are: insertion and integration of asylum seekers, legal support for migrants and aliens, training and employment of intercultural mediators. Organisation of occupational programmes and training for the unemployed, food support for people in difficulty.



The lessons to be learnt which have emerged from this project are:

- it is a low-cost structure with limited human resources, whose strength, which has built up over time, lies in the targeted use of a network of professionals, of intercultural interpreters and of the area services;
- the maintenance cost of the information and consultation service is low, but the investment in intercultural and transcultural knowledge is high;
- there are no marketing costs, the structure is known through informal channels of communication;
- MayDay has managed to be recognized by the Department of Public Health and Social Welfare as a centre of competence;
- this kind of low threshold service can be repeated anywhere.

6. Conclusions

An important achievement of the national programme promoted by the Swiss Federal Public Health Office is that it puts the issue of migrants on the health care system's agenda and increased the visibility of problems and needs in this area.

The national programme includes knowledge transfer and networking among different players in the health care system and in the area of integration. Projects will reinforce direct improvements for the migrant population like the migrant-friendly hospital networking, multilingual information networks intended for migrants, treatment procedures and the availability of interpreting services or counselling structures for particularly vulnerable groups.

Training activities help to build specific human resource abilities and improve transcultural skills of health care staff.

Better, eventually legal solutions regarding the access to intercultural interpreter services must be found and the way in which they are to be financed still needs to be clarified. There is still a lack of professional translation available for certain interpreting needs, such as in GP medicine or in regional hospitals. The use of intercultural translation should therefore continue to be encouraged and optimized. In particular, this service needs to be better known among both health professionals and migrants, and access to it should be made simpler.

Health promotion programmes have to improve evaluation and identify skills and issues that enable better integration of migrants.

Health promotion activities in primary and secondary schools have to implement migration issues.

The effects of health determinants should become less precarious so that the more vulnerable population groups, including migrants, can benefit from more equal access to health and wealth.



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World Health Organization
Regional Office for Europe
Regions for Health Network



Migrants and Health Care: Responses by European Regions (MIGHRER)

Complete reference material

IX. Regional report Tuscany

Elisabetta Confaloni, Beatrice Lazzarotti, Fabrizia Petrei, Maria Laura Russo¹



¹ Reference Structure for the Promotion of Migrants' Health - Tuscan Region - L'Albero della Salute



Summary

In line with the national trend, the Tuscan Region has been deeply affected by the diverse demographic, social, economic and political movement due to migration. In 2008 approximately 320,000 foreign citizens were living in Tuscany. The migrant population is young, with a higher percentage of women (51.5%) and more children on average for each woman.

Employment is the main reason for settling in the region. There is, however, a marked occupational concentration in some employment sectors and most employed foreigners are working in unskilled professions. However, it is worth noting that there is also a vibrant growth of entrepreneurial activities sponsored by foreigners.

One of the most critical areas of migrants health, besides women and child's health, is that of psycho-social problems linked to the migratory process. In particular, difficulties in the development of self-identity for migrant youth and in the inter-generational relationship.

The migration phenomenon has become a focus for many legislative measures driven by the increasingly clear need to face up to the reality of migration. The Tuscan Region, in fact, has been legislating in this sphere since the early '90s, and with Regional Law n. 41/2005 and n. 29/2009, it established an Integrated System of Interventions and Services for the Protection of the Rights of Social Citizenship to promote and guarantee the right to social citizenship, quality of life, individual autonomy, equal opportunities, zero discrimination, social cohesion, the abolition and curbing of situations of hardship and exclusion. In particular, the most recent is characterised by new legislative methods of 'making health' that are targeted and effective in responding to people's needs.

From a strategic point of view it would appear that an awareness clearly exists toward issues involving the health of immigrants and a systems perspective on these issues suggests the need for further commitment in order to tackle the more obvious needs. There is a need to work on one hand towards the stabilisation and universalization of foreigners' right to healthcare, and on the other towards the reasonable and efficient of health expenditures, based on a deep awareness of the indissoluble link between well-being and social integration of migrants.

Tuscany's designated Reference Structure for cultural mediation in health, L'Albero della Salute² has implemented in 2007 the Rete Sensibile training project (Awareness Network) with a regional mandate, to promote the dissemination of cultural awareness on safety in the workplace for migrant people.

Tuscany is also a member of Health Promoting Hospitals Network, that promotes a cross-cultural project. Within the general framework of this project, various fundamental activities have been identified, amongst which is the promotion of a cross-cultural approach to the health needs of migrants.

² From October 12, 2010 - recorded by the Regional Councilman for the Right to Health - designated as the Reference Structure for the Promotion of Migrants' Health - Tuscan Region - L'Albero della Salute.



1. Health system overview, national and regional situation

1.1. Health system functions

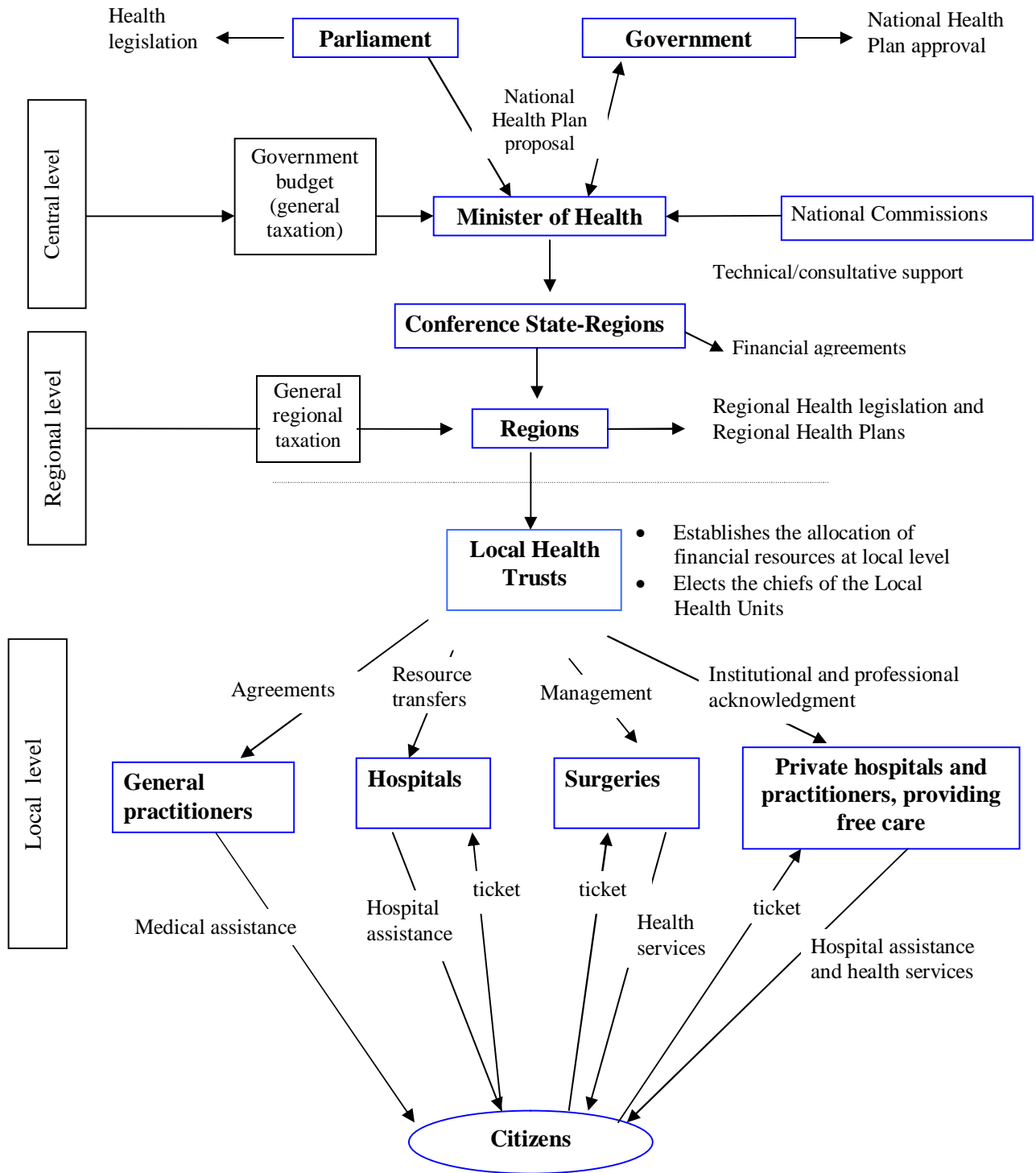
Italy's health care system is a regionally based national health service that provides universal coverage. The Italian Constitution recognizes the right of health protection to every individual as a fundamental right and as an interest of the community, and guarantees free care to those who need it. Every person has the right to benefit from the National Health Service (*Servizio Sanitario Nazionale*: SSN). Everyone is free, in any case, to take out private health care insurance for expenditures not covered by the SSN. Everyone can also choose a general practitioner (MMG) from a public list that guarantees primary care free of charge. MMG consultation is always needed for the prescription of medicines and for the prescription of specialized tests. MMG prescriptions are, therefore, required for admission to public health care facilities (clinics, hospitals etc.). Tickets must be bought for hospital treatment (specialist visits, tests etc.) and are reasonably priced. You can also opt for private practitioners or clinics, prices are higher but you don't have waiting lists.

National Health Service facilities and operators are determined at three different government levels:

- national level:
 - o Parliament approves health legislation and, annually, defines available resources
 - o Minister of Health, together with various technical and consultative Commissions, works out the three-yearly National Health Plan (Piano Sanitario Nazionale: PSN)
 - o The Government approves the National Health Plan
 - o The State-Regions Conference (Conferenza Stato-Regioni) allocates the financial budgets at regional level
- regional level:
 - o The Regions approve Regional Health Legislation, in relation to the legislation approved by Parliament at the national level and implement the three-year Regional Health Plan (Piano Sanitario Regionale: PSR), establish the allocation of funding at the local level and elect the Local Health Authority Heads. Consequent to Constitutional Reform, the Regions now have legislative power while the State establishes the fundamental principles and guarantees homogenous standards and/or levels of performance and services.
- local level:
 - o The Local Health Trusts organise the various entities that supply medical care at local level: MMGs, public hospitals, healthcare providers covered by insurance.



Figure 1. The National Health System and its ramifications (source: based on Ferrera 2006)





1.2. Structural organisation at regional level

The Regional Health Service (Servizio Sanitario Regionale: SSR) is made up of a series of interconnected bodies and organisations. The most important of these are the twelve Local Health Trusts (Aziende Unità Sanitarie Locali: USL/AUSL) - of which the reference territories are divided in turn into areas/districts - and the four University Hospitals Trusts (AOU).

In addition, there is also the Meyer Children's Hospital, which administers and provides dedicated health services for newborns, children and adolescents throughout the regional territory.

The Local Health Trusts are grouped into three Large Areas (Aree Vaste: AV), which are geared to responding at a higher territorial level to the complexities and needs of skilled technical specialisation, and making careful use of the resources stemming from innovation and research.

The Large Areas technical and administrative service bodies (Enti per i servizi tecnico-amministrativi di Area Vasta: ESTAV) on the other hand, underpin the health authorities, in order to support scale economies on one hand and promote top levels of technical specialisation on the other. The final pillar of the organisation is made up of bodies known as Health Societies (Società della Salute: SDS), welfare and health service integration and management planks geared to promoting organisational, technical and management innovation at zone/district level.

Through protocols and conventions, the Health Service also often works in tandem with other bodies and institutions, both public and private, such as the Tuscan universities, scientific institutes and research bodies, in addition, naturally, to the various professionals working in the field of primary care, suitably accredited private professional structures and professionals and the entire system of public and private pharmacies that underpin pharmaceutical treatment throughout the territory.

This complex set of facilities, spread throughout the country, albeit involved with different spheres of intervention, responds to the call for an integration of needs through the pursuit of various strategic activities sharing the same objective and values, defined and set out the regional level by the Regional Health Plans (Piano Sanitario Regionale: PSR). These are the reference documents for every single strategy and activity under the healthcare umbrella, formulated in consultation with the Standing Conference for Regional Social and Health Planning (Conferenza permanente per la programmazione socio-sanitaria regionale)³, and approved every three years with a Regional Board Deliberation, proposed by the Regional Council.

At the local level, on the other hand, the healthcare planning tools consist of the Integrated Health Plans (Piani Integrati di Salute: PIS), the implementing university hospital plans and the agreements and contracts stipulated by the health authorities with regard to activating the Regional Health Plans implementation tools.

³ This is the body through which the municipalities concur on the definition and evaluation of regional policies regarding health and socio-medical matters.



In Tuscany, as in the rest of the national territory, the bodies and organisations described take care of the health needs of the entire reference community by means of these implementation tools.

From a legislative point of view, migrants with valid residence permits are entitled to the same rights to healthcare as Italian citizens, while for migrants without valid residence permits, national legislation delegates the power to provide primary health care to the regions, with the provisos described further on.

The inclusive nature of healthcare in the Italian legislative system, which is grounded on the concept of health as the inalienable right of the individual, is governed by art. 32 of the Constitution, which guarantees health at individual level and not just to Italian citizens. In Tuscany, this value represents an asset guaranteed by the Health Plan, which is also set down in the Regional Health Plan 2008-2010 in regard to the principles, the values and the strategic objectives that the Health Service has a duty to pursue. First and foremost of these are equity, humanisation and health, which should be regarded as individual rights and collective duties, played out therefore through constant interaction between individual, treatment system and community, with collective responsibility for the various spheres of daily living, including those pertaining to respect for the environment in which we live.

These issues echo the deep awareness of the value of equality of treatment, which is one of the planks of the National Health Service, which therefore aims to provide concrete intervention models targeted at the weaker categories, such as that of migrants in some respects.

The regional picture, like the national one, of the provision of health care to migrants tends to vary greatly, due in part to the formalisation of the subsidiary principle⁴, in the healthcare policy sector Health Service Reform Legislative Decree n. 229/1999 and Welfare Assistance Reform Law n. 328/2000, which is one of the pillars of a territorial division of services policy and integrated and participatory territorial planning. This approach has led to huge differences in the various situations, particularly in relation to the provision of services to persons without valid residence permits resulting in cases in which the Third Sector (NGOs) has taken on the health needs of migrants on an independent and self-funding basis or through agreements drawn up with the Regional Health Service. There are realities in which it is the AUSL that directly takes care of the health needs of the "irregular" migrant population, by instituting a regional network of dedicated clinics. There are also occasions on which the public and private sectors work together and both operate within the territory, as in the Tuscan Region, in which private or semi-private facilities such as the clinics run by Caritas, an organisation of catholic charities which provides socio-medical assistance to Italian and foreign people on low incomes and the homeless and foreigners not in possession of valid residence permits. NGOs such as MEDU - Medici per i Diritti Umani (Doctors for Human Rights), an organisation of voluntary

⁴ According to the vertical or institutional subsidiarity principle, public services must be located at the nearest institution capable of implementing them in an efficacious and efficient manner: according to the principle of horizontal or social subsidiarity public services should be prioritized and carried out by individual citizens or associates whenever possible with the support and coordination of the public bodies.



doctors whose mission it is to provide primary health care together with help from trained street patrols who make direct contact with people in situations of extreme emargination, (Roma camps, precarious settlements of so-called "irregular" migrants). Several welfare-Onlus cooperatives provide services of a socio-medical nature, in the face of specific problems such as drug addiction and violence towards women, the situation of "unaccompanied" foreign minors; CAT - Firenze, for example, is a cooperative working in the field of prostitution, providing women - most of whom are foreign and not in possession of valid residence permits - with primary health care, information and prevention by taking an equipped mobile unit into areas where prostitution is rife.

1.3. Health information system

Italian legislation (Law n. 68/2007) defines "immigrants" as people over the age of 14 (minors are registered on their parent's residence permit) of foreign citizenship that enter Italy for a variety of reasons, staying for a period of over three months. This definition is of fundamental importance in that it constitutes the basis for one of the major sources of foreign citizen registration i.e. the Ministry of the Interior archives of currently valid residence permits.

Any foreign citizen wishing to stay in Italy for over three months has a duty to apply for a Residence Permit, a document that proves the regularity of their presence on Italian soil. In reality the inclusiveness of this sort of archive is compromised and limited by the delays inherent in the bureaucratic formalities involved in issuing and renewing the permits, and thus many foreign citizens, despite conforming with the requirements, are not recorded in the Ministry archives.

The most authoritative source currently in a position to provide the most complete data with regard to foreign citizens with valid papers is the National Institute of Statistics (Istituto Nazionale di Statistica: ISTAT) which administers the foreign residents' archive in collaboration with the Municipal Record Offices.

Most of the research and reports produced in Italy on the subject of migrant flows and their characteristics refer directly to the above-mentioned sources and/or to the work carried out by Caritas and Migrantes, catholic organisations that produce an important Annual Dossier on immigration which incorporates and analyses statistical data, extrapolated from the above-mentioned sources and also from sectorial archives, on specific indicators relating to social and employment integration. Caritas/Migrantes' objective is also to put together an estimate to represent the number of foreigners in Italy, integrating data made available by the archives, in an effort to overcome the limitations of the various sources.

The Ministry of the Interior, the Ministry of Health and the Ministry of Education and public bodies and foundations publish national statistics and reports from time to time based on their respective areas of competence, thus providing a multidimensional analysis of the foreign presence and its characteristics. Some databanks, such as those belonging to the National Institute for Social Security (Istituto Nazionale di Previdenza Sociale: INPS) and the National Insurance Institute for Occupational Accidents (Istituto Nazionale per l'Assicurazione degli Infortuni sul Lavoro: INAIL) provide important information on the relationship between



immigrants, the employment worlds and correlated accidents, while the archives of the Ministry of Education, University and Research (Ministero dell'Istruzione, dell'Università e della Ricerca: MIUR) have come up with some extremely interesting data on the integration of foreign minors into the Italian school system since 2008.

The history of sources and collection of data on which the statistical and sociological analysis of the foreign population are based share a common shortcoming, that can be ascribed to the lack of general statistical sources in a position to gather data about the foreign population without valid residence papers. There are currently no joint solutions in place to fill this gap and the invisibility of "irregular" migrants makes any comment on data relative to health extremely delicate, given the impossibility of putting together a reference population for such data.

Principal Sources, Databanks - private and public - and Reports on the socio-demographical characteristics of the foreign population in Italy and in Tuscany

- Annual Caritas/Migrantes Statistical Dossiers on Immigration; Rome IDOS Edizioni
- Economic and Social Research Institute (Istituto di Ricerche Economiche e Sociali), IRES
- Initiatives and Studies into Multiethnicity Foundation (Iniziativa e Studi sulla Multiethnicità), ISMU
- Ministry of Education, University and Research (Ministero dell'Istruzione, dell'Università e della Ricerca), MIUR
- Ministry of the Interior (Ministero dell'Interno)
- National Institute of Statistics (Istituto Nazionale di Statistica), ISTAT - databanks and publications
- National Insurance Institute for Occupational Accidents (Istituto Nazionale per l'Assicurazione degli Infortuni sul Lavoro), INAIL
- National Institute of Health (Istituto Superiore di Sanità), ISS
- National Organisation for Coordinating Foreigner Integration Policy at Local Level - National Council for Economics and Labour (Organismo Nazionale di Coordinamento per le politiche di integrazione sociale dei cittadini stranieri a livello locale - presso il Consiglio Nazionale dell'Economia e del Lavoro), CNEL
- Regional Health Agency Tuscany (Agenzia Regionale di Sanità Toscana), ARS
- Regional Institute for Economic Planning of Tuscany (Istituto Regionale Programmazione Economica della Toscana) IRPET

In terms of monitoring the health of the foreign population in Italy and the relevant indicators, the absence of specific current trends makes it difficult to acquire up to date information that would enable the variables regarding the health and access to health services of foreign citizens to be checked and analysed in a homogeneous and on-going fashion.

The construction of health indicators is therefore affected by the difficulties in collecting the data: there does however exist a series of ad hoc studies, carried out through samples or through qualitative methods, promoted by scientific and research bodies, devoted to the analysis of issues relating to reproductive health rather than to the outcomes of accidents in the workplace. Despite the partiality of the aspects discussed, and given the limitations imposed by



the fact that many of these studies are confined to specific territorial areas, this group of studies is still an important source of useful information in providing a snapshot of the main criticalities concerning the state of wellbeing and the health needs of the Italian population in Italy.

1.4. Research

The two institutions that publish annual up to date reports on the national context as a whole, ISMU and Caritas/Migrantes, include a chapter especially devoted to the health of foreigners. There is also a series of reports published by the National Institute of Health (Istituto Superiore di Sanità) ISTISAN Reports dealing with specific epidemiological spheres, help during childbirth and the voluntary termination of pregnancy in foreign women in particular. Research by the "Health and Immigration" working party set up as part of the National Coordination Body for the Social Integration Policies of Foreign Citizens of the National Council for Economics and Labour (Consiglio Nazionale dell'Economia e del Lavoro: CNEL) stands out for its pioneering quality. The work of the Commission, starting with an analysis of some specific regional realities and taking account of the needs of administrators of the Local Bodies and Directors of Health Authorities, has concentrated on the issue of access to health services, supplying operating suggestions and setting out priorities on which to work at local level: staff training, reading needs, reading demand, setting up services, flexibility of offer, multidisciplinary work and networking. The working party worked on drawing up a health plan for the years 1998-2000 which provided for the first time for the inclusion of immigrants among the vulnerable groups needing specific action and took on the commitment to draw up two reports on the country's state of health, using all the available data on the health conditions of immigrants. Thus the first study into national hospital admissions with unbundled data on foreigners was carried out.

At the request of the Ministry of Health (Ministero della Salute) - the National Centre for the Prevention and Control of Diseases (Centro Nazionale per la prevenzione e il controllo delle malattie: CCM), which signed an agreement with the Epidemiological Observatory on Inequalities at the Marche Regional Health Authority under the umbrella of a national project entitled Promoting the Health of the Immigrant Population in Italy, carried out a study entitled Immigrants and Health Services in Italy, Responses from the Regional Health Systems. This project was carried out in an endeavour to find out what organisational solutions had been adopted by the regions to guarantee immigrants not entitled to sign up to the National Health Service, the so-called "irregular" foreigners (see Paragraph 4), access to MMG and primary care, as provided for in national legislation.

In regard to informed consent, no valid protocol exists at national level to provide directives for health authorities to adhere to, and therefore any material, which has also been recently defined in relation to Italian citizens, is left to the initiative of the individual regional bodies.

In relation to this, the Local Health Trusts of Pisa in Tuscany, launched the "Informed Consent Project" in 2005, which was of particular interest in that it placed the awareness of the patient and his/her family at the root of the right to treatment, with the conviction that only a genuine



and accurate understanding of informed consent can guarantee an informed choice of actions and the consequences of any treatment.

The aim of this project is to tackle the criticalities encountered when communicating with foreign people and to develop a methodology that will guarantee equal opportunities for information starting with informed consent. It is targeted at foreign citizens and health operators in the USL in Pisa. The study also provided for an opportunity to assess the efficacy of the project by means of questionnaires to gauge the level of comprehensibility of the new module on informed consent as seen from a migrant friendly perspective.

2. Regulations and legal framework

2.1. Legal framework

The legislative action taken by the individual nations in the matter of immigration should be seen within the framework of international cooperation, which makes for a fairly diverse and dynamic picture. In this context, in fact, a powerful integration process has been being steadily implemented between the European Union countries which characterised the '90s right up to the Tampere Summit which, in October 1999, provided an opportunity for the Council of Europe to stress the importance of turning the Union into a space for freedom, safety and justice, making the most of the opportunities offered by the Amsterdam Treaty. On this occasion, in fact, it was agreed that all matters relating to the rights of foreigners should become part of European law and therefore the need for the European Union to draw up common policies in the matters of asylum and immigration was also definitively agreed.

At national level, in 1981, Italy passed Law n. 158/1981, ratifying International Labour Organisation Convention n. 143/1975 on the promotion of equal opportunities and treatment for migrant workers. In late 1986, while implementing the above-mentioned Convention, Parliament approved Law n. 943/1986, designed to regulate the employment activities of foreigners in Italy. In February 1990, Law n. 39/1990 which governs immigration and Italy was passed, introducing legislation on refugees, proclaiming total adhesion to the Geneva Convention of 1951 relative to refugee status, ratified in Italy with Law n. 722/1954, by abolishing the geographical limits that Italy had imposed on the recognition of this status.

Again from an international standpoint, the Convention for the Protection of Human Rights and Fundamental Freedoms signed in Rome on 4th November 1950 (ECHR), and ratified by Italy with Law n. 848/1955 was of major importance. With the ECHR, each nation undertook to respect the rights guaranteed by the Convention within the framework of their own national legal systems and in regard to every single person, regardless of sex, race, colour, religion, political conviction, national or social origin, belonging to a national minority group, wealth, birth or any other condition. Even the United Nations demonstrated the recognition of the need to define and support the human rights of migrants with the International Convention for the Protection of the Rights of Migrant Workers and their Families which did not, however, come into force because it would have called for at least twenty ratification instruments. In particular, in Italy, the reasons behind the failure to ratify the Convention lie in the absence, until such time as Law n 40/1998 was passed, of an organic body of legislation on immigration. Italy was



not, therefore, in a position to accede to this Convention, which defined extremely precise and detailed protective measures relating to the legal situation of migrant workers, which were not mere principles but were binding for the states.

The United Nations Organisation is particularly focused on the health promotion of the individual, taken to mean a state of total physical, mental and social wellness and not just signifying an absence of disease or infirmity, a sphere in which it works with great dynamism. On 7th April 1948, the World Health Organisation (WHO) was founded. Italy contributes to this through the European Centre for Environment and Health, in Rome, which was set up by the WHO/Europe after the first Ministerial Conference on Environment and Health (1989).

Health policies at national level for safeguarding immigrants were only implemented fairly recently, i.e. from the early '90s onwards, although it was not until 1998 that the issue was effectively tackled with Law n. 40 (Legge Turco-Napolitano) which was then assimilated into the Single Text (Testo Unico: T.U.) on Immigration (Legislative Decree n. 286/1998). The law completes art. 32 of the Italian Constitution, the primary source of law, which in fact states that

“the Republic safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent. No one may be obliged to undergo particular health treatment except under the provisions of the law. The law cannot under any circumstances violate the limits imposed by respect for the human person.”⁵

Art. 34 of the Single Text (Healthcare for foreigners registered with the SSN), art. 35 (Healthcare for foreigners not registered with the SSN) and art. 36 (Entry permits and visits for medical treatments) define the emergence and consequent formalisation of the right to health and healthcare of all foreign citizens on the national territory: treatment for persons who are legally there are guaranteed on an equal footing to that provided to Italian citizens. The right to treatment has also been extended to anybody in Italy whose stay is not legally valid: urgent and/or essential treatment is therefore guaranteed and may be ongoing, as are preventative care programmes offered by health facilities and hospital admission. The subsequent Law n. 189/2002 in the matter of immigration (Legge Bossi-Fini) made no modifications to the articles relating to health. Currently, as this document is being drawn up, a legislative decree on security is going through the approval process, and there is ongoing political and public debate, sparked by the questioning of the regulations that ban health facilities from tipping off the police authorities, a protection measure that would clash with the possible introduction of the crime of clandestinity.

It is also worth underlining the fact that, within the context of immigration and health, the national legislative framework⁶ needs to be consistent with the laws in force at regional level. In fact, while immigration and asylum policy is part of the so-called “exclusive legislation” of

⁵ There are a great many reference articles in the Italian Constitution that are not specifically devoted to the issue of health but are of prime importance for the rights and social interventions. In particular: arts. 2, 3, 30, 31, 32, 38.

⁶ See Appendix for the main health provisions relating to immigration.



national jurisdiction, policies on healthcare belong to the “rival legislation” which provides for the delegation of some competences to the regions⁷. The Turco-Napolitano Law, n. 40/1998, stands alone exactly because of the crucial role of the regional administrations within the framework of the policies for the reception and social integration of foreigners. Art. 45, in particular, created the National Fund for Migration Policies with the purpose to finance annual and multiannual state, regional, provincial and municipal programmes relating to reception and integration. These encompass various different interventions: Italian language lessons, valorising the culture of origin, cultural mediation in health services, training and updating courses for health care workers, cross cultural education and access to housing.

The Tuscan Region⁸ has been legislating in this sphere since the early '90s, with Regional Law n. 22/1990, for example, which reads:

“pursuant to the general principles set out in art. 3 of the Statute and in harmony with United Nations Resolution in 40/144 of 1985 on the protection of human rights and fundamental freedoms, with EEC legislation and the State initiatives and laws, the Region promotes initiatives intended to guarantee equal opportunities to non-EU immigrants and their families with regard to civil rights, to the Italian citizens and to remove the economic, cultural and social causes that are hindering their integration into the social, cultural and financial fabric of the Region”.

Regional Law n. 41/2005 on a Integrated System of Interventions and Services for the Protection of the Rights of Social Citizenship was intended to promote and guarantee the right to social citizenship, quality of life, individual autonomy, equal opportunities, zero discrimination, social cohesion, the abolition and curbing of situations of hardship and exclusion.

The Legislative Proposal on Immigration, passed on 17th November 2008 and later approved in June 2009 by the Tuscan Regional Council⁹, at a difficult political and social time, characterised by the conflict of two concepts: one, intended to limit access to health services by some of the people living in Italy and the other, a model of governance that intends to actualise the concepts of citizenship and the uptake of rights. The Tuscan proposal re-establishes the right of all foreigners to access the health system, particularly the more vulnerable ones, highlighting its investment in a global approach to health and the ‘universal’ right to it. Facilitating access to health services for those without valid residence permits (people who are not structurally irregular, but whose regularisation should be encouraged by simplifying bureaucracy, taking responsibility for the healthcare of women and children, valuing cultural mediation, as well as responding to the need for considerable organisational efforts) retraces a historic path in the provision of services. As said earlier, in fact, in Italy an individual’s right to health - not a

⁷ See also Arts. 117, 118, 119 of the Italian Constitution.

⁸ See Appendix for a list of main regional provisions.

⁹ Legge 29/2009 “Law for the reception, integration and protection of foreign nationals in the Region of Tuscany.” It is worth mentioning in this regard, the recent ruling of the Constitutional Court No 269/2010, which rejects the request of the President of the Council to oppose certain provisions in this law.



citizen's right to health - sanctioned by art. 32 of the Constitution, has been made possible by the breaking down of obstacles to access in order to encourage the sort of preventative behaviour that multicentric studies (Zincone 2001; Morrone *et al.* 2003) have shown to be uncharacteristic of migrant people. The Tuscan proposal is therefore characterised by new legislative methods of 'making health' that are targeted and effective in responding to people's needs.

2.2. Service delivery

There are no health care systems specifically for foreigners in place. The differences in their treatment as compared with that of Italian citizens arise with regard to the possibility of accessing the same services and welfare levels: although equality of treatment is guaranteed for those registered with the National Health Service, this does not apply to people who do not comply with the legal requirements, and cannot therefore register with the SSN. "Irregular" immigrants do, however, have a right to medical assistance, on presentation of an STP card (Tesserino Straniero Temporaneamente Presente) complete with identification number, which gives the right to primary medical care, hospital admission and outpatient care based on the principle of urgent need of help, continuity of care and prevention for the protection of individual and collective health. This code number is also used for prescriptions for medication on a regional basis and for any refund of expenses by the health bodies, while guaranteeing patient anonymity and, to date, protecting the patient from being reported to the authorities.

Foreign Citizens entitled to register with the National Health Service	Foreign Citizens not entitled to register with the National Health Service
<ul style="list-style-type: none"> - Foreigners in possession of residence permits who are in regular employment, self-employed or on the job seekers' list - Foreigners legally living in the region or who have applied for renewal of their residence permits, for employment reasons, for freelance work, for family reasons, for political asylum, awaiting adoption, custody, citizenship. <p>Any regular dependent relatives are also entitled to health care. Minors, children of foreigners registered with the SSN, are guaranteed the same treatment as registered minors.</p>	<p>Foreigners without residence permits are still guaranteed urgent or essential medical and hospital treatment, which may be ongoing, for diseases and accidents. In addition to urgent treatment that cannot be deferred without endangering life or compromising health, this also applies to essential treatment of diseases that are not immediately dangerous but which could compromise health and endanger life if not treated.</p> <p>In particular the following are safeguarded</p> <ul style="list-style-type: none"> - courses of preventive medicine - pregnancy and maternity - the health of minors - inoculations - international prophylaxis interventions - the prophylaxis, diagnosis and treatment of infectious diseases



	<p>Foreigners in possession of residence permits for a period of less than three months are precluded from registering with the SSN, however they are obliged to take out appropriate cover with an insurance company either in Italy or abroad. Access to health structures by foreigners who are not in possession of valid residence documents will not be reported to the officers of law and order unless this is connected with criminal activities.</p>
<p>Elective health procedures are guaranteed against payment of the appropriate regional fees. All urgent or essential or ongoing outpatient or hospital treatment for diseases or accidents and courses of preventative medicine for the protection of individual or collective health are guaranteed free of charge in the case of those who state that they are not in possession of sufficient financial means (indigence).</p>	
<p style="text-align: center;">The Regions guarantee compliance with legislation as provided for in Presidential Decree n. 394/1999</p> <p>They have a duty to identify appropriate ways in which to guarantee that scheduled essential and ongoing treatment is carried out within the framework of the regional medical structures and public and private accredited health facilities, whether outpatient or hospital, and possibly in collaboration with voluntary bodies with specific experience.</p>	

The Tuscan Region adopted the basic principles set out in national legislation and included them in the Regional Health Plan 2005-2007 and made them become operative by agreeing a contract with the general practitioners (Medici Medicina Generale: MMG) and public paediatric doctors (Pediatri di Libera Scelta: PLS) who become, as stated in the PSR, the primary actors responsible for the protection of immigrant health.

The MMG and PLS guarantee primary health care throughout the region to foreign persons not in a position to register with the SSN but who are in possession of an STP Card, issued by the regional administrative offices of the relative USL, arranging methods of payment for their services later with the administrative offices of the SSR.

Private welfare bodies are brought in to integrate and support the public services, although complete mapping of this is not yet available in Tuscany. There is for example the Niccolò Stenone Onlus Association in Florence - an voluntary not for profit association that provides a medical/dental service to "irregular" immigrants and anybody in situations of great social marginalisation in need of free specialist and highly skilled care; the association has a protocol of agreement with the AUSL in Florence.

There now follows a short list of Third Sector organisations or organisations under the umbrella of public or private bodies involved directly or indirectly with the health needs of the foreign population in Tuscany and in Italy¹⁰.

¹⁰ This does not claim to be an exhaustive list, but simply to provide reference points at regional level. Complete mapping is not easy to achieve given the huge variety of organizations involved.



Organisations active at national level	Organisations active at regional level
ALMATERRA (Intercultural Association) AMSI (Foreign Doctors in Italy Association) ANOLF (National Association Beyond the Frontiers) ARCI (Association of Social Promotion) ASGI (Association of Legal Studies on Immigration) CARITAS ITALY CESTIM (Centre of Immigration Studies) COSPE (Cooperation for the Development of Emerging Countries) ISMU (Foundation for Initiatives and Studies on Multi-Ethnicity) INPM National (Institute for the Promotion of Health among Migrant Populations and Combating Poverty-related Disease) MEDU - Doctors for Human Rights MSF (Doctors without borders) NAGA (Voluntary Association for Socio-medical Treatment and the Rights of Foreigners and Nomads) OISG (Italian Observatory on Global Health) SIMM (Italian Medical Society for Migration) OXFAM Italia Onlus	DONNE INSIEME ASSOCIATION NOSOTRAS (Intercultural Women's Association) ARCI (Association of Social Promotion) - Tuscan Regional Committee ASGI (Association of Legal Studies on Immigration) - Tuscany CARITAS - Tuscany L'ALBERO DELLA SALUTE - designated by the Tuscan Region, as the Reference Structure for the Promotion of Migrants' Health - Tuscan Region. OXFAM Italia Onlus - Arezzo MEDU (Doctors for Human Rights) - Florence CAT (Social Cooperative) MICHELUCCI FOUNDATION - Florence REGIONAL FOREIGNERS COUNCILS COSPE (Cooperation for the Development of Emerging Countries) - Florence

Despite the universalistic approach to the right to health in Italian legislation, there are, however, various inconclusive outcomes for migrant health protection. Daily practice lays bare various weak points in the organisation of the health service that impact on the full uptake of health services by the migrant population. One example of this is the lack of formalisation and setting up of cultural language mediation services in the Tuscan Region, services that despite being prevalent in many companies are often inadequate even in places where they are most greatly needed. This leads to the development of informal mediation practices which in fact draw in both the socio-medical operators and the users themselves: recourse to "improvised translators" recruited in situ from among foreign users with a knowledge of Italian, or within the networks of family and friends of the person in need. One therefore sometimes comes up against situations in which a son or spouse is called on to interpret even during medical appointments that involve particularly sensitive situations in terms of individual intimacy and privacy.



3. The migration phenomenon

3.1. General characteristics and extent of the migration phenomenon in the region

Awareness of the continuing nature of the migratory phenomenon has only recently caught on in Italy, although it is almost thirty years since it became a destination country for migratory flows. This delayed awareness and undervaluation of the phenomenon have led to weakness and lack of consistency in social policies for the protection and development of the rights of migrants, refugees and minority groups. Furthermore, Italy is becoming an immigration country just when the rest of Europe is implementing entry lockdowns and drastic entry limitation policies; all of which sets a protectionist and repressive stamp on Italian policies in regard to immigration.

In 2008 approximately 3,400,000 foreigners were registered on the municipal records, almost half a million up on the previous year, accounting for 5.8% of the resident population. The regional distribution of foreigners is highly erratic, characterised by a powerful concentration in the Northern area and, to a lesser extent, in the central regions: more than one foreigner in three lives in the North-West, 26.9% in the North-East, 25% in the Centre and a mere 12.5% in the South. On one hand this concentration appears to be the outcome of a significant migratory movement from abroad, along with figures for newborns, but we should not lose sight of the effect of internal migrations within the national territory in which the more economically dynamic regions exert a strong pull on internal migratory flows. In 2007, in fact, the flow of foreigners moving from the Southern parts of the country was greater than that moving in the opposite direction.

Among the foreigners who arrive in Italy there are also those who have had to escape from persecution, violence or war and are seeking the kind of shelter they have been denied elsewhere.

According to the UNHCR, over 14,000 foreign citizens applied for international protection in Italy during 2007, with a 36% rise in demand compared with 2006. This increase has affected various Southern European Countries and those that have recently joined the European Union. From the collected data, it is immediately obvious that some nationalities continue to feature annually among the asylum seekers, in particular those from Eritrea and the Horn of Africa, an area with a constant forced migratory flow. Since the decentralised procedure for determining refugee status (April 2005), there has been a rise in the number of applications considered. In 2007, 13,509 applications were considered, 10.4% of which resulted in a recognition of refugee status, 46.7% led to a negative outcome with humanitarian protection, and 26.3% were turned down without humanitarian protection.



3.2. Composition of migrant flow

According to a Caritas 2008 Dossier estimate, approximately 320,000 foreign citizens were living in Tuscany; of these, there were slightly over 275,000 foreign residents¹¹, accounting for 7.5% of the total regional population. Comparing this percentage with the Italian average, which is around 5.8%, shows that there is an important trend, peculiar to the establishment of migrants on the Tuscan regional territory.

An examination of residence permits issued in Tuscany and the reasons backing these, according to an estimate put together by Caritas in 2007, shows that employment is the main reason for settling in the region, accounting for 54%; 37% of family reasons being the importance of family reunion, enabling those who arrive in search of employment to settle down in their country of immigration, which then becomes the place in which they live. When considering the question of residence permits issued in Italy, it is worth bearing in mind the fact that Romanian and Bulgarian citizens have been part of the European Union since early 2007 and that they are therefore at liberty to enter Italy freely, and thus the residence permits archive contains no data on to these nationalities, although these are the most common and most dynamic in both Tuscany and Italy itself.

In Tuscany, as in Italy, no national group of foreigners is in a stronger position than any other, which evidences a powerful migratory polycentrism. The foreign component, in fact, is split into a large number of different nationalities with numerically significant presences, the top five nationalities actually only account for 60% of the foreign population in Tuscany (see Table 1).

Within the framework of a general and common preponderance of migrants from Eastern Europe, Tuscany has a greater concentration of Albanian and Romanian citizens than the national average. They alone accounted for 39% of migrants living in Tuscany in 2008. Albanians proved to be the most numerous group, with over fifty five thousand individuals, accounting for 20.2% of the total, followed by Romanians with almost 19%; the third largest community was the Chinese, with over twenty five thousand residents and accounting for 9.4%. Here too, and in even greater numbers than the Albanians, we have come up against a peculiarly Tuscan characteristic: there are twice as many citizens from the People's Republic of China in the migrant population at regional level than there are in a national context.

As far as the gender composition of migratory flows in the region goes, for every hundred resident foreigners, over half (51.5%) are women, with females predominating over males in seven out of ten provinces, only in the Pisa and Prato areas do men account for over half the foreign residents.

With regard to employment, the construction and industrial and related sectors absorb a total of 60% of the male workforce of foreign extraction, whereas only 19% of immigrant women work in these sectors, of whom 18% work in industry and only 1% in construction. The situation is

¹¹ By "resident" foreigners we mean the population of foreign citizens registered with the Municipal Record Office, therefore this total excludes all those not in possession of valid residence permits (so-called "irregular" foreigners) and seasonal migrant workers, by definition. Resident foreigners are regarded as the most stable subset of foreigners present.



reversed in regard to activities connected with the service and home help sectors, which employ approximately 62% of all foreign women in the region and only 16% of male workers.

There is, however, a marked occupational concentration in relation to employment sectors but occupational segregation of foreign workers also exists on a professional level. Most of the foreigners in employment are, in fact, working in unskilled professions and the data on the credit sector, which evinces no foreign employees, is an example of this. Insertion into the employment market on the basis of what has been defined as subaltern integration, brings with it a good many contradictions which, as well as failing to exploit the potential of foreign workers, will also have a serious knock-on effect for the second generations as they try to crack the job market. In 2008, almost 19,000 companies were owned by foreigners (11.5% of the national total) up 32% on the preceding year. Lastly, the data on the rate of foreign entrepreneurship is interesting: 6.9% of foreign residents are now entrepreneurs, the highest percentage of any region in Italy.

3.3. Migrant impact on social and economic standards

Over a period spanning approximately thirty years, Italy has changed from a country of immigrants to a destination for migratory flows, and our country still does not appear to have drawn up a proper, consistent model of "societal reception"¹², and still qualifies as an example of a place that is defined as having a "Mediterranean immigration pattern". Apart from Mediterranean agriculture, long identified as a fertile ground for immigrant labourers, it should be underlined that the small business systems in Central-Northern Italy, construction and the lower urban and tourist tertiary sectors have found it increasingly difficult to find manpower, thus relying more and more on the immigrant population. Another type of employment sought by immigrants is characterised by the Italian social security system, which has led to strong demand, explicit or implicit, for domestic help and carers for the elderly, which has found a strong outlet in the availability of foreign women. In Tuscany, several indicators show that firms are inclined to take on a higher percentage of foreign workers than the incidence of migrant labour in the working population. The overall rise in employment takes in a significant body of foreign workers, accounting for roughly half the rise in the employment figures for the first half of this decade. Taking account of the different composition by age, the employment rate of foreigners is higher than that of Italians, the differences in the case of the male component being particularly marked, while in the case of foreign women, the employment rate is lower than that of Italian women. It is clear that, despite the experiences of other European

¹² It represents that set of factors that shape regular or irregular insertion, promote the linkage between certain given requirements of the economic and social system and support or deter efforts at integration (Ambrosini, 2001). The driving elements in this mosaic include the body of legislation, which establishes the coordinates for immigration in relation to a certain country; the mindsets and dispositions that lie at the root of prejudice and stereotyping with regard to the attitudes and mentality of the migrant population; the institutions and services that usually implement reception and support activities, carried out by various social actors ranging from the Catholic Church to trade unions, to the world of associative and voluntary input.



countries, a non-integratory spontaneous first generation model has prevailed thus far in Italy, based on employment of migrants in sectors that have largely been deserted by the Italian workforce and therefore based on the acquisition of economic citizenship through work, marked out by what is still an extremely weak social citizenship in terms of lack of opportunities for access to housing, schools, the other social services and the right to vote. The contribution of the foreign population to the regional demographic evolution as a whole has had many positive effects, since it is thanks to the presence of foreign citizens that the widespread demographic decline has been brought to a halt and the overall population has begun to rise again. The arrivals from abroad, apart from lowering the average age of the population, fill out those age bands that would otherwise be rarefied in the current demographical evolution. The migrant world is, in fact, a structurally young one, with a larger number of women of child-bearing age and more children on average for each woman; a factor that is attributable to their greater propensity to start a family at a younger age than Italians.

The National Council of Economy and Labour (Centro Nazionale dell'Economia e del Lavoro: CNEL), through the National Organisation for Coordinating Foreigner Integration Policy (Organismo Nazionale di Coordinamento per le Politiche di Integrazione Sociale degli Stranieri), has been carrying out a research project on the integration indices for immigrants for many years, which forms the basis for an Annual Report.

Each year the CNEL publishes a report detailing and comparing the integration potential of the various different Italian territories on a regional and provincial level, on the basis of indices selected as significant markers for the potential positive insertion of foreign citizens. These statistical indicators pick up both the size and the characteristics of the employment dimension, the sum of which produces the overall index of the integration potential of each area under consideration.

With regard to the three areas under consideration, the ranking position in absolute terms of the Tuscan Region comes into the medium-high band. The regional territory's greatest strength appears to be the dynamism of its employment market. In relative terms, a look at the ranking, comparing the opportunities for foreigners and those open to the autochthonous population shows that the lifestyle of Tuscan citizens is on a different level to that of foreigners living in the region: in comparative indices Tuscany drops several positions, down into the medium-low bracket.

3.4. Migrant social determinants of health and healthcare needs

The population concentration of younger age groups brings with it an extremely significant health patrimony. When discussing migrant health, just as any that of any individual, a broader approach to a good many other (health determining) factors that may have a direct or indirect bearing must be taken. As previously mentioned in paragraph 3 of Chapter 1 on the sources and availability of relevant data, there is currently no up to date provision of data on this matter, specifically devoted the state and evidence of health of migrants, but although there are gaps in this field, they are partially filled from time to time by ad hoc studies that attempt to



provide a snapshot of a particular issue or territory. It is therefore possible to trace a picture that attempts to map out the general trends, or at least some of the main relevant criticalities and characteristics from the available data.

Women's health is one of the major issues within the context of migrant health. It tends to be women who, for reasons largely connected with reproductive health, avail themselves of socio-medical services, bringing with them a strong risk of fragility due to the weakening of social and familial ties that were once a guarantee of help and protection. The fact that foreign women do not enjoy an optimum state of health is evidenced mostly by high risk during childbirth, an unsatisfactory follow-up during the post partum period, high and sometimes frequent recourse to VTPs and inadequate cancer prevention¹³.

Along with maternal/infant health, accidents at work are one of the main reasons for recourse to medical assistance by the foreign population. INAIL stresses the fact that the increase in the number of foreign workers does in fact correspond to an increase in the number of accidents in the workplace: a rise of 8.7% in 2007 at national level, with over 140 thousand complaints and 174 fatal accidents (INAIL, 2008).

Foreign workers are, in fact, particularly vulnerable to the danger of accidents not just because they find it easier to find employment in unskilled and high risk sectors, but also because of communication/cultural difficulties, linked for example to an inadequate grasp of the concepts of risks and safety. In Tuscany this trend is borne out by the slow but steady rise in accidents reported by foreign workers, which have risen progressively over the last three years from 12.3% of all accidents recorded in 2005 to 14.5% in 2007 (INAIL, 2008. see Table 2). In 2007, the Tuscan Region embarked on qualitative research into the working conditions of foreigners in various particularly high-risk sectors such as building and the leather and textile industries. So far it has emerged that, predominantly in the building and agro forestry sectors, forms of exploitation of the workforce still go on, with heavy repercussions on safety: many medium-small enterprises tend to rely on employee cost-cutting measures based on informal agreements and side-stepping the regulations in order to ensure market competitiveness (IRES, 2007).

Another critical area is that of mental problems linked to the migratory processes, which often determine or at least encourage the risk of a steady erosion of a migrant's original cultural framework. This brings with it the possibility of a particular vulnerability of the personal defences available to an individual in his world of origin. Little systematic and organic research has been done into the signs of mental health problems in the foreign population. The Department of Mental Health at the USL of Prato carried out a study into access to psychiatric services by the migrant population, geared to forming the basis for constructing a specific sector dealing with the mental health of foreign groups, both in terms of research/action and in terms of training.

¹³ There is not enough room here for an exhaustive tally of the many works produced on this subject. Cf. among others, ISTISAN Report 2007 which contains an interesting bibliography



The aims of the research were to:

- identify user profiles for the institutions offering treatment and care to the migrant populations, thus contributing to the identification of health promotion strategies and access to services;
- determine the formal care networks used by migrants, and devise intervention quality indicators;
- test a protocol for mental health cultural-linguistic mediators, with a view to building quality indicators for a service of this kind;
- describe the interaction between the visions of suffering and unease of migrant users and the service operators, in an attempt to identify potential sources of incomprehension, misunderstanding and shortcomings in the treatment and care interface.

The first research finding was that migrants are very reluctant to access institutional care services in regard to mental health problems, and secondly that networks and communities play a very essential role at times of crisis in the life of an individual (Bracci F. and Cardamone G., 2005).

In a different migrant context, it is interesting to note the activities of the Department of Mental Health in the Castel Volturno area of the province of Caserta, in Southern Italy, which have led to the setting up of the Observatory for the Mental Health of Migrants, which will study the phenomenon in relation to psychological problems, psychosocial unease and the specific symptoms of mental illness among the migrant population. The Cumbersome Nonexistent Presences research project, a study of the territorial situation in relation to mental problems, belongs within this framework. Its conclusions show that the most frequently encountered psychopathological problems can be traced to difficulties in adapting, presenting as anxiety, depression and psychosomatic illness in particular, and they highlight the fact that these owe their origins to the immigration experience and the conditions of hardship or existential shortcomings people have to deal with (Ortano *et al.*, 2008).

Another interesting dimension is the mental health of minors. A group of 46 migrant children was observed at the Children's Neuropsychiatry Clinic at the San Gallicano Hospital in Rome during the period January to June 2008. The ensuing data was then compared with data from a control group of Italian children of the same age. The final results show that migrant children had a lower capacity for social adaptation and a higher incidence of emotional and behavioural problems (Rango *et al.*, 2009)

Despite their diversity, these critical areas have various recurrent basic knotty problems in common. These can be split into two macro-categories: the first concerns the barriers to access to the service; the second concerns obstacles encountered while using the service itself. With regard to the first point, quite apart from the more specifically cultural factor that often determines a different perception, and therefore management, of one's own state of



health/illness, the absence, scarcity or partial nature of available information has a major effect on migrant people, who struggle to make sense of procedures that are often very different to those of their countries of origin.

This position of disinformation can also be ascribed, as said before, to the situation of socio-economic vulnerability in which migrants sometimes find themselves, and which stands in the way of their making full use of all the opportunities and skills available to help them deal with and safeguard their own health. Migrants' difficulties in accessing health services are also bound up with some structural characteristics and organisational methods of the services themselves, however: many women, for example, state that they are unable to make use of the health service because their work schedules clash with health service opening hours or because they find it difficult to get to the health facility itself. To skeletonise, the most frequent barriers to access are of a juridical/legal, financial, bureaucratic/administrative, organisational and informational nature. Possible obstacles to the uptake of socio-medical services are language, communication, interpretation and behavioural barriers. For example, problems in articulating health needs, due to language or cultural differences, especially in emotionally or psychologically stressful situations (for instance requesting an abortion or oncological tests); trouble in understanding the verbal information provided by the operator because no language mediation service is available and there is a clear perception of prejudice, stereotyping and unreadiness on the operator's part; trouble with understanding written information because of the complexity of the language, in structural, syntactical and lexical terms, thanks to the patchy availability of certified translations; consequent difficulty in following and understanding the course of treatment prescribed and staying on top of the procedures (where to go and what to do); difficulties in following medical advice (for instance keeping appointments, coming back for checkups after childbirth or VTPs etc.).

All these criticalities point increasingly to the need for the regional socio-medical system to tackle the new challenges it faces with greater awareness, challenges that largely hinge on the ability of the services to tailor themselves to a client base that is changing with time, to stop behaving like simple service suppliers but as bodies capable of providing an active service geared to prevention and health education.

4. Policy agenda

4.1. Policy agenda

In Italy, the subject of immigrants' right to health has only found its way onto the agendas of political parties, associations and trade unions since the early '90s. Interest in health matters has also risen in relation to research into the potential risk factors for people who find themselves in a different environment and in relation to efforts to raise political awareness of citizenship requisites or valid residence status. During the early '90s immigration was seen as a temporary phenomenon and therefore any services were set up in a mindset of urgency and extraordinariness. The response to health needs largely consisted of a network of welfare structures based almost entirely on volunteer welfare services which took on a crucial role in responding to the demands of the migrant population, in an attempt to supplement the



precariousness and lack of legislative provision. In this sector too, a perceptible sort of “dual speed” was at work in the public bodies and associations with regard to the subject of immigration. The associations and trade unions, the private welfare and voluntary organisations played a major role both in sensitising the political sphere to the need to recognise health as a primary right, as distinct from the possession of valid citizenship requisites or valid residence status, and in identifying the risk factors that might impinge on foreign citizens once they landed on Italian soil.

During the '90s in fact, the private welfare and voluntary organisations working largely at local level, boosting their coordination abilities, broadcasting information and putting pressure to bear on the institutions, pulled together to guarantee the right to access to health care for regular and irregular immigrants, the reorganisation of socio-medical services and their re-direction towards a “migrant friendly” approach. The private welfare and voluntary bodies brought a lot of bottom-up pressure to bear, only bringing in the institutional actors at a later stage: the Ministry of Health embraced the proposals for associationism with a first official Act in 1994, reiterating the Decree guaranteeing free enrolment in the SSN for unemployed regular immigrants.

The turning point in migrant health policy came in 1995, with the introduction of a provision establishing the right of all foreigners on Italian soil to health care, regardless of their regularity of residence status and with no danger of their treatment being followed up by a tip-off to the police. In 1997, with the input of some associationist exponents, the Articles on health were drawn up that were then incorporated into the *Turco-Napolitano* Law that marked the consolidation phase of access to the right to health prevention.

In putting together the legislation on immigrant health, associationism played a major role in guaranteeing health care to both regular and irregular foreigners, since the decisional process to which the immigrant health policies were subjected in the early '90s owed a great deal to the activism of the voluntary bodies and associationism, which were crucial to achieving a more inclusive legislation. As mentioned in the above paragraphs, it must be stressed that the tensions and criticalities relative to the dimension of migrant health are also born of the complexity and ambiguity encountered at various institutional and legislative levels. The demand for healthcare for foreign citizens rests on fragile and ambiguous divisions of institutional competence and responsibility, which may or not be understood every time political intervention measures are drawn up.

4.2. Stewardship

In August 2008, the WHO published the final Report produced by the Commission charged with studying the impact of health determinants. The substance of the Report was the imperative for all governments to act on health determinants in order to eliminate health inequalities between countries and within those countries themselves.

The Tuscan Region has been working in this direction, taking its lead from the clarifications contained in the policy papers, emphasising the importance on one hand of bolstering citizens' ability to make informed health choices (empowerment), encouraging the adoption of healthy



life styles and, on the other, of implementing integrated, cross-sector strategies with the various system actors in order to be able to share common health objectives.

To this end, one of the aims set out in the Regional Health Plan 2008-2010 is to

“define an integrated health promotion model to underpin regional and local initiatives, aggregate the outcomes of good practice in health matters, lifestyles, combating disease and poverty, and providing for a reorganisation of the current health promotion documentation system over the three-year period, in an endeavour to improve informational and cultural output”. (Regional Health Plan 2008-2010, Chapter 5: A plan for seizing new opportunities in levels of care, p. 45).

As part of its intention to promote citizen health, the Tuscan Region has implemented several measures for cultural and civil growth, cross-sector actions and synergies at international, national, regional and local level, targeted at bringing into play all those factors that can affect health determinants, and improving lifestyles, launching promotion and education processes. Although these interventions and activities are not specifically geared to the migrant population, most of them encompass and underpin active health concepts that aim to encourage a more tailored service uptake of migrant women and men.

International level

Collaboration with the WHO, through the framework agreement for the five-year period 2003-2007, enabled a solid national health promotion strategy, based on social and financial determinants, to be set in motion. In their working paper Concepts and Strategies for Investments in Health - Challenges and Opportunities for the Tuscan Region the WHO stresses the fact that a system capable of looking at the nation's health in a broader regional development context is a crucial element in developing efficacious strategies within the framework of investing in health.

The WHO framework agreement has further enabled us to join international networks (Network Regions for Health), to adopt development models such as Children's Environment and Health Action Plan (CEHAPE), to take part in transnational studies and research such as the Health Behaviour in School-aged Children (HBSC) on adolescents (11-13-15 year olds) and their lifestyles. In particular the network of Health Promoting Hospitals (HPH) has focused socio-medical operator attention on the issues of local community health, ensuring that the hospitals have a social and cultural responsibility for promoting wellness. The scientific part of the HBSC research was carried out in collaboration with the University of Siena, with the direct involvement of educational establishments, enabling them to acquire an organic and systematic picture of the lifestyles of Tuscan adolescents.



National level

The recommendations in the Ministerial Gain Health - Easy Healthy Choices Programme have been successfully integrated into the healthy lifestyle development plan activities of the Tuscan Region. The Ministry's activities, in this regard, have become a strategic factor in the ongoing comparison and monitoring of health promotion and prevention activities geared to lifestyle and also in Health Authority and Health Society planning.

Regional level

Over the three-year Regional Health Plan period, the processes of cross-sector integration and operativity were bolstered, and collaborations with educational establishments and the world of associations were developed in particular.

In 2005, the project "L'Albero della Salute" (The Tree of the Health), was set up at the Local Health Trust of Prato and, after five year of collaboration, it was designated as the Reference Structure for Cultural mediation in health by Tuscan Regional Council. Currently it is the designated Reference Structure for the Promotion of Migrants' Health - Tuscan Region. Its mission being to make available its powers of analysis, model building, programme and practice definition to the entire Tuscan region, with a view to fostering health promotion in immigrants, in tandem with the socio-medical and hospital agencies in testing and activating what is defined as a "systems" cultural mediation model. This model provides for the inclusion of the objectives set out above as part of an umbrella communication programme for local services with the question of rapport as related to cultural difference at the core of the services themselves, in tandem with and in support of the provision of cultural-linguistic mediators.

4.3. Service delivery

As previously discussed, the administrative procedures that give migrants access to the health service only differ according to whether they are or are not in possession of valid residence permits. In the 1998 Single Text, the ban on SSN operators tipping off the police authorities about irregular patients was also upheld. This is an issue that has currently resurfaced because of the potential introduction of the crime of clandestinity. No legislation has been drawn up with regard to the use and uptake of the health services by migrants, and the proactive nature of services in regard to migrants rests very much on the goodwill of local health authorities.

Financing

The Italian health service is of an essentially universalistic nature and there is little recourse to private health insurance. Foreigners on Italian soil in possession of valid residence papers have equal rights to Italian citizens and their health costs are subsumed by the costs of the regional health service. Foreigners without valid residence papers are exempted from payment for services "should they be in possession of insufficient funds, excepting contributions paid at the



same rate as Italian citizens”, costs that fall back on the Ministry of the Interior. This is a particular important point, given the financial precariousness in which “irregular” immigrants often live.

Specifically, comma 6 art. 35 of the 1998 ST makes a distinction between those who are financing the services and those at whom they are targeted. As set out in art. 43, comma 5 of the implementing Regulation, and Circular n. 5/2000, the costs inherent in urgent or essential hospital care fall to the Ministry of the Interior (which will apply for reimbursement by the patient’s diplomatic representative and, should this not be forthcoming, to reimburse the cost of treatment to the structure that has carried it out, from a special fund for the indigent of which it is a Trustee). The Local Health Trust involved will be responsible for the costs of healthcare as in art. 35, comma 3 of the ST, including any unpaid contributions. The implementing Regulation (art. 43, comma 4) provides for an opportunity to declare one’s own state of indigence through self-assessment presented to the health facility providing the health care.

Resource generation

The 2008-2010 Regional Health Plan is consistent with the previous ones, although it makes a significant point of valorising the training of socio-medical staff at all levels, in the conviction that professionalism, knowledge and organisational capability are the true capital of any health system. Specific attention is reserved for the so-called “intercultural skills” of the operators, who are increasingly required to act and interact with people of various provenances, nationalities and languages. The need to implement a system that takes account of the various initiatives set in motion by these training needs, monitored at various levels over the last decade in Tuscany, has led the Region to plan and promote a series of actions and large scale projects, underpinned by legislative measures and investments in resources that put the spotlight on overhauling consultancy services, birth control education and informed sexuality in a migrant friendly approach. Investment in intercultural training for personnel employed in these fields, who are often migrants’ first point of contact with the health service and local society, is therefore regarded as being of fundamental importance. The Tuscan Region’s Mum Health Programme (RCD n. 259/2006, Annex C) took its cue from an ongoing background of values, albeit presenting in different ways in the three previous editions of the Tuscan Health Plan, setting up integrated interventions, involving both of the main components of the meeting in the services: the social and health service workers, protagonists of programmed meetings and support for the promotion of the active provision of services, on one hand; and on the other hand, migrant women, the targets of the planning and preparation of multimedia health education.

Migrant access to health information has become an increasingly core issue for the Tuscan Region, albeit in the absence of any standardised and/or legislatively defined procedures. Information and communication campaigns directed at citizens and migrants alike are becoming increasingly common, with a view to guaranteeing equality of access to and use of socio-medical treatment and promoting blanket migrant health. It is therefore vital to take the utmost care over the construction of documents and to use certified procedures for translations into



other languages. The designated Reference Structure for the Promotion of Migrants' Health - Tuscan Region - L'Albero della Salute has incorporated these factors into its objectives and spheres of activity, making sure that information documents relating to the many communication campaigns promoted by the Region and the regional Health Authorities are simplified and translated. One such example is the "Naturalmente Mamma" (Naturally Mum) booklet on breastfeeding; an information leaflet on the dangers of carbon monoxide; the "Sicuro non cado" (Sure I Won't Fall) campaign for safety at work and the prevention of falls in building yards; the "Mai più sola" (You are no longer alone) on violence against women; information leaflets on health centres and patient call systems at the Accident and Emergency Department in Lucca and many others.

5. Good practices and projects

5.1. Rete Sensibile

Within the framework of the activities provided for under Decree n. 6686/2006, during 2007-2008, L'Albero della Salute put together the "Rete Sensibile" (Awareness Network) regional training project, to promote the dissemination of cultural awareness on the subject of safety in the workplace for migrant people. This project was addressed to the local Occupational Health and Safety Services (Prevenzione, Igiene e Sicurezza nei Luoghi di Lavoro: PISLL) in all the Tuscan Health Trusts (USL) and provided for the implementation of a training course split into four modules: Migrants in Tuscany; Migrants and Work, a Socio-Anthropological Reading; Tools for Building Prevention Interventions; System Resources and Territorial Networks. The aims of the course were to:

- provide socio-demographic information and analysis on migrant groups;
- provide data and information on the financial and employment motives of migrants, together with their histories and most recurrent employment situations;
- analyse cultural diversity, in general terms and in regard to the employment world, with a view to fostering the cultural awareness required to relate to it;
- perform a critical analysis of the meaning of prevention in the workplace, in the light of socio-cultural and ethical values;
- build up participants' skills in relation to concepts currently being employed in reading and interpreting health determinants;
- value the guiding principles that lie behind legislation and policy on migrants that directly affect or indirectly rebound on prevention activities in the workplace;
- make a critical examination of the main models and some of the practices relating to intercultural communication;
- encourage a critical assessment of the concept of "networking" and "system", providing tools and methods for identifying the various actors working in the region that would help to build effective prevention interventions in regard to the issue of safety at work;



- drawing up and analysing useful strategies for involving the key stakeholders, providing planning models of interventions likely to promote migrants' informed responsibility for their own health in the workplace.

The ultimate aim of the project was to value the profile of the operators in prevention departments as advocacy agents for foreign workers, a category that is at great risk of social fragility, along with other profiles such as minors, women, victims of trafficking and social and political persecution, at whom these social national and international policies are addressed.

In order to achieve these aims, a mixed methodology was selected, put together in two residential introductory training days, a period of distance learning, followed by two final residential days.

44 of the participants completed the training course and pre/post assessment tests showed that the participants had acquired a significant amount of knowledge. Prior to commencing the course, the participants answered 57% of the questions correctly, with some variations at Area Vasta level, and on completion of the DL, when the participants took the self-assessment test again to see how much they had learned, 85.5% correct answers were achieved overall, a 28.4% improvement. The replies to the questionnaire on course satisfaction were positive overall. Of the general points, the overall quality of the course and the in-depth study of the issues covered were seen by the participants as the best points, while the methodology, which involved the distance learning component, was the factor that on average scored lower levels of satisfaction, although still in positive terms.

5.2. HPH Network

The Tuscan Health Promoting Hospitals Network (HPH) came about with the purpose of launching a pilot project by the European Office of the World Health Organisation in 1993. The Tuscan HPH Network was launched in May 2001 and involves all the Health Trusts: every single AUSL is taking part in the HPH Project and has their own dedicated committee and coordinator.

The University Meyer Hospital, with its Health Promotion Programme, coordinates the Tuscan HPH Network with a mandate from the Regional Department for the Right to Health.

With regard to the new HPH Network Agreement for the years 2007-2010, the projects launched during the previous five years were confirmed, including Humanisation/Reception, Intercultural, Smoke-Free Hospitals on which work has already begun in terms of target population.

The HPH Network has also drawn up a distance learning project, through TRIO, the e-learning portal for citizens in the Tuscan Region addressed to all hospital operators.

Within the general framework of the project, various fundamental activities have been identified, amongst which is the promotion of an intercultural approach to the health demands of migrants. The minimum requisites for an "Intercultural Hospital" model have also been defined, the most important of these being:



- the provision of a cultural-linguistic mediation service;
- regular programmed meetings with representatives of the main foreign communities;
- the promotion of exchanges with operators in other countries;
- the inclusion of HPH Intercultural in Authority strategies;
- hospitals taking part have also undertaken to organise annual training events on intercultural matters, that will gradually see all socio-medical operators taking part.

The Intercultural Project arose from the desire to carry out a collaborative survey throughout the regional territory, geared to building an SOS Intercultural Team in each Authority, consisting of operators with a working knowledge of a foreign language who would, during their working hours only and only when absolutely necessary, be willing to be contacted by colleagues having problems with non-Italian speaking patients. This Team would be able to provide a basic interpreting service, either in person or by telephone when - for organisational reasons and having observed the usual procedures - the cultural-linguistic mediator cannot be tracked down within a reasonable timeframe (this assessment is confirmed by the situation already existing in some of the HPH Group Authorities). Currently, however, a legal opinion has caused this particular plan to be suspended.

A store of files translated into different languages is being put together, consisting of files found on the Web, produced by Regional Authorities and other SSN Authorities or private bodies. It is often the case, in fact, that several different hospitals or health structures produce, at a cost in terms of money and time, multilingual material that other Authorities have already created and uploaded onto the Web with no reference to copyright or stating that it is available to all¹⁴. Sharing this material through a single collection point could improve the interface with migrants and help to make operator-foreign user dealings more effective. The prime objective is to make it easier for non-Italians to access health services, to raise their awareness of health problems (infectious diseases, sexually transmitted disease, diseases rife in poor areas and "enforced" communities), facilitating the work of the health operators and promoting health. Methods for accessing the collection site and downloading material have been systematised and distributed to the voluntary associations and migrant communities in the region, and feedback suggests that they are proving useful. No specific evaluation criteria relative to the Intercultural Project have been drawn up as yet¹⁵, the general evaluation criterion for the HPH Project is annual productivity which, in the case in point, is assessed by quarterly monitoring of access to the site, which has seen a 110% hike in log-ins since the Project was launched.

¹⁴ This is a case, for example, of information relating to accidents in the workplace that can be used by any Industrial Medical service and can be handed out to all immigrants working in the field of construction, or of information on pregnancy management, Pap Tests, contraception, the rights and duties of hospital in-patients, child health etc.

¹⁵ Cf. Annexes: Table summarizing the aims and the results achieved.



6. Conclusions

In line with the national trend, Tuscany has been deeply affected by the diverse demographic, social, economic and political movement determined by migration. As we have seen, the migration phenomenon, now a structural part of Tuscan society, has become a focus for a great many initiatives and legislative measures driven by the increasingly clear need to face up to the reality of migration, in its many different forms. Actors in the socio-welfare professions have also and especially been brought into play, not just because of the influence that health determinants (such as socio-economic conditions) are known to have on the conditions of individuals, but also because of the importance of the more or less direct repercussions that damage to the health of an individual can have on the environment in which he/she lives, on the reference group and population, in the light of diminishing available contextual resources and the emergence of the need for the group to take charge. These considerations are helping to fuel a new political approach to the right to health, one that is no longer interpreted in linear terms of "equal health rights" but of "equity": each and every individual must be guaranteed an opportunity to achieve the level of health that is right for them. This involves the implementation of differentiated interventions, where necessary, targeted at the most fragile and at risk categories. The very recent approval by the Tuscan Regional Council of the law on immigration¹⁶ would appear to go some way towards this, explicitly guaranteeing that all those "people living" on the regional territory, "even where not in possession of residence papers", the opportunity to access urgent and undeferable socio-welfare interventions, necessary to guarantee respect for the fundamental rights of each person on the basis of the Constitution and international law. This law is currently the focus for great discussion and heated debate, having encountered fierce opposition from the political national Government majority, who have taken a stand in favour of restrictive action, even in the health sphere, with a view to combating irregular immigration. However it should still be viewed on one hand as a fundamentally important recognition of the inviolable rights of the person, the right to health in particular, regardless of citizenship and residence permits; and on the other as a solid legislative basis for tackling what could well be described as the challenge to the present and to the immediate future of society as a whole: the inclusion and the participation of the over three hundred thousand foreign citizens who live, work and study in Tuscany.

The regional law described above belongs, moreover, within the framework of trust and support for peaceful coexistence and the integration referred to also in the: "Social Inclusion and Citizenship for Immigrants in Multiculturality" Integrated Regional Plan (Tuscan Region, 2008). The areas of intervention in which work is to be carried out in this sense, range from health (including occupational safety) to education, to improvements in housing and intercultural dialogue. Health in particular, among the various sectors of social life, is evidenced as being symbolic of the integration difficulties faced by foreigners, made worse by shortcomings of an informational, cultural and linguistic nature which cause them not to make full use of formal rights to which they are entitled. Policy making in the Tuscan Region revolves around this

¹⁶ Technically, the modification was introduced as a sub-amendment to Art. 6 presented previously and substituted the entire legal text of Art. 6 to 37, turning the articles into commas.



awareness: research carried out in 2006 into planning in the matter of tailoring health services to the migrant population in various Italian regions shows that the political action taken by the Region demonstrates that the difficulties inherent in this dimension have been taken fully on board, and action has been taken in almost all the spheres (IRPET, 2009) in particular:

- Accessibility - Equipping/creating advisory centres for women of foreign origin - Flexible opening hours - Implementation of guidelines for immigrant healthcare - Training for both health and administrative operators - Diffusion of cultural mediation in health matters.
- Promotion - Third Sector networking - Action to incentivise foreigners to register with the SSN - Health information in several languages.
- Prevention - Dedicated health education/information programmes for immigrants.
- Health Authority projects budgeted for - Valorisation of general practitioners.

From an organisational point of view and from the Region's stated intentions, it would appear that an awareness clearly exists toward issues involving the health of immigrants, a systemic perspective on these issues suggests the need for further commitment in order to tackle the more obvious criticalities. There is a need to work on one hand towards the stabilisation and universalisation of foreigners' right to healthcare, and on the other towards the rationalisation and optimisation of health expenditure, based on a deep awareness of the indissoluble link between the well-being and social integration of migrants.

This awareness should form the basis for a more effective push towards integrating the objectives and the activities of the regional government: health taken to mean global health, is not merely a matter for the regional health services, it takes over every other part of an individual's life and the life of the community he/she belongs to. Policies relating to the entry and residence of foreigners, economic, social, employment and housing policies, policies governing the world of education and training, must keep pace with each other, interacting reciprocally and working towards shared objectives in particular.



Annexes

Main regulatory references on health matters relative to immigration

National level

- **Presidential Decree of 23 July 1998**
approving the National Health Plan for the 1998-2000 triennium. (Ragiusan (Rassegna Giuridica della Sanità), March-April 1999, Nos. 178-179, pp. 84-114. Original text published in Official Journal, 10 December 1998, No. 201, Ordinary Supplement)
- **Legislative Decree of 25 July 1998 no. 286**
"Combined text of measures governing immigration and norms on the condition of foreign citizens". Original text published in Official Journal, General Series, Arts. 34, 35 and 36.
- **Presidential Decree of 31 August 1999 no. 394**
"Regulations for the execution of the unified text of rules on immigration and the conditions of foreigners ([1]), in conformity to Art. 1, paragraph 6, of Lgs. Decree No. 286 of 25 July 1998". Ordinary Supplement to the Official Journal No. 258 of 3 November 1999 - General Series Arts. 42, 43 and 44.
- **Ministerial Circular no. 5 dated 24th March 2000 Applicative provisions of Legislative Decree no. 286**
"Combined text of measures governing immigration and norms on the condition of foreign citizens.- Procedures regulating the provision of medical assistance", Original text published in Official Journal no. 126 of 1 June 2000 - General Series.
- **Presidential Decree of 23 May 2003**
"Approval of the National Health Plan 2003-2005", Ordinary Supplement to the Official Journal No.139 of 18 June 2003 - General Series. Part II, Paragraph 6.6.
- **Presidential Decree of 7 April 2006**
"Approval of the National Health Plan 2006-2008" Original text Published in Official Journal no. 139 of 17 June 2006. Paragraph 5.7
- **Information Note, Ministry of Health of 17 April 2007**
"Clarifications in the matter of health care for non-EU citizens, following the recent Directives issued by the Ministry of the Interior" - DGRUERI/VI/I.3.b.a/ 5719/ P
- **Ministerial Circular no. 5 dated 3 August 2007**
"Residence Rights for EU Nationals - Directive no. 38/2004 and Legislative Decree no. 30 of 3 February 2007" - Protocol DG RUERI/II/12712-P/I.3.b/1
- **Interministerial Committee for Economic Planning, Deliberation no. 114 of 9 November 2007**
"National Health Fund 2007 - Current account - Allocation of resources earmarked for the pursuit of priority and nationally important objectives, pursuant to Art. 1, comma 34, Law no. 662/1996", Published in Official Journal no. 26 of 31 January 2008. (N.B. There are similar annual provisions as from 1997).
- **Information Note, Ministry of Health of 19 February 2008**
"Clarifications in the matter of health care for EU citizens living in Italy"- Protocol DG RUERI/II/3152-P/I.3.b/1

Source: Geraci, Marceca, 2008



Regional Tuscan level

- **R.L. no.18 of 12 March 1977**
Institution of family, maternity, infant and child assistance services.
- **R.L. no. 22 of 22 March 1990**
Interventions for upholding the rights of non-EU immigrants in Tuscany.
- **R.L. no. 42 of 2 September 1992 (Arts. 13 and 14)**
Performance of duties in the matter of social welfare.
- **R.L. no. 28 of 26 April 1993**
Legislation on the relations of voluntary organisations with the Region, local bodies and other public bodies - Set up of the Regional Register of Voluntary Organisations.
- **R.L. no. 40 of 23 June 1993 (Arts. 1 to 6)**
Governing the collegiate health bodies.
- **R.L. no. 72 of 3 October 1997 (Art. 21)**
Organisation and promotion of a system of citizenship and equal opportunities rights: reorganisation of integrated socio-welfare and socio-medical services.
- **R.L. 24 November 1997, no. 87**
Governing relations between the social cooperatives and the public bodies operating at regional level.
- **R.L. no. 85 of 26 November 1998 (Arts. 1 to 10; 13, 14 and 15)**
Delegation to local bodies and general discipline of functions and administrative duties regarding the safeguarding of health, social services, education, professional training, assets and cultural events, conferred on the Region by Legislative Decree no. 112 of 31 March 1998.
- **R.L. no. 17 of 23 March 1999**
Interventions for the promotion of international cooperation and partnership activities, at regional and local level.
- **R.L. no. 2 of 12 January 2000**
Interventions for the Roma and Sinti populations.
- **R.L. no. 31 of 20 March 2000,**
Involvement of the Istituto degli Innocenti in Florence in implementing regional promotion and support policies in the matter of infancy and adolescence.
- **R.L. no. 32 of 26 July 2002 (Arts. 1 to 7; 21, 21 bis; 25 to 27)**
Combined text of Tuscan Regional legislation in the matter of education, instruction, guidance, professional training and work.
- **R.L. no. 42 of 9 December 2002**
Governing the Social Protection Association. Modification to Art. 9 of Regional Law no. 72 of 3 October 1997 (Organisation and promotion of a system of rights of citizenship and equal opportunities: reorganisation of integrated socio-welfare and socio-medical services).
- **R. Del. no. 155 of 24 September 2003**
Regional Act triggering the Health Societies experiment.
- **R.L. no. 43 of 3 August 2004**
Reorganisation and transformation of the Public Institutions of Welfare and Charity (IPAB). Legislation on personal social services providers. Special provision for IPAB "Istituto degli Innocenti di Firenze".
- **R.L. no. 63 of 15 November 2004**
Anti sex and gender discrimination legislation.



- **R.L. no. 40 of 24 February 2005**
Regional health service regulations.
- **R.L. no. 41 of 24 February 2005**
Integrated system of interventions and services for safeguarding social citizenship.
- **R.L. no. 59 of 2 November 2005**
Legislation in the matter of public housing and the alienation of refugees as per Art. 17 of Law no. 137 of 4 March 1952 (Help for Refugees) i.e. Art. 34 of Law no. 763 of 26 December 1981 (Organic legislation on Refugees).
- **R.L. no. 64 of 2 December 2005**
Protection of the right to health of detainees and prisoners in penitentiary institutions located in Tuscany. This law guarantees the principle of equality of healthcare treatment between free people and those detained and imprisoned - therefore with no distinction whatsoever between Italian and foreign citizens - and guarantees essential levels of healthcare with regard to preventative, diagnostic, therapeutic and rehabilitative treatment, on an equal footing to that of free people.
- **R.L. no. 29 of 9 June 2009**
Legislation covering the reception, the participatory integration and the safeguarding of foreign citizens in the Tuscan Region. Published in BURT no. 19 of 15 June 2009

Source: <http://www.consiglio.regione.toscana.it/leggi-e-banche-dati>

Table 1. Foreigners living in Italy and Tuscany - The top 10 nationalities (ISTAT, 2008)

Foreigners living in Italy The top 10 nationalities			Foreigners living in Tuscany The top 10 nationalities		
Nationality	Total no.	% of the total foreign resident	Nationality	Total no.	% of the total foreign resident
Romania	625,278	18.2%	Albania	55,706	20.2%
Albania	401,949	11.7%	Romania	51,763	18.8%
Morocco	365,908	10.6%	China	25,818	9.4%
China	156,519	4.5%	Morocco	21,387	7.8%
Ukraine	132,718	3.9%	Philippines	8,695	3.2%
Philippines	105,675	3.0%	Poland	7,659	2.8%
Tunisia	93,601	2.7%	Ukraine	6,979	2.5%
Poland	90,218	2.6%	Senegal	6,183	2.2%
Macedonia	78,090	2.3%	Peru	5,519	2.0%
India	77,432	2.2%	Germany	5,093	1.9%
Tot. top 10 nationalities	2,127,388	62%	Tot. top 10 nationalities	194,802	70.8%



Table 2. Foreigners - Accidents at Work Reported to INAIL by Sector in Tuscany

Sectors	Total						Fatal Accidents					
	2005	% of tot 2005	2006	% of tot 2006	2007	% of tot 2007	2005	% of tot 2005	2006	% of tot 2006	2007	% of tot 2007
Agric.	727	13.7%	725	14.8%	760	16.2%	1	11.1%	1	7.7%	1	25.0%
Industr. and servic.	8,005	12.2%	8,489	13.0%	9,324	14.3%	10	13.3%	8	9.4%	7	11.1%
Tot	8,732	12.3%	9,214	13.1%	10,084	14.5%	11	13.1%	9	9.2%	8	1.9%

Source: INAIL, 2008



The HPH Network - Intercultural Hospital project	
Aims	Results
Set up a cultural-linguistic mediation service	Mediation provided in all Authorities (100%)
Inclusion of intercultural HPH in business strategies	Internal work groups set up in each company (70%) Interculturality included in strategies (Communication Plan 80%, Training 100%, Health Education 40%)
Regular meetings with community representatives	Regular meetings with community representatives (50%)
Operator exchanges with other countries (Cooperation Projects)	Working on DC exchanges (70%)
Health Profile (health indicators and indicators of uptake of services by foreigners)	Reports produced on foreigners' uptake of services and health indicators in the Profiles (85%)
Definition of Standards	Application of Standards
food: respect for culture, information on food and pathologies	choice of foods (70%) pathology cards (30%)
faith: respect for faith, referrals to ministers of religion, intercultural calendar	definition of procedures and referrals to ministers of religion (50%) calendar (45%)
death: respect for ritual, referral to ministers of religion, information material	definition of procedures and referrals to ministers of religion (50%) information material (20%)
birth: respect for childbirth according to culture, pregnancy and childbirth in the region (Percorso Nascita)	Participation in antenatal courses, inoculation programme for children
pain: guaranteed treatment, records, information	evaluation scale and information material

Extract from the Proceedings of the Tuscan Hospital Network for Health Promotion Regional Conference, Florence - 10th May 2006



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Complete reference material

X. Regional report Varna

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Summary

Immigration in Bulgaria is a new and continuously changing phenomenon, enhanced by entry into the European Union (EU). The favorable economic, administrative and educational prospects of Varna have turned the Region into an attractive destination for significant numbers of immigrants. On account of its geographical location, Bulgaria is a main country of transition for illegal migration and trafficking, and the illegal foreigners are estimated to be around 30,000 people. Victims of human trafficking, especially women and children, are particularly vulnerable to health problems and are more likely also to suffer from mental diseases.

The health of migrants is acknowledged as an issue of significant public health importance and a policy challenge. This is evident in Bulgarian legislation, starting from the Constitution which guarantees equal treatment to foreigners with respect to all rights and obligations. The Law on Health regulates equal rights in terms of medical services enjoyed both by Bulgarian nationals and aliens who hold a long-term residence permit in Bulgaria. In particular, health insurance and the provision of medical services for migrants are regulated, with details set by domestic legal instruments. Specific legislative norms have been developed to regulate all strategies and actions referring to migrants' health and healthcare services.

Migration policy involves an intersectoral approach to migration and migrants' health: for this reason a National migration and integration strategy 2008-2015 was developed bound to the National Employment Strategy, National Strategy for Demographic Development, National Housing Strategy, National Poverty Reduction and Social Exclusion Strategy, National Health Strategy, etc. Another very important factor is the capability to realize effective partnerships among central and local governments, civil society groups, international organisations, NGOs, academic institutions, social protection service providers, media, and other key partners.

A lot of specific projects based on these key factors have been implemented for migrants' health, such as the research project of the Bulgarian Helsinki Committee on the rights of immigrants in Bulgaria to facilitate medical assistance and provision for reimbursement of medicines. Another good example is the project to support provision for vulnerable groups of migrants, such as disabled, pregnant alien women and single refugee mothers.

Another important initiative is the Academic Refugee Studies Initiative in Bulgaria to strengthen the dialogue with the civil society on the problems of the refugees and to develop knowledge and skills for work with refugees in various training sectors such as employment, education, social activities, etc.

1. Health system overview, national and regional situation

1.1. Health system functions

The Republic of Bulgaria is situated in the eastern part of the Balkan Peninsula and covers a territory of 111,000 km² with a population of 7,606 million (2007) [21]. The socio-political transformations that have taken place since 1989 have had a big impact on the health system. Radical reforms were carried out that involved all key areas of the health care system and



impacted on its organisational structure, financing and the role of the main bodies. Major legislation relating to the system's transformation was enacted in 1998-1999 with the adoption of 3 main legislative acts - the Healthcare Insurance Act (1998), the Law on Healthcare Establishments (1999), and the Law on the Professional Associations (1998). In 2004, a new Law on Health was adopted.

The Bulgarian health care system is organized on three levels of care provision: primary, secondary and tertiary health sectors. Primary health care is based on a model of general practice. The general practitioners (GPs) act as gatekeepers to specialized outpatient and hospital care. They provide a broad package of primary care services comprising preventive, diagnostic-therapeutic, rehabilitation and medico-social health care activities. The GPs are registered and accountable to the regional division of the Ministry of Health (Regional Healthcare Centre) and have contracts with the regional office of the National Health Insurance Fund (NHIF). Access to primary health care is not constrained and every Bulgarian citizen is free to choose a GP within the region of residence [6]. According to the Law on Foreigners in the Republic of Bulgaria [8] and the Law on Asylum and the Refugees [10], all foreigners legally residing in the country and refugees with a granted humanitarian or protection status are entitled to the same rights as the Bulgarian nationals.

The secondary level of health care involves specialized outpatient and inpatient care. In accordance with the Law on Healthcare Establishments, specialized outpatient care is provided by single and group practices for specialized care; medical and dental centres, independent medical-diagnostic and medical-technical laboratories, and diagnostic-consultative centres [9]. Physicians or medical establishments contract with the NHIF in order to participate in statutory provision; any providers that do not sign contracts can provide private services on a fee-for-service basis. Inpatient medical care is provided by hospitals - categorized into the following main groups: for acute, extended and rehabilitation treatment; for multi-profile or specialized inpatient care; functioning on a national, regional or municipal level. Dispensaries specialized in oncological, dermatological, pulmonary and psychiatric diseases, as well as the newly created hospices, were also classified as inpatient care facilities [9]. Although the health care reforms saw a significant reduction in the number of hospital beds (reaching the figure of 5.68 per 1000 population for 2007), Bulgaria still has an extensive hospital network that provides easy access to inpatient care. However, facilities and qualified staff are concentrated in urban areas and people from small and isolated rural areas have difficulties in accessing them. Tertiary level services provide highly specialized care and include national institutes and centres of oncology, cardiovascular diseases, physiotherapy and rehabilitation, infectious diseases, haematology, radiology, sports medicine, emergency care etc. These are owned, administered and financed by the Ministry of Health. Emergency care services cover the whole territory of Bulgaria and each of the 28 administrative districts has a Regional Centre for Emergency Care [6].

The main legislative body regarding health issues is the Parliament and its Commission for Health. The Ministry of Health (MH) develops and implements national health policy, defines the goals and priorities of the health system, works out national health programmes, and develops draft legislation concerning the health sector. Each of the 28 administrative regions in Bulgaria has a Regional Health Centre (structures of the MH) - supporting the implementation of the



national health policy at regional level and ensuring communication between local and central authorities. The MH is also responsible for the emergency care network throughout the country, as well as the public health network consisting of a National Centre and 28 Regional Inspectorates for Public Health Prevention and Control in each of the country's administrative regions. The Ministry owns and administers a number of national research centres, the university hospitals and a number of regional specialized hospitals including psychiatric hospitals, hospitals for pulmonary diseases, and specialized hospitals for rehabilitation from chronic diseases. In addition, the Ministry administers the Executive Agency on Pharmaceuticals, which registers medicines and drugs, and controls the national pharmaceutical market. The MH coordinates activities with other ministries (of Finance; Environment and Waters; Education and Science; Labour and Social Policy, etc.); the National Health Insurance Fund, the Associations of Bulgarian Physicians, Dentists, Nurses, Midwives and other Health Care Professionals in Bulgaria [6].

The main sources of health system financing are compulsory health insurance (through the NHIF), state and municipal budgets, voluntary health insurance funds; local and foreign legal bodies and individuals, and co-payment. State and municipal budgets cover free of charge emergency care; psychiatric care; blood transfusions; obligatory immunizations and obligatory treatment; epidemiological studies and epidemic control activities; health programs and projects of national, regional, and local importance; state sanitary control; education, science and qualification; health care construction, basic repairs, modernization, improvements and reconstruction; health administration; national centers and institutes with no direct treatment activity; expensive treatment out of the scope of the obligatory health insurance [6]. The MH also funds specialized health institutions at national and regional levels, and the public health system.

With the Healthcare Insurance Act [7] a system of compulsory and voluntary health insurance was introduced in Bulgaria. The compulsory health insurance is implemented by the NHIF and its territorial divisions (Regional Health Insurance Funds). The obligations to insure and the rights to be insured apply to: all Bulgarian citizens; foreign citizens or persons without citizenship who have long-term residence permits for the territory of Bulgaria and persons with a refugee or humanitarian status or who have been granted the right of asylum. The compulsory health insurance contribution is 6% of person's defined income, which is divided between the employer and the employee. Self-employed persons pay the entire contribution; working members of families insure non-working members; contribution for the unemployed and poor, pensioners, students, soldiers, and some other vulnerable categories are covered by central and local budgets.

The NHIF was established as an autonomous public institution for compulsory health insurance. Its main function is management of financial resources for medical care with the intention of total coverage of major health needs of the population and a guarantee of accessible, affordable and high quality healthcare [7]. Since July 2000, through its regional bodies, the NHIF finances the entire health care network for outpatient care. Reimbursement to GPs is based on per-capita monthly payments per insured person on the patient list. Specialized outpatient care and laboratories are reimbursed by means of a fixed fee-for-service. Dental care



is mostly paid out of pocket, based on fee-for-service, although a limited number of dental services are included in the basic benefits package. Since 2006, the hospital services are fully financed by the NHIF on the basis of clinical pathways. The NHIF also exercises medical and financial control over medical care providers through its regional structures [6].

A free choice of a medical care provider is guaranteed by the health insurance system to all insured, who choose to use the services of both private and public health establishments, which have concluded contracts with the NHIF. Complementary to the compulsory health insurance, every individual has an optional right to voluntary health insurance [7]. It is carried out by shareholder companies, registered in accordance with the Commercial Law, however the demand for supplementary voluntary insurance is limited so far. Out-of-pocket spending is currently estimated to 20% of the total health care expenditures. Every Bulgarian citizen is supposed to be insured to receive a package of health care services, determined and paid for by the NHIF. The large number of uninsured is still a big problem for the system (nearly 1,100,000 in 2005) [6].

There is diversity in ownership of the establishments; whether state-owned, municipal or private, they all have equal status. The municipalities own a large number of diagnostic and consultative centres for specialized outpatient care, multi-profile municipal hospitals for acute care, some specialized hospitals and outpatient clinics. In addition, municipalities are responsible for specialized paediatric and gynaecological hospitals and for specialized regional dispensaries. After the legalization of private practice in 1991 many institutions in the outpatient sector started functioning as private entrepreneurs by signing contracts with the NHIF for medical care provision. Private hospitals form a smaller proportion; however, their number is constantly increasing [6].

The number of non-governmental organisations involved in the health sector is numerous - representing the blind, the deaf and the disabled, patients with multiple sclerosis, diabetes and cancer, and others.

1.2. Structural organization at regional level

Varna region is situated in the North-Eastern part of Bulgaria and covers a territory of 3,820 sq. km (3.44% of country's territory). It comprises of 12 municipalities, 10 towns and 149 villages with a total population number of 459,613 inhabitants (31 Dec, 2007). The density of the population (130 people per square km) is much higher than the country's average [21]. Notable issues impacting on healthcare system organisation and service delivery in the region are the presence of a great number of young people, students, seasonal workers, tourists and the tendency for immigration of people coming from other parts of the country or other countries.

The population of the Region is very well covered with a sufficient number of primary and specialized outpatient healthcare establishments [24]. There are 432 individual and group GP practices in the Region, and on average, there is a GP for about 920 people (31 Dec, 2008). The specialized outpatient facilities comprise 73 medical centres, 9 diagnostic-consultative centres, 411 individual practices and 7 hospices. A serious problem is the uneven territorial distribution of specialists throughout the district and the dense concentration in the regional



centre. The diagnostic facilities include 67 medico-diagnostic laboratories (clinical, microbiological, pathological, parasitological, radiological and ultrasound) - mostly concentrated in the city of Varna. The inpatient care sector comprises 15 hospitals: 1 University Multi-profile Hospital for Active Treatment; 5 Regional Multi-profile Hospitals for Active Treatment; 6 Specialized Hospitals; 2 Dispensaries for Specialized Prophylaxis and Treatment, 1 Hospital for Rehabilitation and a Home for Medical and Social Care for Children [24]. Nine of the hospitals are public (state and municipal) and six private. The established public-private hospital system in the region has the capacity to cover the population needs for inpatient healthcare. The University Multi-profile Hospital, the Naval Hospital and most of the other hospitals in Varna have inter-regional functions and capacities. They provide qualified diagnostic and therapeutic services, and work capacity assessment to the population (national and foreign residents) of the Region and the whole North-Eastern part of Bulgaria.

The Region is sufficiently provided with pharmaceutical facilities - 235 pharmacies [24], which however are unequally distributed throughout its territory and mainly concentrated in Varna and other cities. The system of emergency medical care covers the whole territory of the Region. The Centre of Emergency Medical Care is one of the 28 independent centres in the country, based in the regional centre - Varna with 9 branches spread on the territory of the region.

Agencies and institutions operating at regional level in migrant health field

There are very few regionally based structures that are specifically directed to refugees and migrant surveillance and services. The regional sub-division of the Migration Directorate of the Ministry of Interior is in charge of information provision and administrative control of the foreigners residing in the region. The territorial units of the State Agency for Refugees (SAR), Transit, Registration-and-reception and Integration Centres) for asylum seekers' accommodation, support and services provision are not equally distributed throughout the country and are mainly concentrated around the capital. None of them is located in Varna region. There are no migrant-sensitive healthcare delivery establishments in the Region. The healthcare establishments, which contract with SAR and some NGOs (Caritas, Bulgarian Red Cross, Nadya Centre, the Council of Refugee Women, etc.) provide specific medical services or additional medical care (outside the scope of the health-insurance package), such as outpatient and inpatient treatment; family planning training, infectious diseases and STD treatment and prevention, psychiatric aid, dental services, etc. The Pope John Paul II Medical Centre, the Kniaz Boris III Medical Institute, and the National Hospital for Infectious Diseases are also located in Sofia. Most of the non-governmental and international organizations operating in the refugee and migrant field are settled in the capital. Very few of them have regional divisions and representation. One of these is the Bulgarian Red Cross (BRC) with its Refugee Migrant Service. Refugees and migrants residing in the Region can use the facilities of these nationally-based structures; however, their concentration in the capital makes accessibility difficult.

Migrants, refugees and asylum-seekers pending determination of their status have the same rights and access to medical assistance and free-of-charge medical services and social support as Bulgarian nationals. They can use all regionally- based healthcare and social support



structures that are available to Bulgarian citizens. These include GP practices, specialized outpatient and inpatient healthcare delivery structures (public and private), emergency care centres, work-place health provision, drug-addiction and substance abuse facilities, locally based health promotion programme activities, and all local social assistance, labour and welfare services.

Intersectoral actions

To adequately address migrant health needs, intersectoral engagement and close co-operation and partnership are required among different institutions, agencies and structures - central and local government, civil society groups, international organisations, NGOs, academic institutions, social protection service providers, the media, etc. There are good examples of intersectoral actions addressing migrants' health and its determinants at national level, though fewer on a regional level. For instance, within the BRC "Local Integration of Refugees in Bulgaria Project", activities including medical assistance and social support have been developed, but they have been implemented mostly on a national level and concentrated in Sofia. The BRC Regional branch in Varna has had just episodic involvement in a few cases of regionally resident refugees looking for assistance.

Regardless of this, refugees and immigrants residing in the Region have been involved in national programmes and projects which have been implemented also on a local level and involving regional health and social care establishments and structures. Apart from the national programmes specifically focused on this vulnerable group (the National Program for Integration of Refugees and the Programme for Literacy, Qualification and Employment of Aliens Who Have Been Granted Refugee or Humanitarian Status), migrants living in the region have been involved in other national programmes involving nationals and foreigners alike, for example the Programme for Health Prophylaxis and Prevention of Infectious Diseases and STDs; the National Programme for Prevention, Treatment, and Rehabilitation of Drug Addictions; the Prevention and Control of HIV/AIDS Project of the Global Fund to Fight AIDS, Tuberculosis and Malaria; and child and maternal health programmes, etc.

1.3. Health information system

Two main flows of health care information from the local/regional to the national level occur in Bulgaria. The first starts from the healthcare establishments through the Regional Health Centres to the National Centre of Health Information and the National Statistical Institute. This flow transmits the information related to population health status, demographic events, and registered diseases, as well as the functioning of the health care system and its sectors. The second major flow of health information is mostly related to the financial aspects of the health care establishments and the provision of medical services. It is directed from the healthcare delivery structures through the Regional Health Care Insurance Funds - to the NHIF. Attempts have been made for connecting the information systems of all structures related to health in a common database network. A project is also in train for developing the patient electronic record and implementing the Electronic Health Record System in Bulgaria.



The competent body for executing the administrative control on foreign residence on the territory of Bulgaria is the Migration Directorate at the Ministry of Interior with its regional structures. According to the Law on Foreigners in the Republic of Bulgaria [8], when entering the territory of the country every foreign citizen completes an address notification form. Any individual or legal body providing asylum or accommodation to a foreign citizen should notify the Service for Administrative Control of Foreigners or the local police department within 5 days. All hotels and similar accommodation establishments are also obliged to provide information on a daily basis to the responsible administrative structures. According to the Law on Asylum and the Refugees [10], a foreign citizen who has been granted refugee or humanitarian status is obliged within 14 days of the decision to notify the administrative services of the respective municipality in order to be registered in the local residence register.

One of the biggest problems relating to migrants in Bulgaria is the lack of reliable, officially accessible statistics on international migration. Due to a lack of a precise, unified methodology for analysing migration movements, and co-ordination between institutions observing these movements the data on permanent and long-term foreign residents in Bulgaria is contradictory and not reliable. On the contrary, the statistics on refugees in Bulgaria are trustworthy and systematic, thanks to the centralized system for surveillance within the State Agency for Refugees and the network of organisations operating in the refugee field [3]. Other deficiencies in the health information system are the lack of systematic and officially accessible immigration statistics on a sub-national/regional level and the scarcity of information on migrants' health. The country's health information system does not disaggregate data in a way that permits analysis of the main health issues and basic health indicators among migrants.

The first migration studies in Bulgaria are being undertaken and are primarily focused on emigration [15]. Systematic migrant population health surveys are lacking. Single studies involving assessment of migrants' health needs and service provision have been carried out within projects of some of the agencies and NGOs working in the field or the newly established academic Centre for European Refugee, Migration and Ethnic Studies. However these are not specifically focused on health, not comprehensive and on an episodic basis (for example the Research project of the Bulgarian Helsinki Committee on the rights of immigrants in Bulgaria 2005 - supported by OSI and the UNHCR). Limited-scope studies of the Bulgarian Helsinki Committee [3] reveal a rather unfavorable situation regarding the health-insurance status of migrants in Bulgaria. Approximately 23% of the immigrants have no health insurance; 70.3% of women and 60.4% of men are registered with a General Practitioner, yet quite a few immigrants prefer to use the services of a physician from their own community and pay additionally for medical services, although they have healthcare insurance and are registered with a GP. Men are more likely to choose this alternative and unofficial route than women.

Laws on health information

The legislative framework for health information comprises the following main acts: The Health Law (2004), the Healthcare Insurance Act (1998), the Law on Healthcare Establishments (1999). In accordance with the Law on Health:



“The healthcare delivery establishments, the Regional Health Centre, the physicians, dentists, pharmacists, and all other medical specialists as well as non-medical specialists working in the National Health System collect, process, utilize and protect health information” [11].

According to the Law on Healthcare Establishments:

“The healthcare establishments apply technologies and systems collecting health information ... and provide all requested information on the activities performed as well as medico-statistical data in compliance to an Order of the Minister of Health” [9].

Under the Healthcare Insurance Act the NHIF information system is regulated, and there is a register of all healthcare-insured persons in Bulgaria, including foreigners with long-term residence in the country [7]. As from the date of commencing the status determination procedure, the SAR makes the monthly compulsory health insurance contributions for asylum-seekers by using resources from the state budget. In view of this responsibility, software with data regarding the health-insured asylum-seekers has been jointly developed with the National Social Security Institute and the NHIF [22].

The system of data collection on migrants is regulated by the Law on Foreigners in the Republic of Bulgaria [8]. The Migration Directorate at the Ministry of Interior is in charge of the provision of official and systematically collected data on the number of the short- and long-term foreign residents as well as those with granted protection and Bulgarian citizenship. The Law requires the Ministry of Interior to maintain unified Register of all foreigners with long-term or permanent residence in the country. It is expected this data will be transferred to the National Statistical Institute and become a basis for its population surveys and migration studies. However, representative comprehensive and systematic studies based on reliable migration data are still lacking in Bulgaria.

2. The migration phenomenon

2.1. General characteristics and extent of the migration phenomenon in the region

Current developments relating to the pattern of migration in Bulgaria began some 20 years ago. After several decades of restrictions on free movement during the socialist regime, the democratic changes in Bulgaria after 1989 resulted in opening up of the borders. This led to waves of large-scale emigration. They were a result of the lifting of administrative barriers and restrictions, the very large difference in standards of living between Bulgaria and developed countries, the reticence of the regime of the 1945-1989 period, etc. Firstly, the outward migration was on a political and ethnic basis while in the following years emigration has been predominantly determined by economic circumstances and factors. External migration from Bulgaria was driven mainly by disparities in earnings and unemployment and the greater opportunities abroad to find a job which could guarantee higher standard of living [2].



According to official data of the National Statistical Institute for the 1989-2006 period about 900,000 people have emigrated, which was about 10% of the total population in 1989 [21]. Accession of the country to the EU in 2007 increased its attractiveness for immigrants.

Recently, Bulgaria has been increasingly affected by immigration flows. The country has a specific status within the European migratory area due to its geographic location as well as its political and economic situation. The region plays an important role in the interaction between the developed countries of the EU and other countries of Eastern Europe and Asia.

Due to a lack of unified methodology for analyzing migration movements the data is not completely reliable. This leads to contradictions in the assessments and variations in the registered number of immigrants in Bulgaria, which varies between 60,000 and 108,000 for permanent foreign residents and between 30,000 and 50,000 for seasonal and irregular immigrants [3]. In 1994, a new category of immigrants was introduced in Bulgarian legislation - refugees and people with humanitarian status [3]. The number of foreigners seeking asylum in Bulgaria in the period 1994-2006 was 15,391 whereas refugee status had been granted to 1,412 and humanitarian status to 3,497 foreigners [25, 27]. One of the pull factors for people seeking asylum in Bulgaria is the financial, social and health assistance that applicants for refugee status automatically receive upon registration and during potential appeal. The majority of asylum seekers are economic migrants. The geographical location of Bulgaria makes it a main country of transition for illegal migration and traffic of people [26]. The illegal foreigners in Bulgaria are estimated to be around 30,000 persons [3].

According to projections, a further decrease and stabilisation in outward migration is expected in the coming years. An increase in the scope of immigration is projected related to EU membership of the country and its perspectives for development. For certain groups of immigrants, immigration to Bulgaria is temporary, and they look upon Bulgaria as a country where they will prepare for further emigration. In the meantime, there are visible signs of the growing attractiveness of Bulgaria as a final destination country in recent years; the number of non-nationals coming to Bulgaria for permanent and long-term residence has been gradually increasing [3]. Immigration has visibly increased since the beginning of 2007 when Bulgaria got a full EU membership and fully opened its labour market for EU citizens, who do not require a work permit. This has facilitated entry of labour from the EU, which was previously burdened by long and complicated procedures. This is also important in the context of the growing inflow of foreign direct investment. Furthermore, people of Bulgarian origin from Southeast European nations, particularly from Macedonia, the Ukraine, and Moldova, have begun applying for Bulgarian citizenship in much greater numbers. The projections are for a steeper increase in these trends in the following years [5].

As systematic and officially accessible immigration statistics on a regional level are lacking, all data refers to the national scale of the immigration phenomenon. The data available on a regional level comes from the estimates of the population censuses in the country (the last two carried out in 1992 and 2001) demonstrating that about 1,530 foreigners settled in Varna region in this period [20]. At the end of 2006, national police data, for instance, reveals about 60,000 foreigners registered as received a permanent residence permit in Bulgaria. Most of them are concentrated in big cities and urban areas, as they offer a more cosmopolitan



atmosphere and much greater opportunities to find employment or start a business. The capital Sofia and Plovdiv, the second largest city, host the largest immigrant communities in the country; 33.6% and 8.8% of permanently residing foreigners live in these cities and districts. Other urban centres with sizable migrant population are the port cities and districts of Varna (8%) and Burgas (4.9%), followed by the towns and districts of Stara Zagora, Pleven, Blagoevgrad, Russe, Veliko Tarnovo and Shumen [3, 21].

In conclusion, membership of the EU not only creates opportunities for migration out of Bulgaria, but also includes Bulgaria in the group of countries which can offer a "normal" standard of life. Bulgaria is thus seen as a European country, and is credited with a higher status, which may influence emigrants to return, while immigrants start flowing in. This marks the beginning of a repositioning of Bulgaria on the migration scene as a country of return migration and immigration [2]. The policy context and economic circumstances have influenced the migration situation of Bulgaria and shaped its future trends. The increased possibilities for free movement of people, the growing attractiveness of Bulgaria with its EU membership, the country's crucial geopolitical situation, the market liberalization process, the favourable legal framework and possibilities for migrants integration, the policies developed for securing protection of their rights have all stimulated recent immigration flows. Varna Region (along with the capital and a few other big cities in Bulgaria) has been attracting the major migration flows of the country - both external and internal. The favorable economic prospects for migrants and good conditions for their integration in these regions are the main pull factors for migration.

2.2. Composition of migrant flow

In terms of their origin, in 2006, 77% of the immigrants came from Europe, 19% from Asia, 2% from America, 1% from Africa and 1% were stateless [2]. The permanent and long-term residents in Bulgaria come mainly from the Commonwealth or Independent States Countries (61.6%) and most of all from the Russian Federation, as well as from so-called the "second circle of neighbourhood" countries (9.5%), such as Turkey, Albania, Macedonia, Bosnia and Herzegovina, Ukraine. EU citizens represent only 8% of the foreigners having received permanent residence in Bulgaria [3]. There is also an increased interest from Chinese and Armenian immigrants in settling for long-term residence in Bulgaria. On the other hand, there is a clear decrease in the number of immigrants coming from Africa (mostly Nigeria and countries from the north part of the continent) and Latin America. Data for 2006 indicates that 14,694 foreigners have received a fixed term residence permit of a stay up to 1 year, coming mostly from Macedonia, Turkey, Great Britain, the Russian Federation, Greece, USA, Ukraine, Germany, Cyprus, and Italy. While becoming more and more attractive to economic immigrants, the country is less attractive to refugee and humanitarian protection seekers, coming most of all from Afghanistan, Iraq, Algeria, Armenia, and Iran. For many of them Bulgaria is not the terminal but a buffer country in their intention to move to Western Europe [3]. It is projected that the immigration flows in the near future would be dominated by less developed and Muslim countries as Syria, Iraq, Lebanon, Jordan, Palestine, Yemen, Iran, Afghanistan, Pakistan, as well as from Morocco, Algeria, Tunis, Egypt and the Balkans [13]. Other tendencies are the



increased interest for permanent residence of British citizens, the retaining of the large number of German and Greek citizens, and an increased desire among citizens from Cyprus and Italy to acquire long-term residence statute [15].

Men dominate the immigration communities - they represent 62% of all immigrants in the country. The gender ratio disparity in favour of males is greatest among the Arabian, African, Turkish, Kurdish, Afghanistan, Iranian and Vietnamese communities, which is probably due to the cultural traditions and social norms in the countries of origin. The gender ratio is better balanced for the Chinese, Armenian and Macedonian immigrants, whereas among the immigrants from Russia (women representing 80% of the immigrants) and the other countries from the NIS and Central and Eastern Europe - it is in favor of the women [3]. The portrait of the female migrant in Bulgaria is quite positive, which is a striking difference in comparison with the results of gender migration studies in Western European countries. The woman immigrant in Bulgaria is an active, integrated, satisfied person, who has retained her language, culture and relations with the community of her compatriots, but who feels Bulgaria as her second motherland [14].

The profile of immigrants in Bulgaria is relatively young: 93.4% of immigrants are representatives of the young and active population, with 30% in the age group of 18-30. With regard to their civil status - the majority of migrants in Bulgaria are married or cohabiting with a partner (63.4%). There is a considerable percentage of intermarriage with Bulgarians (57.4%). The average immigrant family has one (42.7%) or two children (41.8%), 46.8 % of whom are Bulgarian citizens [3].

The average immigrant in Bulgaria is very well-educated: most migrants (54%) have completed secondary education, 37.1% hold a university degree (Bachelor's or Master's), 2.1% hold a higher academic degree, and the same percentage of migrants has only primary education. On average, the educational status of the immigrants in Bulgaria is higher than that of the local residents [2]. The employment rate of immigrants is high - up to 74%. Only 38% of the immigrants are engaged in low-qualified occupations [3]. Surveys do not confirm the widespread opinion that immigrants are strongly involved in illegal activities and "grey economy" [5]. 56% of employed immigrants have their own trade business or are employees in joint venture firms or international companies, acting in Bulgaria. They rarely work for Bulgarian companies; they often offer jobs to Bulgarians. Furthermore, they succeed in niches where Bulgarians often fail [14].

In summary, immigration in Bulgaria differs from immigration into the developed Western European countries, USA and others. Immigration in Bulgaria began later and is incomparably smaller in size [15]. Unemployment among immigrants in the developed countries is rather higher than among the local people and immigrants are treated as the "periphery" and "marginals" of the labour market, as well as people who have to take unwished jobs from the local people. Immigrants in Bulgaria are regarded as partners who can be hired, but can also hire employees. The immigrants rather create jobs than to take away jobs from Bulgarians. Moreover, they have success where Bulgarians sometimes do not, in spite of the difficulties which they meet with the language barrier and cultural adaptation [14].



2.3. Migrant impact on social and economic standards

In more or less all countries tensions appear between new arrivals and some of the native population. Proponents of migration note the positive economic role immigrants can play, for instance in terms of addressing specific labour shortages and the problems linked to ageing populations. Opponents of migration, on the other hand, fear adverse impacts on the labour market, public finances, social conditions and the distribution of income. In the case of Bulgaria, however, the size of immigration flow is still limited as is its social impact. Social tensions for host regions are lacking.

The character of the immigrant in Bulgaria is quite positive - economically active, flexible, entrepreneurial [14]. There are neither extremist tendencies among immigrants, nor a refusal to integrate. Therefore, negative impacts on the living standards of the host populations do not show themselves. On the contrary, there is evidence for a positive economic and social impact of immigration on the host community, and in particular, in terms of looking at migrants as a convenient new source of workforce. Until now, however, there has not been a tension among the local people and the immigrants in the labour market in Bulgaria.

Demographic trends in the country over the last nearly 20 years and in a long-term perspective are unfavourable in terms of depopulation and high rate of population ageing. Ageing population has a number of harmful economic and social consequences, first of all reflecting on the labour force in the country. The changing age population structure was very seriously influenced by the emigration outflows of Bulgarians to other countries [4]. Despite the stable economic development in the past few years, some key economic indicators of Bulgaria still remain the lowest in the European Union. As a result, a brain-drain and emigration of labour force - even though not with previous grave dimensions still occur. These trends cause serious shortages in the domestic labour market that could be partially filled with third-countries' nationals [2].

The ongoing demographic processes and labour market developments indicate that still in the near future there will be a need to import labour force from abroad. There is already a shortage of workers in certain areas - weavers, builders and people who are directly connected with production. Bilateral agreements were made with other countries such as Armenia, Egypt, Turkey, Ukraine, and Vietnam. This was accompanied by changes in the legislation for the regulation and legalization of foreign labour. As a result, a small number of Vietnamese electricians and welders were brought over. In addition, there are a large number of labour migrants with working visas from Turkey and Macedonia [5].

There are two basic groups of immigrants playing a comparatively more important role than the others in the Bulgarian labour market. One of them is coming from the Near and the Middle East and the other is coming from China. Published data on immigrants' participation in the labour market are fragmentary and irregular. According to data of the Employment Agency the number of the foreigners coming from countries outside of the EU and taking jobs in Bulgaria is permanently increasing. If they were 1,242 in 2007 or about 100 in a month, in January 2008 they are 235. During the whole 2007 the biggest element is the number of work permits for



citizens from Turkey, followed by those from Macedonia, India, Ukraine, etc. In 2007 the total number of unemployed persons with permission to stay permanently in Bulgaria was 1,204, coming from over 44 states all over the world, with the largest numbers coming from Russia and Ukraine, followed by Serbia, Poland, Armenia, Moldova [14].

Another recent phenomenon for Bulgaria is the so called "modern migration", in which people with money migrate to places in which the local population is relatively poor and where they can have a life that they could only with difficulty afford in their own country. This trend for Bulgaria is mainly reflected in people coming from Great Britain. There are whole villages in which the majority of the houses belong to English people. The benefit of this immigration is the fact that the places characterised by "foreign demand" are really prospering as a result of this type of migrant - there are more investments and spending has grown. Recently, Bulgaria is also making a profit from a great foreign interest in investing in the country and so there is another reason for immigration. There are quite big numbers of foreign factories (funded from Greece and Turkey) whose leaders are also foreigners, companies working in the tourist field from Germany and Spain, and others. Such companies open many working places for Bulgarians and thus help economic growth.

2.4. Migrant social determinants of health and healthcare needs

Population movements generally render migrants more vulnerable to health risks and expose them to potential hazards and greater stress. In addition, limited access to healthcare during transit increases the resultant burden of untreated non-communicable conditions. On the other hand, migrants travel with their epidemiological profiles, their level of exposure to infectious agents, their genetic and lifestyle-related risk factors, their culture-based health beliefs, and their susceptibility to certain conditions. Some foreigners, for instance, who seek or have been granted protection in Bulgaria have a deteriorated health status as a result of malnutrition, chronic diseases, stress, etc. Some of the asylum-seekers come from countries with region-specific diseases, which require diagnosis and treatment. There are no mechanisms in Bulgaria to detect health conditions prior to migration. All of the aliens, however, receive social and medical assistance automatically upon registration and during potential appeal. Migrants have the same rights and access to medical assistance and free-of-charge medical services under the procedure as Bulgarian nationals.

Victims of human trafficking, especially women and children, are particularly vulnerable to health problems and are more likely to suffer from communicable and non-communicable diseases, as well as from mental health problems. Specific programmes for development and implementation of specialized rehabilitation programs involving multi-disciplinary teams of psychologists, social workers, psychiatrists and interpreters are provided by SAR, the Centre for Assisting Torture Victims, and Nadya Centre.

Migrants often have to deal with poverty, marginality and limited access to social benefits and health services; however, this is not the case in Bulgaria. There are no impoverished immigrants in Bulgaria (without counting the refugees) [2]. With regard to the educational status, the picture is also favorable. The average immigrant in Bulgaria is highly educated and



on the average, the educational status of the immigrants is higher than that of the local residents. Immigrants in Bulgaria are not “marginal” to society. Their living conditions are reasonable and not exposed to more health hazards in comparison to the local population. Many of them have even higher standard of living than the host population. The employment rate among immigrants is rather high and they are mostly engaged in highly-qualified occupations and there are few low-skilled and seasonal migrant workers. Migrants are involved in and benefit from national social security compensation and rehabilitation schemes for occupational disease or injury. The workplace is also used as a place for health services provision.

As far as refugees are concerned, however, there are possibilities for workplace discrimination. As soon as refugee status is granted, foreign citizens have equal rights with Bulgarian citizens, as far as labour issues are concerned. Under the conditions of a market economy, the refugees, like all Bulgarian citizens, have to search for and find jobs on their own. There are many difficulties to face, in that the labour demand????? could be limited in an economy in stagnation. People with refugee status encounter greater difficulties, which is due to the language barrier and the lack of accumulated local employment experience. While other conditions are more or less the same, Bulgarian employers would prefer their future employees to have relevant local experience and good knowledge of existing institutional relations [19]. Surveys reveal that a disturbing proportion of short-term or irregular immigrants (23.5%) is uncertain about the contractual relationship with the employer or work without any formal contract, most likely on account of unavailability of work permits [3].

There are some serious problems that could negatively impact on access to healthcare services, which is a significant determinant of health. Around half of all migrants (51.4%) had no knowledge of Bulgarian when they first arrived in the country, and 31% of them did not speak English [19]; therefore the linguistic barrier and the insufficient sensitivity and training of health professionals are an obstacle. Many of the immigrants are not familiar with their health insurance rights and obligations, which does not allow them to make use of the basic package of health activities guaranteed with the budget of the NHIF. A great part of the medical specialists are also not well grounded in the healthcare rights of refugees and asylum-seekers in Bulgaria [3]. Programmes and services that are “migrant sensitive” are still lacking in Bulgaria. Another big problem is the lack of precise statistical data, rigorous research and information on migrants’ health and healthcare needs. There is no data on specific hereditary factors and diseases that need to be addressed. Systematic research and reliable information is still needed on the social determinants of migrants’ health and healthcare needs.

3. Regulations and legal framework

3.1. Legal framework

The legal framework of the country concerning rights of migrants and health is compliant with international legal acts in the field of human rights [3]. The country has acknowledged the fundamental human right of asylum stated in the Universal Declaration of Human rights and the European Convention of Human Rights and Fundamental Freedoms. Having joined the Geneva



Convention of 1951 related to the status of refugees and the New York Protocol of 1967, the Republic of Bulgaria implements the commitment to providing a just refugee status procedure, a right of asylum, social and health insurance and support, free access to education, professional training and qualification aiming at better social integration process of aliens seeking protection and asylum on its territory [15]. Other international directives concerning rights of migrants and health ratified by the country are: Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers, and Council Directive 2005/85/EC of 1 December 2005 on minimum standards for procedures in Member States for granting and withdrawing refugee status, etc [3].

Health insurance and the provision of medical services for migrants in Bulgaria are regulated in detail by domestic legal instruments which are in line with the international and European practice in this area. The right to health and healthcare has been recognized as a fundamental right of immigrants [3]. Specific legislative norms have been developed to regulate all strategies and actions referring to migrants' health and healthcare services. The main legislative documents comprising the legal framework in Bulgaria related to this field are the: Constitution of the Republic of Bulgaria; Law on Asylum and Refugees; Law on Foreigners; Law on Health; Healthcare Insurance Act; the Law on the Integration of Disabled Persons; The Social Assistance Code; the National Framework Contract; Ordinances of the Ministry of Health (on the Access of health-insured persons to medical institutions for out-patient and in-patient medical assistance, the Basic package of healthcare activities guaranteed with the Budget of the NHIF, and the Types of immunizations in the Republic of Bulgaria and the terms for their delivery); and Instruction Letters of the National Social Security Institute (regarding the activities of its territorial units in relation to clarifying and proving the current health insurance status of insured persons and regarding the Payment of health insurance contributions, etc) [22].

The Constitution of the Republic of Bulgaria guarantees "the equal treatment of foreigners with respect to all rights and obligations" [18]. The Law on Health contains a special provision regulating the equal rights in terms of medical services enjoyed by Bulgarian nationals and aliens who hold a long-term residence permit in Bulgaria [11]. The Law on Asylum and the Refugees is the document that lays down the conditions and procedures for granting special protection to aliens in the territory of Bulgaria, as well as observation of their rights and obligations. According to this act, aliens seeking protection and refugees have equal rights and obligations to those of Bulgarian citizens, including rights to access and use health care services, rights to social assistance, psychological assistance, health insurance, accessible medical care and free use of medical services under the procedure and to the extent applicable to Bulgarian nationals. In this document, activities related to the medical services and health insurance for aliens who seek or have been granted protection are regulated in relation to their health insurance situation during the status determination procedure, as well as the mandatory medical procedures for irregular migrants [10].



3.2. Service delivery

Service availability to migrants

The commitments of Bulgaria regarding foreigners residing in the country are implemented by the State Agency for Refugees (SAR) within the Council of Ministers in close and effective co-operation with the Representative of the United Nations High Commissioner for Refugees (UNHCR), the Bulgarian Office of the International Migration Organization (IMO), and many governmental structures and non-governmental organizations. A centralized system for refugees' surveillance and services provision has been established in the country with the SAR co-ordinating the actions of governmental institutions in connection with granting specific protection of aliens on the territory of Bulgaria. The institutions involved in the process of healthcare delivery to migrants and refugees are the Agency with its territorial units and a network of governmental, non-governmental and international organisations operating in the refugee field. Main entry points to health care for foreigners legally residing in Bulgaria are the General Practitioners, and for asylum seekers and detained in prisons the medical services and staff at the respective reception, integration or detention centres [3, 22]. A great number of medical institutions, both public and private, operating on a national and local level are also directly involved in the provision of medical services to refugees and migrants.

SAR has several territorial units that also have healthcare delivery functions, such as: *Transit centres* - for registration, accommodation, medical checks and conduction of procedures for aliens seeking asylum; *Registration-and-reception centres* - for registration, accommodation, medical examinations, social, psychological and medical assistance and carrying out procedures for granting the appropriate status to aliens seeking-asylum; *Integration centres* - for organizing training in Bulgarian language; professional training and qualification; social protection; provision of cultural, sport and other activities, necessary for the integration of the foreigners, who are seeking or have received protection in Bulgaria [25]. These territorial units are not, however, equally distributed throughout the country and are mainly concentrated around the capital.

The Refugees Agency, following the accommodation of asylum-seekers in the registration-and-reception centres, conducts compulsory medical checks and examinations including AIDS, Wassermann, parasitoses and malaria tests. There are medical facilities at the Registration-and-reception centres, with isolation wards for persons with contagious diseases and asylum-seekers who need everyday medical care and observation. Where necessary, medicines for the treatment of urgent cases are secured. Foreigners accommodated in these centres receive mandatory medical examination by a doctor working for the respective Regional Directorate of Interior. They are entitled to bed, clothing, free-of-charge food and medical care, including screening for HIV and TB and treatment [3].

As from the date of opening the status determination procedure, SAR makes the monthly compulsory health insurance contributions for asylum-seekers by using resources from the state budget. After receipt of the temporary refugee certificate, asylum-seekers can choose a General Practitioner [22]. Pursuant to the Law on Asylum and Refugees [10] and the Healthcare Insurance Act [7], pending the determination of their status, the asylum-seekers have the same



rights and access to medical assistance and free-of-charge medical services under the procedure as do Bulgarian nationals. There is a special focus on women, children and chronically sick asylum-seekers; where needed, these people are referred for medical examination and treatment, including dental services, to the Pope John Paul II medical centre within the NGO Caritas-Bulgaria. There is an agreement between the SAR and the National Hospital for Infectious Diseases regarding the diagnosis and treatment of asylum-seekers whose status requires specific medical assistance. In cases, when additional payment for medical services has to be made outside the basic package guaranteed within the budget of the NHIF, the Agency seeks the support of various sponsors and covers the treatment [22].

Aliens who have already been granted refugee or humanitarian status have the same rights and obligations as Bulgarian nationals in the area of health insurance and access to medical assistance [3]. The State Agency for Refugees terminates the payment of monthly health insurance contributions from the date of submission of the decision granting the status. From this date, the aliens who have been granted protection are obliged to pay health insurance contributions under the procedure regulated in the Healthcare Insurance Act. Health-insured aliens are entitled to medical assistance within the basic package of health activities guaranteed within the budget of the NHIF. The basic package of primary out-patient medical assistance includes health information activities, health promotion, prevention of diseases, follow-up observation, diagnosis and treatment, control of infectious disease, and other activities. Hospital-based treatment is also covered by the NHIF for all insured refugees and immigrants. The NHIF reimburses partially or totally the medicines for home treatment; these medicines are determined by virtue of a special order issued by the Minister of Health. In terms of additional medical services, the Refugee-and-Migration Service of BRC ensures out-patient and in-patient treatment at the national multi-profile Tzar Boris III hospital in Sofia, training on family planning and prevention of STDs, psychiatric aid and psychotherapeutic group work on the basis of a contract with "Nadya" Centre (an NGO dealing with victims of torture/trauma); psychological consultations to asylum seekers residing in SAR's Reception-and-Registration Centres, and other activities related to migrants' health [22].

In summary, the legal framework regulates the access to medical care, depending on the migrant's status, and ensures free-of-charge HIV and TB treatment for all migrants on Bulgarian territory. All foreigners seeking asylum have health insurance paid by the SAR, while those with granted refugee status are self-insured. All health-ensured foreigners are entitled to the right to have a personal General Practitioner. All people registered by SAR receive initial medical examination, part of which is screening testing for HIV and syphilis. People living with HIV have the right to receive free-of-charge ARV treatment in the National Hospital of Infectious Diseases on being granted a refugee status. The legislation does not allow for the HIV-positive status as grounds for refusal of refugee status. Hepatitis B and C testing is not performed by the medical services operating under SAR. However, refugees are also covered by national programmes for health prophylaxis and the prevention of contagious, infectious diseases and STDs.

Access to emergency medical care for foreigners residing in the country is covered just as for all Bulgarian nationals. It is provided by the local units of the centralized State system for emergent medical care and is financed by the State budget.



Psychological assistance and medical treatment is offered to migrants with mental health, drug addiction and substance abuse problems. Drug-related treatment is mainly delivered by a combination of public (state or municipal) and private institutions. Outpatient psychosocial treatment is predominantly financed by the National Programme for Prevention, Treatment, and Rehabilitation of Drug Addictions. Medically-assisted treatment for these patients is funded by the NHIF. The financing of residential psychiatric treatment is the responsibility of the government through the Ministry of Health and through municipal budgets.

For the implementation of activities related to the provision of social, medical and psychological assistance for asylum-seekers, refugees and immigrants, there is close co-operation across SAR, the UNHCR Branch Office in Bulgaria, and a great number of NGOs operating in the field, such as: the BRC's Refugee-Migrant-Service, the Bulgarian Helsinki Committee for Human Rights, Caritas-Bulgaria, the Council of Refugee Women in Bulgaria, the Centre for Assistance of Torture Survivors, Nadya Centre Foundation, Sofia University Legal Clinic, the Association for the Integration of Refugees and Migrants, and others [3].

3.3. Shadow practices and problems

Despite the formal legislative provision for medical services for migrants and the established network of institutions functioning in this field, serious problems are emerging in practice. There are some gaps in the legal framework that cause administrative limitations to healthcare accessibility and negatively impact on migrants' health. In some cases, for instance, there are problems emerging in relation to immunization for aliens who seek or have been granted protection, as according to the Ordinance regarding the Types of immunizations in the Republic of Bulgaria and the terms for their delivery, the compulsory immunizations are only provided free-of-charge to Bulgarian nationals, foreign nationals who hold a permanent residence permit in the country, and citizens of countries with which Bulgaria has agreements for free provision of healthcare [16].

A great part of the asylum-seekers are unable to pay the consumer fee-for-visits to doctors, dentists or a health establishment as during the status determination procedure they have no income, but receive small monthly allowances. A substantial number of uninsured refugees after granting the status cannot afford to cover all expenses in a case of potential medical treatment [22]. Most affected by the insurance provisions are irregular migrants whose legal status prevents their access to healthcare services. Therefore, further consideration should be given to providing sustained health insurance between countries of origin, transit and destination.

The uneven territorial distribution of establishments, institutions and NGOs operating specifically with migrants and their concentration in the capital city, as well as the lack of migrant-sensitive healthcare delivery structures, also impose restrictions to healthcare access.



4. Policy agenda

4.1. Policy agenda

Migrants' health and its key determinants have linkages with various policy areas - social, economic, political, trade, labour, public health, education, security, etc. A successful migration policy should adopt a holistic approach to migration and migrants' health, which takes into account all cross-cutting issues and areas. It involves focussed cooperation and effective partnerships among central and local governments, civil society groups, international organisations, NGOs, academic institutions, social protection service providers, media, and other key partners. A very important factor is the capacity of the health system to engage other relevant sectors for successful action on the determinants of migrants' health.

Bulgaria has achieved a certain progress in this process; there are positive experiences and proven good practices relating to migrants' health and integration. A great number of initiatives involving different sectors and institutions have been undertaken in Bulgaria to assure the protection of migrant health. These actions are based on the recommended good practice of EU Member States and address a broad range of political areas such as employment, health, work safety and protection, education, social protection and delivery of health care. With the adoption of the Law on Asylum and Refugees and many other legal acts and regulations, Bulgaria made its first steps towards the elaboration of a comprehensive set of policies for migrant integration including its health dimension. Strategies and programmes were undertaken with a view to ensuring that immigrants and refugees have equal access to rights and opportunities for developing their potential. A *National migration and integration strategy 2008-2015* was developed tied into the National Employment Strategy, National Strategy for Demographic Development, National Housing Strategy, National Poverty Reduction and Social Exclusion Strategy, National Health Strategy and further strategic documents concerning the respective policy field [4].

National Programme for Integration of Refugees

The National Programme for Integration of Refugees was developed by an Inter-ministerial Task Force with representatives of State institutions and agencies, local authorities, UNHCR representation and NGOs assisting refugees, and adopted in 2005 [4]. It is aimed at providing conditions for equal access to housing, social assistance, healthcare, Bulgarian language training, social and cultural orientation for the newly recognized refugees, and also social services to vulnerable refugees/humanitarian status holders. Substantial part of the activities implemented within the Programme (financed mainly by the State budget and UNHCR projects funds) are related to key determinants of migrant health and intended to improve the access of refugees to health services. These include analysis of the legislation in the area of public health and health insurance for refugees and drafting proposals for amendments; involvement of refugees into national programmes for health prophylaxis and prevention of infectious diseases and STDs; training seminars with GPs and dentists on refugees' specific health issues and needs; joint training programs for the staff of governmental agencies; training and inclusion of experienced refugees as mediators in the process of providing healthcare to migrants;



development and dissemination of information materials regarding refugees' rights in the area of health-insurance and healthcare; holding awareness-raising meetings with aliens who seek or have been granted protection with a view to clarifying their rights and obligations; and enhancing the capacity of non-governmental organizations to support the social integration of migrants and facilitate their equitable access to health promotion and care, etc. With the implementation of the Programme, special attention has been paid to the vulnerable refugee groups - unaccompanied minor and juvenile refugees; victims of violence and torture; individuals with medical problems (those who are mentally ill and disabled); young refugee women who are trafficking victims; families with many children; pregnant women and single mothers with children; elderly people, etc. The activities carried out to facilitate their access to rights and services are: involvement in various forms of psychological and social work, healthcare, home services, cultural activities; social protection and inclusion of vulnerable groups of migrants into national health insurance and social security schemes; consultations to refugees with special needs regarding their rights provision; assistance before institutions and agencies; legal aid and support for solving problems [26].

A great number of institutions are involved in the Programme's implementation, such as: SAR; UNHCR; the Ministries of Health, Labour and Social Protection, Education and Science; local and regional authorities; local social welfare services; the NHIF; the National Social Security Institute; the Bulgarian Union of Physicians, the Union of Dentists in Bulgaria, the National Employment Service and its territorial units; the Bulgarian Business Leaders Forum, Bulgarian universities and other educational institutions; international and national non-governmental organizations, such as IOM Bulgaria, the Association for Integration of Refugees and Migrants; the BRC; the Bulgarian Helsinki Committee, the Council of Refugee Women, the Centre for Assistance of Torture Survivors, Caritas NGO, Nadya Centre and others.

State Agency for the Refugees

The State Agency for the Refugees is the governmental body, which in co-operation with the central bodies of the executive authority, the BRC and other NGOs organises the activities related to the provision of social, medical and psychological care for the foreigners seeking or having received protection; assists the integration of foreigners who have received protection; works out independently or participates in the preparation of draft normative acts and international agreements related to the protection of foreigners and works out programmes for integration of the foreigners seeking or having received protection in the Bulgarian society; facilitates the control of the implementation of the provisions of the 1951 Refugee Convention and the 1967 Refugee Protocol and submits information and statistical data; commissions studies and research and organizes conferences and seminars; and issues information materials on the refugee issues. The *UNHCR* Representation in Bulgaria leads and coordinates international protection and social assistance activities for asylum seekers and refugees, with special attention to the needs of women and children. It provides financial support and guidance for free legal advice for asylum-seekers and refugees through the Bulgarian Helsinki Committee, including legal representation in courts and other institutions. It monitors and supports government and NGOs in implementing national legislation on asylum



in conformity with international instruments and standards. UNHCR facilitates workshops on refugee and human rights law and holds round tables on a regular annual basis with representatives of different ministries, NGOs, media, etc. Furthermore, UNHCR has been supporting building the capacity of refugee-assisting NGOs and is their main sponsor [3].

Bulgarian Red Cross

The Bulgarian Red Cross, through Refugee-Migrant-Service, also assists refugees with physical and mental health services, in-kind goods, social counselling, and jointly with the Council of Refugee Women in Bulgaria, facilitates the refugees, who need help, with their registration at the "Social Assistance" and "Labour Office" directorates. It has been organizing and conducting Bulgarian language courses and vocational training as a part of the Programme for Social Counselling and Integration of Refugees in Bulgaria. The Bulgarian Helsinki Committee for Human Rights through its Refugee-Migrant-Service provides legal assistance by means of consultations and legal representation before the Supreme Administrative Court and the competent district courts, and protection of migrants and refugees rights. The focus of Caritas-Bulgaria in the area of asylum is on the special needs of vulnerable groups. It provides medicines, medical care, social advice, and psychological assistance, as well as primary examinations, dental services, and emergency interventions within a sub-project with the John Paul II Medical Centre. It also assists vulnerable refugee women by providing special medical care when they are referred by the Council of Refugee Women in Bulgaria (CRWB). The CRWB provides counselling, escorts, interpretation and facilitation of refugees' contacts with hospitals, court, social welfare bureaus, municipalities, labour offices, social institutions, NHIF, police, documents and visa section of the Ministry of Interior.

Association for Integration of Refugees and Migrants

The Association for Integration of Refugees and Migrants is another NGO supporting the promotion of social and cultural integration of recognized refugees and migrants by means of targeted programmes and projects. Its most important social services refer to: providing assistance to SAR, the Ministry of Labour and Social Policy and UNHCR in the process of elaborating a national programme for integration of recognised refugees into the Bulgarian society; organizing training courses for refugees and migrants on Bulgarian language, history, traditions and culture and on the role of the Bulgarian state institutions, local authorities and NGOs; training of representatives of governmental, non-governmental sector and local authorities on all aspects of the social work with refugees and migrants; providing expertise on the rights and obligations of refugees and migrants; organizing courses on the development of national and transnational projects with EU funding; and providing social advice to refugees and migrants with regard to access to social assistance, registration with the employment services or acquisition of Bulgarian citizenship.



International Migration Organization

An international organization actively involved in supporting migrants' health is the International Migration Organization - with its Migration Health Department. It responds to the needs of any type of migrant population and throughout all phases of the migration process, including post-emergency situations, through preventive health interventions, diagnostic services, medical treatment, mental health and psycho-social assistance, health promotion, environmental control, etc.

4.2. Others and intersectoral activities

An academic structure also involved with migration policy and research is the Centre for European Refugee, Migration and Ethnic Studies at the New Bulgarian University. It develops educational programmes and projects in the area of migration, refugees and ethnic problems, formulates expert opinions and recommendations for improving the migration policy, promotes the rights of refugees and immigrants, and promotes public debate.

A positive feature of the functioning of the asylum system in Bulgaria is the co-operation between SAR, the UNHCR and BRC on one hand, and the State Employment Agency, the State Agency for Social Assistance and the Regional Inspectorates for Education, on the other, regarding a well informed, better co-ordinated and unified approach to refugees' social and employment needs and execution of their social rights. For instance, if refugee status is granted, the refugees receive services from SAR, where they are offered employment training, education, and integration efforts. If they complete the programme, they are fully eligible for housing assistance, welfare, and health benefits. They receive six month language education and two months of cultural and vocational training. The latter is available also through the Labour Bureaus of the State Employment Agency. SAR offers a strong assistance programme to integrate newcomers into the workforce, beginning with Bulgarian language education, vocational training skills, grants for training aimed at acquiring professional qualifications, government allowances and subsidies to newcomers [23].

A National Council on Labour Migration has been established within the Ministry of Labor and Social Protection. An Intersectoral Expertise Working Group has been also formed (comprising experts representing different governmental sectors, social partners, NGOs, local authorities) for analyzing and reforming the migration policy. The 2005 National Employment Action Plan, in its section on integration promotion and combating the discrimination against disadvantaged persons on the labour market, includes a specialized program for refugees: the Programme for Literacy, Qualification and Employment of Aliens Who Have Been Granted Refugee or Humanitarian Status. The Programme envisages activities related to the provision of labour motivation, literacy courses and vocational training for refugees registered in the Labour Offices and is implemented by the Ministry of Labour and Social Policy, the Employment Agency in partnership with the SAR. Aliens who have been granted refugee or humanitarian status receive additional assistance and support in the process of seeking a job from the Refugee-and-Migration Service of the BRC and CRWB. This support includes information about vacancies, accompanying and assisting the aliens with filling in the documents for the purpose of



registration at the directorates "Labour Offices", retraining courses, mediation for finding a job with companies managed by aliens working in Bulgaria, etc [4].

The social assistance for asylum-seekers is ensured by the SAR under the conditions and procedure applicable to Bulgarian nationals. The support provided is aimed at securing the social protection of the most vulnerable groups - the sick, disabled, elderly, young children, single parent, etc. They are granted lump-sum benefits funded from the state budget and in-kind humanitarian aid provided by charity organizations. Disabled refugees have the right to social benefits, disability aids and services available to Bulgarian nationals. After a decision is made on granting status, the SAR terminates the payment of monthly food benefits and health insurance contributions, the provision of social aid, and the accommodation at the Registration-and-Reception Centres. The refugees who do not have any income and subsistence are referred for registration to the directorates "Social Assistance" and "Labour Office" by SAR and the Refugee-and-Migration Service of BRC. In cases with individuals aged over 65 who are unable to take care of themselves, measures are taken for additional social assistance under a programme financed by UNHCR and implemented by Caritas-Bulgaria, SAR, CRWB, plus referral to choosing a GP and provision of medical care and medicines, and placement in a home for elderly people, if necessary [23]. After the age of 70, the aliens with granted status are entitled to apply for old-age social pension pursuant to the Social Assistance Code [17].

Despite the interagency and intersectoral co-operation and the established institutional network and partnerships for refugees and migrants' health, there remain problems in practice with regard to accessibility to healthcare services. The concentration of relevant institutions in the capital and their limited function on a local level, the inappropriate utilization of services with higher use of hospital services rather than GPs, the insufficient co-ordination between hospital, primary care and community social services for migrants, the lack of co-operation with the health care systems in migrants' countries of origin are problems that have a negative impact on migrants' health. More migrant-sensitive health services are needed in Bulgaria, as well as systematic research and reliable information on the social determinants of migrants' health and healthcare needs both - on national and regional level.

The limitations of some administrative procedures are also a problem regarding accessibility to social and medical assistance and employment opportunities. For instance, with the support of SAR and the Refugee-and-Migration Service of BRC, some refugees and families are accommodated, for a certain period of time, in temporary accommodation. As a result of the adoption of the new Law on Asylum and Refugees in 2002, the time allowed for the procedure to determine status was reduced to 6 months, after which period aliens who have been granted refugee or humanitarian status have to meet their housing needs by themselves, which has proved difficult. Although refugees in Bulgaria have the legal right to apply for council housing, in reality it is highly unlikely that with the extremely reduced capacity of council house estates they would ever be treated on equal basis with the Bulgarian citizens on the long waiting lists. Unless they have a permanent and valid address, aliens who have been granted refugee or humanitarian status cannot receive an ID [23], and so cannot register as unemployed at the employment offices, cannot register at the social assistance directorates in order to apply for social assistance and other benefits and cannot register with a GP.



5. Good practices and projects

Besides the National Programme for Integration of Refugees and its healthcare implications on migrants and refugees health, other programmes and projects relevant to the health of immigrants in Bulgaria are: the "Prevention and Control of HIV/AIDS" Programme, financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria, 2007; the Research project of the Bulgarian Helsinki Committee on the rights of immigrants in Bulgaria (including rights to health and healthcare services) 2005 - supported by Open Society, Budapest, and the UNHCR and the Red Cross project in Bulgaria "Local Integration of Refugees in Bulgaria" - facilitating medical assistance and provision for reimbursement of medicines [3]. For the successful achievement of their objectives, they engage the healthcare system with its structures in close co-operation with different sectors, agencies and institutions.

A good example of positive successful practice involving the health sector in conjunction with other sectors is the support provisions for vulnerable groups of migrants, such as disabled people, pregnant alien women and single refugee mothers.

At the start of the procedure for determining their status, asylum-seekers undergo mandatory initial medical checks and thorough examinations. The individuals with serious chronic diseases are referred by the SAR to choose a GP, to receive treatment, and for expert evaluation and certification of the degree of disability and permanent work incapacity by the Labour Expert Medical Board. Aliens who seek or have been granted protection, who are aged 16 and above and who have been certified by the expert board as having permanent work incapacity of over 71%, are referred to the regional divisions of the Ministry of Labour and Social Protection - the Social Assistance directorates to receive a social disability pension (pursuant to the Social Assistance Code) [17]. Aliens who have been granted protection and have permanent disabilities are also entitled to monthly allowances for social integration depending on the type and degree of the disability and their individual needs pursuant to the Law on the Integration of Disabled Persons [12]. SAR and the Refugee-and-Migration Service of BRC provide support and advice in respect of the referral of aliens who seek or have been granted protection to expert evaluation and certification of their work capacity. An assistant, an interpreter and, where needed, transport services are ensured for the period of the expert evaluation. Aliens who have been granted refugee or humanitarian status, who are alone and are unable to take care of themselves, are referred to the "Social Assistance" directorates for accommodation in social services facilities (centres for social rehabilitation and integration of socially disadvantaged persons, homes for physically and mentally disabled children and adults). The aliens who have been granted protection and have permanent disabilities have the same rights as Bulgarian nationals in respect of the right to targeted assistance and preferential conditions for the purchase and repair of aids, facilities and devices for disability alleviation and compensation in accordance with a list that is approved on an annual basis by the Minister of Labour and Social Policy [23].

Specific measures involving the cooperation of different agencies, services and institutions are provided for the support of pregnant alien women who seek or have been granted protection in Bulgaria. They are referred to specialized medical assistance within the range of the basic package of health services guaranteed by the budget of the NHIF. Where additional



consultations and examinations are necessary, outside this range, medical services are provided at the Pope John Paul II Medical Centre with Caritas-Bulgaria and the Kniaz Boris III Transport Medical Institute on the basis of a contract with the Refugee-and-Migration Service of BRC. SAR provides additional social assistance, counselling, psychological assistance and support for the placement at medical institutions for delivery, the purchase of medicines and sanitary materials. A programme has also been developed for training of pregnant refugee women on issues regarding nutrition and care for the health of the mother and the child, and is run by the health system facilities in co-operation with NGOs. Information materials regarding the rights of pregnant refugee women, women in childbirth, and mothers raising children aged up to 3 are made available. Additional social assistance is provided by the Social Assistance services. Pursuant to the Law on Family Allowances, pregnant refugee women who have been granted status and have an average monthly income per family member for the previous 6 months lower than BGN 200, are entitled to a lump-sum pregnancy benefit. Alien women with granted refugee or humanitarian status are entitled to a lump-sum benefit for giving birth to a child, regardless of the family's income, where the child is born on the territory of the Republic of Bulgaria, live at birth, and not abandoned for placement and raising at a specialized institution for children [23].

Single refugee mothers are another vulnerable group of migrants who are supported through the co-operative efforts of different institutions and multi-agency assistance. The practical measures for facilitating the social adaptation and integration of this group of refugees include: ensuring additional social assistance by SAR; provision of social counselling; psychological assistance and support by the SAR, the Nadya Centre and ACET; referral to specialized medical assistance; ensuring participation in Bulgarian language and vocational training courses for the purpose of acquiring professional qualifications and the capacity for self-subsistence; payment of fees for kindergartens; buying learning aids and sports items under the programme of the Refugee-and-Migration Service of BRC and provision of monthly benefits for children attending school; ensuring accommodation at the Centre for Single Mothers "Rojdestvo Hristovo" in the city of Sofia and provision of canteen meals for the children by Caritas-Bulgaria [23].

A good example of team-work and co-operation between Bulgarian state institutions, academic structures, international and non-governmental organizations in their efforts for implementation of the international and European standards in the work with refugees and strengthening of the dialogue with civil society on the problems of the refugees is the *Academic Refugee Studies Initiative in Bulgaria* (ARSIB) [1]. It started in 2002 as an initiative of the UNHCR Representation in Bulgaria and the SAR and later on integrated more than 12 universities and NGOs, such as the Refugee-and-Migration Service of BRC, Caritas-Bulgaria, ACET, CWR in Bulgaria, the AIRM. With this initiative, Bulgaria has become one of the first countries in Central and Eastern Europe to develop academically based specialized programmes for education in social work with refugees. A new specialty has been established that develops knowledge and skills for work with refugees in various spheres of social life: social activities and services, employment, education, local government, etc. Special educational programs have been developed involving application of various forms of training, including practical training in "Social clinics". A success for ARSIB is the involvement of the Minister with responsibility for refugees, as a lecturer on the topic "Interaction between institutions in the field of asylum and



refugees". Within the Initiative, round tables, conferences and seminars are held involving broad representation of academics, the healthcare workforce, central and local government, community outreach workers, and NGOs [1].

6. Conclusions

The immigration phenomenon in Bulgaria is new and dynamic. Recently, with the accession to the EU, the country is increasingly affected by immigration flows. The favourable economic, administrative and educational prospects of Varna have turned the Region into an attractive destination for major immigration flows. The health of migrants is acknowledged as an issue of significant public health importance and a policy challenge. In this respect, a great number of legislative and inter-sectoral multiagency initiatives have been undertaken in Bulgaria to assure the protection of refugee and migrants' health. These actions, based on recommended good practices within EU Member States, address a broad range of areas such as employment, health, work safety and protection, education, social protection and delivery of health care and involve the co-operation of state institutions, NGOs, academic structures and international organizations. There are positive experiences and proven good practices with regard to migrants' health and integration; nevertheless, there are serious problems emerging in practice that could negatively impact on migrant health and represent a challenge for future policy responses. These are related to:

- Lack of precise, reliable data, systematic research and disaggregated migrant health information, especially on a sub-national/regional level;
- Uneven territorial distribution of the structures and institutions, with a concentration in the capital; and insufficient interagency and intersectoral co-operation on a local/regional level;
- Actions and provisions being disproportionately focused on refugees and asylum-seekers (fewer in number but more visible part of the foreigners) rather than on the larger and increasing economic-immigrant population;
- Lack of migrant-sensitive health services and insufficient sensitization of healthcare workforce;
- Insufficient publicity and information about health insurance rights and obligations of immigrants and existing services.

Therefore, encouraging research and information dissemination, health and migration knowledge production; increasing multi-sectoral involvement, expanding interagency cooperation and dissemination of good practices on regional level; promoting migrant-sensitive health services; sensitizing and training health service providers and relevant stakeholders are all actions of recognized importance to deal better with migrant health problems in Bulgaria and the Varna region. These are essential for a comprehensive, coordinated and multisectoral policy approach towards migrant health and form the medium-term challenges ahead.



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Complete reference material

XI. Regional report Västra Götaland

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¹ Secretariat to Public Health Committee



Summary

Since the post war period, the proportion of immigrants in the Swedish population has been steadily increasing. Today about 17% of the Swedish population has an immigrant background, with the proportion slightly higher in the Region of Västra Götaland where in 2008, 23% of the population had immigrant background. During the recent decades immigration from Asian countries has dominated the trend, and since the 1990s, there has been a strong blank immigration phenomenon (above all refugees).

According to the national survey on living standards and health performed during 2000-2005, people with immigrant background had, in general, worse health than those with Swedish background. However, when socioeconomic factors were adjusted, the differences were considerably reduced. This shows that socioeconomic factors to a great extent can explain why people from outside Europe report worse health.

Immigration has been an issue since the last forty years in Sweden. From 1985 the government launched a number of reforms which affected immigration. One of the important components of such a public health policy is to build coalitions between actors at the regional, local and national levels with the common objective to reduce inequalities in health.

In order to meet multicultural health problems, a project to create a new local hospital in Angered, a multicultural area in Gothenburg (Göteborg), was started in February 2007. Various characteristics of the catchment area population were collected and analyzing using a number of information sources.

The result showed that almost 50% of the population were born abroad, the majority of them outside Europe. There were a substantial numbers of refugees suffering from stress associated with previous traumatic experiences that interfered with integration into Swedish society. The characteristic lifestyle features included low physical activity and high prevalence of smoking, alcoholism, with higher morbidity and mortality rates. Thus the aim is to better integrate the population with foreign background, to plan for a high standard of treatment and to promote health and wellbeing in the population.

1. Health system overview, national and regional situation

1.1. Health system functions

The Health System in Sweden is the responsibility of regions or county councils. However, health care should be organised in accordance with Swedish law, which guarantees a certain degree of conformity and a minimum level of quality throughout the nation. Nevertheless, regions have quite a high degree of autonomy in the way they can organise health care for the inhabitants. The health care system in the Region of Västra Götaland is organised with Primary health care as the entry point. The intention is that Primary health care should be able to provide for 90% of needed health care to citizens, where specialised health care should deliver the remaining 10%.



There are around 20 hospitals in the region², including a University Hospital that provides post graduate training and carries out research. Research and development is also carried out at several other large hospitals in the region. Responsibility for health care rests with the Västra Götaland Region, which is one of Sweden's largest employers, employing around 44,500 people in the health care sector. One third of the region's health care activity is primary care, which is performed at around 160 health care centres. The remaining two thirds consists of planned and emergency care. The largest health care units are Sahlgrenska University Hospital (SU), Södra Älvsborg hospital, Skaraborg Hospital and NU Hospital.

Sahlgrenska University Hospital in Gothenburg (Göteborg) plays a central role as a regional hospital. Health care at the county level is conducted here, along with highly specialist care and research, development and education. Sahlgrenska is the largest hospital in northern Europe and is highly reputable internationally in the fields of cardio, coronary and respiratory care and paediatric health care. It also runs successful activities in endocrinology, transplants and orthopaedics. Sahlgrenska University Hospital is also the leader in Sweden in research into immune biology and vaccines.

The centre for health care education, research and development is the Sahlgrenska Academy at Gothenburg (Göteborg) University, which has three main units. The medical faculty is the largest of these units, and has twelve institutions and the Wallenberg laboratory. The Faculty of Odontology comprises a single institution and provides basic education for dentists, dental hygienists and dental technicians along with research, patient care and specialist training. The Faculty of Health Caring Sciences comprises three institutions and provides comprehensive basic training and a fast-growing research activity and training of researchers.

Training, research and development are also carried out at Skaraborg Hospital, Södra Älvsborg Hospital and NU Hospital. These activities are co-ordinated with Sahlgrenska Academy and with the university colleges in Borås, Trollhättan/Uddevalla and Skövde.

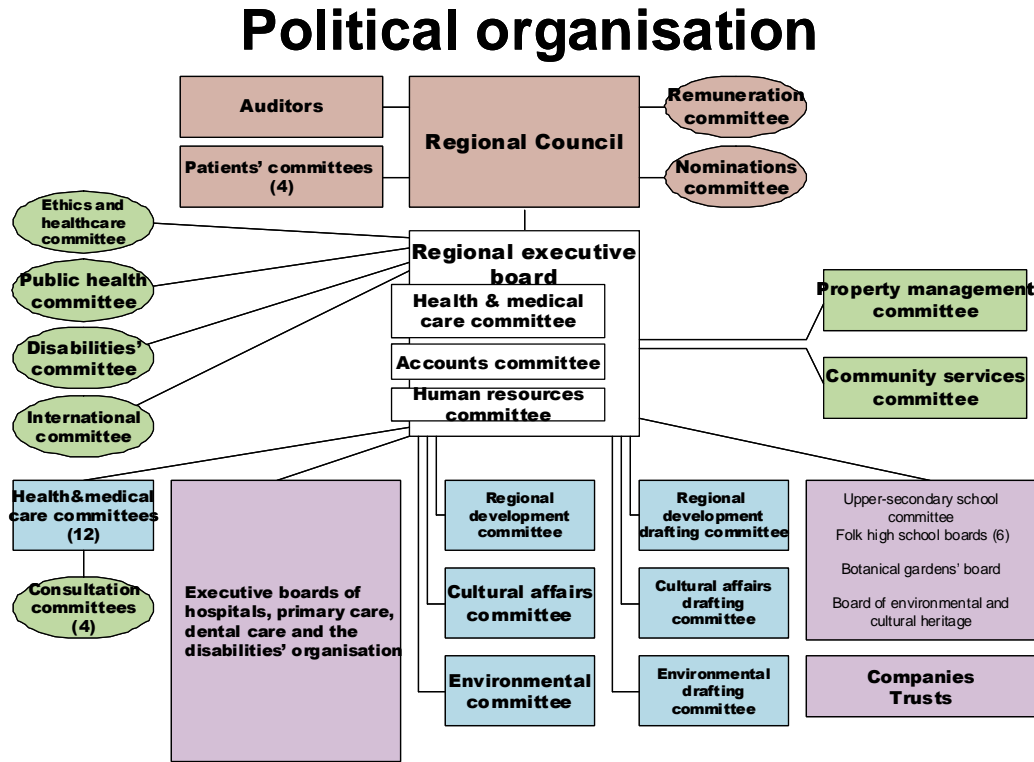
1.2. Political organisation

Citizens elect the Regional Council in general elections every four years (latest in 2010). The Regional Council (149 members) and the Regional Executive Board (17) makes up the highest decision-making body.

² A concise presentation of Region Västra Götaland, including regional health care, is found at <http://www.vgregion.se/en/Vastra-Gotalandsregionen/>



Figure 1. The political organisation of Region Västra Götaland



Political committees form the basis- The Health & Medical Care Committee and Local Health Care Committees purchase hospital care, primary and dental care. The Regional Development Committee operates side by side with the Cultural Affairs Committee and the Environmental Committee.

The Regional Council has the right to decide on taxes for financing health care and other regional responsibilities such as education and infrastructure.

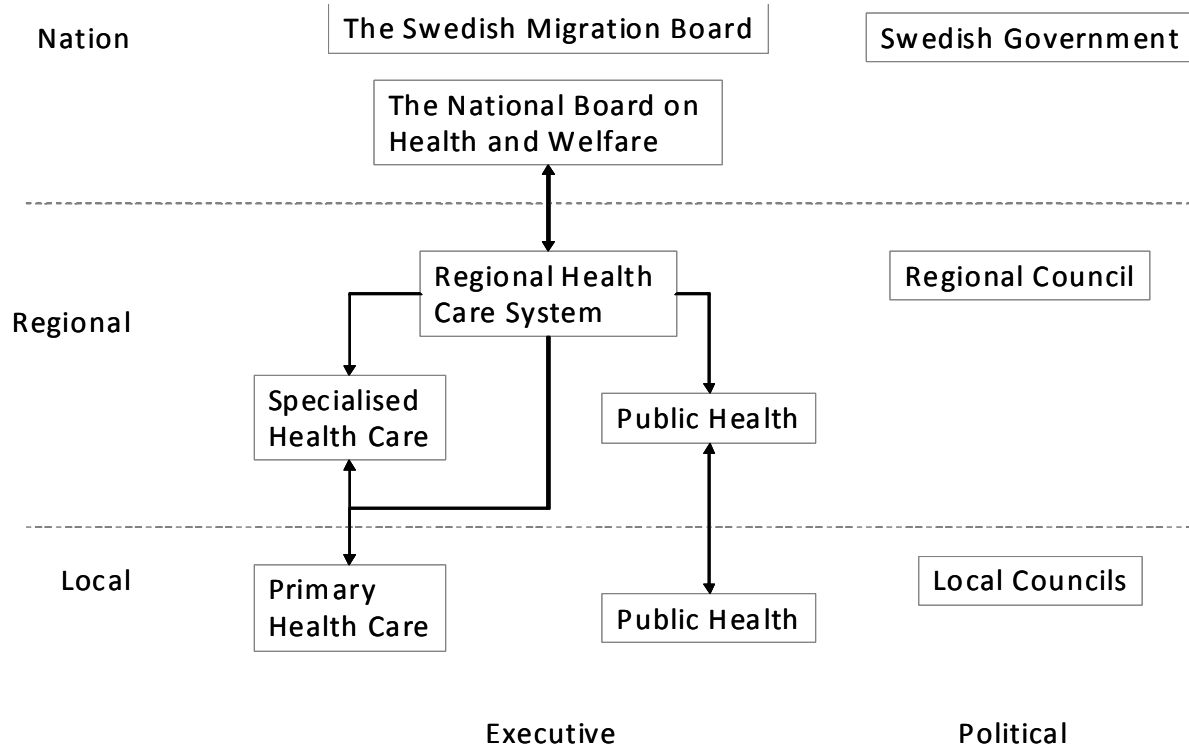
Structural organization at regional level

There are at least two issues related to health of immigrants: health expressed as (immediate) the need for health care and health as a concept of well-being. There are also at least two aspects related to whether public health and health care programmes are intended for immigrants only or universal for all. The main responsibility of the region of Västra Götaland is the latter. Programmes and initiatives for immigrants are often regulated by law and are the responsibility of the state or municipality levels. The general idea is that the state, represented by the Swedish Migration Board³, buys the health care needed from the regions' health care. This applies mainly for asylum seekers.

³ http://www.migrationsverket.se/info/start_en.html



Figure 2. Organigram describing the Swedish Health Care System per executive authorities and political levels



The main principle of the universal aspect is that immigrants should use the same health care organisation as native born Swedes. However, an important restriction is that Swedish citizenship is required in order to access the health care system. Refugees are granted health care via the state level (Swedish Migration Board). Thus, health care is straight forward - what applies to native born Swedes, also applies to immigrants - in principle.

Public Health outside the Health Care sector is quite a different matter. Health of immigrants is a key public health area in Sweden, integrated in the public health policy in the Region of Västra Götaland. Public Health work among immigrants therefore relates to all other areas of Public Health.

1.3. Health information system

As in the other regions and county councils in Sweden, there are no dedicated databases on immigrants' health situation. In the Region of Västra Götaland, the data generated by health care visits contain strictly medical data and very few socioeconomic data. Therefore, there is no adequate data on immigrants. Relevant health indicators are found in dedicated studies when necessary. Thus it is not possible to compile routine information on health of immigrants other than at ecological level, with well known risks for making erroneous conclusions.



One possible source of information is health surveys which are carried out regularly where people are asked about their living situation as well as their perceived health. The main problem is of course non-response among immigrants, simply because they do not understand the questions. Efforts to raise response rates by translating into the most common languages have been more or less futile since there are so many different languages or incompatible accents. The most adequate data on immigrants' health situation are compiled at the National Board of Health and Welfare⁴, sometimes in collaboration with the regions and municipalities. The National Board of Health and Welfare works with matters related to immigrants and refugees in its role as an expert and supervisory authority. These matters are part of the task of building up know-how within social services. The Board follows up how the county councils provision of care for asylum seekers, including relevant health discussions and control of infectious diseases. Information about female circumcision is directed to immigrants from relevant countries as well as in schools, medical services and other bodies that could come into contact with this problem.

The reception of refugee children arriving unaccompanied is also investigated by the Board with a number of reports published each year. However, these provide a national rather than a local level perspective.

According to the Swedish Health Care Act (SFS1982: 763), everyone has the right to receive health care when there is an immediate need, even if they are not residents. This means that asylum seekers can access health care only when there is an immediate need.

The Act on Contagious Diseases Control (SFS1988: 1472) regulates societal protection against communicable diseases. Certain, more severe, infectious diseases (e.g. HIV, TB and Hepatitis) are considered dangerous to society and thus, strictly monitored. The region is responsible to report to the national authorities (the Swedish Institute for Infectious Disease Control) in order for appropriate measures to be taken in order to control such diseases. It is mandatory for each person suspecting a severely contagious disease, without delay, to contact Health Care for proper diagnosis and treatment for appropriate surveillance measures. All diagnostic procedures and treatments due to such measures are free of charge.

Health Care for asylum seekers and refugees is the responsibility of the Migration Board. In practice, this means that provision of health care is carried out by the ordinary health care system but is compensated by the Migration Board. There are restrictions on what kind of health care is compensated- as stipulated in the Regulation on Reimbursement for health care to refugees (1990: 927; 1994: 734; 1994: 1,525). These measures include:

- Medical examination at arrival

For those older than 18:

- Emergency care and health care that cannot wait
- Antenatal and postnatal care
- Counselling on contraceptives

⁴ <http://www.socialstyrelsen.se/english>



- Health care due to Act on contagious diseases control
- Dental care that cannot wait

For those under 18 years:

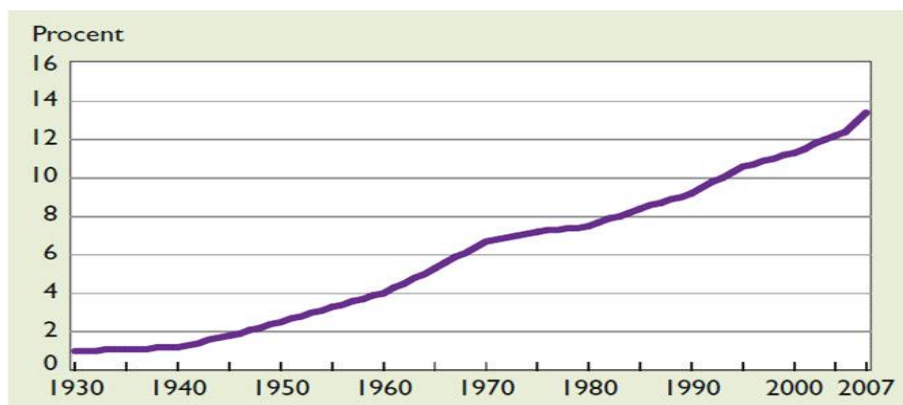
- All health care
- Medical prescriptions

2. The migration phenomenon

2.1. General characteristics and extent of the migration phenomenon in the region

The proportion of immigrants in the Swedish population has been steadily increasing in the post war period, as seen in Figure 3.

Figure 3. Proportion foreign born in the Swedish population 1930-2006 (percentage)



Source: National Board of Health and Welfare 2009

Several factors affect the number of immigrants going to Sweden, including political instability in other parts of the world, the labour market in Sweden and government regulation of immigration (Socialstyrelsen 1995). In the 1950s and 1960s, immigrants came from the neighbouring Nordic countries and from southern Europe. But this trend ended in the 1970s since the Swedish labour market was no longer as attractive as before. At the same time, people in politically unstable countries in Asia and South America found a place of refuge in Sweden. Thus migration from Asian countries together with the 1990s refugee immigration from the Balkans has dominated migration in Sweden. The Nordic immigrants from the 1950s and 1960s are now of the age where they have been reduced in number due to death than by re-emigration. Since the beginning of the 1970s and mostly in the 1980s, new immigration trends were those of refugee immigration and the immigration of close relatives. At the same time, labour immigration was minimal. The newly-arrived immigrants have found it harder and harder to compete for jobs since working needs in the country have changed due to the



disappearance of unskilled work. Education and the ability to communicate became more and more valuable in working life. It was hard for newly arrived immigrants to get a foothold in the labour market even during the economic boom around 1990. The economic crisis of the 1990s, combined with a record number of refugee immigrants, made the problem worse. In addition, the large flow of refugees at the beginning of the 1990s coincided with the economic crisis in Sweden and job availability decreased. The number of asylum seekers admitted into the country depends partly on instability in different parts of the world and partly on Swedish immigration policies. One example of this is the war in former Yugoslavia, which resulted in a substantial flow of asylum seekers to Sweden in 1992 and 1993.

Family ties dominated 1990s migration

A widespread misconception is that immigrant and refugee are synonymous concepts. Only one eighth of people who have immigrated during 1990-2003 have been refugees. A refugee is a person who is in need of protection. In addition, almost twice as many people have been granted residence permits to live in Sweden on humanitarian grounds. Approximately four out of ten immigrants have cited family ties as grounds for residence. When considering immigration in recent years, it can be seen that the share of refugees has decreased while immigrants with family ties now account for half of all immigration. Returning Swedes are not included in these shares.

How has post war migration affected Sweden's population?

One direct consequence of post war migration is that the number of foreign-born persons increased by nearly 1 million during the period from 1945 to 2003. Indirectly, immigration has also contributed to both more births and deaths. According to our calculations, immigration contributed to around 1 million births from 1945-2003. Immigrants are young when they arrive in Sweden and belong to a selective group of people with a low mortality rate. The number of deaths among immigrants and their children is still low, at only 140,000. The calculated birth surplus is 870,000, which is almost as large as the immigration surplus, 970,000. Migration from 1945-2003 has thus contributed to an additional 1,840,000 people in Sweden. In comparison, from the end of 1944 to 2003, Sweden's population increased by 2,380,000 people. Therefore, according to figures available, without migration, the birth surplus would only amount to 540,000.

Regulation affects the flow of refugees

Today, regulation of migration between countries is the norm with one exception-migration between the Nordic countries, which has been without restrictions since the 1950s. Labour immigration started to be regulated in 1967 for citizens of countries outside of the Nordics. The Swedish immigration policy has been directed since the 1980s towards regulations and ordinances for asylum seekers and their families. 1980, 1989 and 1997 are important years for



new and amended legislation. The Swedish migration policy also contributed to periods of increased influx of asylum seekers and during other periods when the policy has been more restrained, had led to the reduction of the flow of asylum seekers.

Emigration and re-immigration of Swedes

Since the end of emigration to the United States (U.S.) in the 1920s, emigration of Swedish people remained very low until around 1950. During the 1950s and 1960s, around 5,000 people per year emigrated. A new emigration pattern first emerged in the 1990s doubling that of the 1970s and 1980s to around 10,000 to 20,000 people per year. The increased emigration of the 1990s can be placed in the context of the economic crisis, globalisation and Sweden's entry to the EU. Roughly two thirds of Swedes return at some point. The most popular countries to move to are the U.S., Norway and the United Kingdom (UK). An analysis of Swedish migration statistics shows that approximately 200,000 Swedes, i.e. Swedish-born persons, are residents abroad. If we compile data from other countries' statistical offices and make calculations for countries where there is no information, the number increases to approx. 300,000. This difference can be explained by around 100,000 Swedish-born persons, who are registered in the Swedish population register, residing abroad for a shorter or longer time period. The international recommendations state that a one-year rule should be applied with regard to migration. If a person is resident in a country for less than one year, they should remain in the Swedish population register and not be counted as part of the population of the country they are resident in. However, many countries have shorter time requirements for residency. So part of the difference can be due to varying definitions between countries. However, the most important cause for the difference is probably deficiencies in the statistics on migration such as for example, persons leaving Sweden without registering their move.

Conceptual framework for migrant health approach

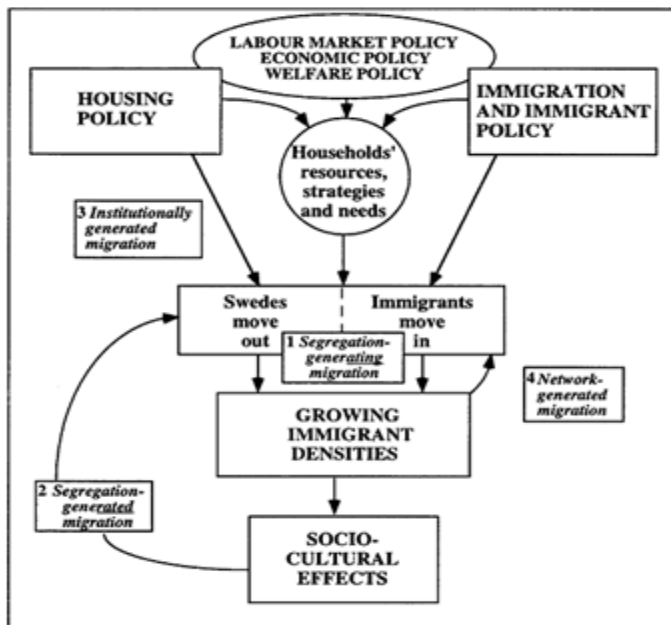
It is important to acknowledge that many aspects of living conditions and health determinants for those inhabitants with non-Swedish origin are shared with many Swedish-born people with very low incomes and material resources. Residential segregation is a result of migration. Decisions to migrate is taken by individuals who want to move "to another country or region to better their material or social conditions and improve the prospect for themselves or their family", as nicely put by IOM. This is the starting point for a suggested conceptual model in order to understand how contextual factors interact with individual factors and result in a specific residential segregation. The model is outlined in the figure below⁵.

⁵ The model is derived from research presented to a Swedish Inquiry Committee on the Welfare System 2001. It is also presented in Urban Studies (Andersson R. Socio-spatial dynamics: Ethnic divisions of mobility and housing in post-Palme Sweden. Urban Studies, 35 (3): 397-428, 1998).



Residential segregation in Sweden today is characterised by a divide between people with moderate to high income; and people with non-Swedish origin, as well as people of Swedish origin with very limited material resources. A possible incentive might be that members of households respond to the current contextual situation according to their different access to resources in relation to their prospects. If they consider the possibilities “to better their material or social conditions” will be better elsewhere, they might decide to move. But the households will end up in different areas depending on their available resources for housing. Better off households tend to settle down in affluent areas whereas households lacking substantial resources will be directed towards areas with apartments to rent. This might be labelled as “Segregation-generating migration”.

Figure 4. Conceptual model of residential segregation (Andersson 1998)



When the labour market deteriorates, unemployment tends to rise faster in residential areas with higher proportion of households with already limited resources, eventually leading to increasing poverty in these areas and migration due to need for new jobs, some households will move out to other places, resulting in less demand for rented apartments which in turn will lead to high turn-over rates in these areas causing instability and reduced social cohesion. Since the multi-family houses need to be filled for economic reasons these unoccupied apartments became a housing solution for all those people in need of social assistance. The concentration of poverty increases as the reputation of such areas decreases. The load on the welfare institutions in the area increases with the number of poor people, the number of languages spoken, ends up with higher workload for welfare institutions - in the best case - same amount of resources. The quality of welfare services will be questioned; it will be become more difficult to staff the offices, leading to negative socio-cultural effects. These lead to a secondary



migration of households with enough resources to move out from these areas, thus further concentrate poverty and socially marginalised households. This kind of migration might be labelled "Segregation-generated migration".

Typically, during the two last decades this type of migration has been characterised by Swedish households with low to moderate incomes moving out from suburban areas and leaving behind households of non-Swedish origin with high rates of unemployment with a strong need for social support. This pattern of migration has also (unintentionally) been supported by governmental housing and economic policies, e.g. subsidising construction of owner-occupied housing, mortgage costs can be used for tax-reduction which was beneficial for middle- and high-income households. This might be labelled "Institutionally generated migration".

All in all the housing-, immigration- and economic policies led to social segregation where households were distributed within urban areas in accordance with tenure forms and levels of income and welfare.

2.2. Composition of migrant flow

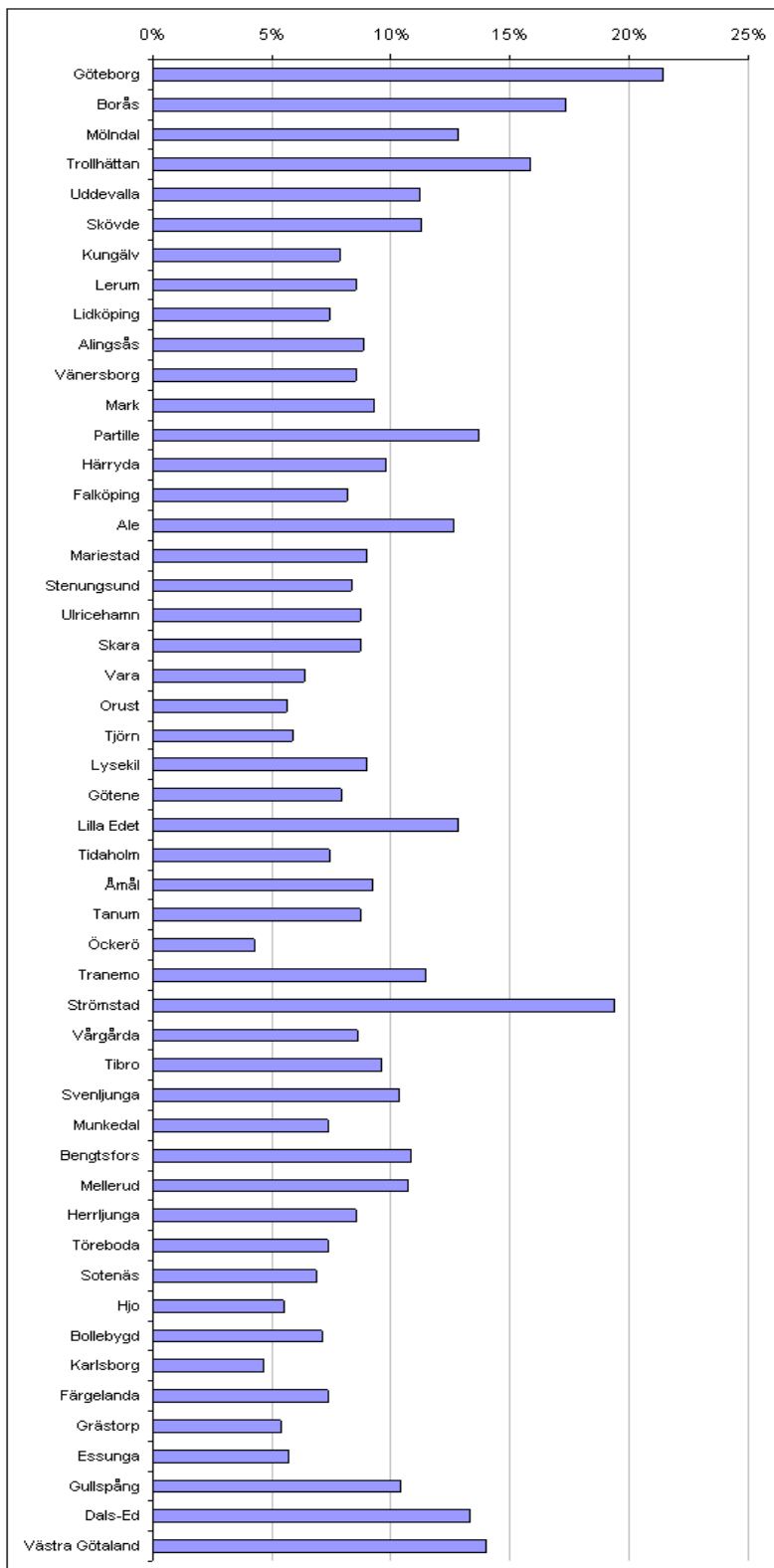
Today, about 17% of the Swedish population has immigrant background (Statistics Sweden 2009). The proportion is a little higher in the Region of Västra Götaland where in 2008, 23% of the population came from an immigrant background.

The municipalities are sorted by decreasing size of population. Thus, Gothenburg (Göteborg) with its approx. 500,000 inhabitants is at the top and Dals-Ed with less than 5000, is at the bottom. The lowest figure is the total for the region of Västra Götaland (just over 1.5 million people in all).

Immigrants are from numerous countries throughout the world. The largest percentage comes from the Middle East region as refugees. Table 1 shows the distribution of immigrants in to Region Västra Götaland per country of citizenship as per 2007. A bit over 14 thousand immigrants arrived in the region 2007; the single country with the largest contingent was Iraq.



Figure 5. Proportion of people with immigrant background as part of population per municipality in the Region of Västra Götaland 2007



Source: Statistics Sweden 2009



Table 1. Immigrants' country of origin 2007

Country of citizenship	Region Västra Götaland		Sweden
	Number	%	%
Sweden	2 733	19	16
Iraq	1 816	12,6	15,3
Poland	1 004	7	7,6
Somalia	655	4,5	3,8
Norway	654	4,5	2,4
Germany	581	4	3,6
Serbia	467	3,2	1,9
Romania	464	3,2	2,6
Iran	415	2,9	1,4
China	358	2,5	2,4
Thailand	354	2,5	2,6
United Kingdom	232	1,6	1,5
Finland	218	1,5	2,6
Turkey	204	1,4	1,5
Denmark	182	1,3	5,1
Hungary	168	1,2	0,8
France	162	1,1	0,9
India	155	1,1	1,2
USA	139	1	1
Bulgaria	126	0,9	1,2
The Netherlands	126	0,9	1,1
Pakistan	115	0,8	1,2
Russia	113	0,8	0,9
Lithuania	110	0,8	0,9
Iceland	96	0,7	0,4
Spain	83	0,6	0,5
Stateless	108	0,7	0,9
Other nations	2 563	17,8	18,7
<i>Total</i>	<i>14 401</i>	<i>100</i>	<i>100</i>

Source: Statistics Sweden

2.3. Migrant impact

Migrant impact on social and economic standards

The Region of Västra Götaland experiences a growing polarization with a cluster of municipalities around the Gothenburg (Göteborg) area where economic growth is strong, having an inflow of people and a clustering of migrants, mainly refugees, while at the same time there is an economic decline in rural parts from which especially young adults move out. This is clearly not sustainable development. There is a growing awareness and even hostility



against non-Swedish people, a growing discontent from young immigrant people who find themselves excluded from the labour market, with small chances of getting a job, growing frustration in the disadvantaged suburban areas, now and then with clashes between inhabitants and police, where fire brigades and ambulances are reluctant to go to these areas.

Migrant social determinants of health and health care needs

According to the national surveys on living standards and health carried out from 2000-2005, people with immigrant background had, in general, worse health than people with non-immigrant background. Those people born outside of the EU15 reported worse health than those within EU15. The reported health status from the latter group was comparable to that of the Swedish born (Socialstyrelsen 2009).

The chance for people born outside of Europe to report "bad" or "very bad" health was three to four times higher than those born in Sweden. However, when socioeconomic factors were adjusted, the differences were considerably reduced. This shows that socioeconomic factors can play a role to a great extent in order to explain why people from outside of Europe report worse health.

According to this report, women who were born outside of Sweden reported, just as Swedish born women, worse health than men. Self reported health among children seems to be more complicated. Interviews with children of immigrant background born outside of Sweden report more psychosomatic symptoms than children with immigrant background born in Sweden, whereas the latter group report psychosomatic symptoms at about the same degree as children with non-immigrant background. Coming to more severe psychiatric diseases, such as suicides or psychoses, the pattern is reversed: children of immigrants are under higher risk than immigrants themselves. These diseases are at least as incident among those children and adolescents who have grown up in Sweden, as compared to their immigrant parents.

Immigrants have arrived in Sweden due to a number of different reasons and the health patterns among immigrants can be expected to vary according to different mechanisms. Labour immigrants mostly belong to the more healthy part of their country of origin. Some of refugees might have physical or mental disabilities, which are grounds for allowing those people to stay in Sweden. In order to describe and analyze this heterogeneity among immigrants we need studies that identify the underlying mechanisms among different immigrant groups. As of today, there are no ongoing studies, at neither national nor regional level, to tackle this kind of analysis. Such mechanisms might be grouped into three different categories:

- Mechanisms with roots in the culture, society and population from where the individual has come
- Mechanisms relating to the immigration process in itself and how immigration issues are handled in Sweden
- Integration mechanisms in Sweden after the immigrants have been granted citizenship.



Mechanisms with roots in the culture, society and population from where the individual has come

Many immigrants come from countries where certain serious infectious diseases are more prevalent. Examples might include Tuberculosis, Hepatitis type A and B and HIV/AIDS. Continual direct and indirect contacts with their countries of origin may cause the immigrant to become ill even after obtaining Swedish citizenship.

The immigrant arrives in Sweden with a lifestyle and living habits characteristic of their background. These habits will continue to affect the way of life in Sweden and might also affect the habits of their children.

Eating habits and tobacco usage differ among countries and contribute to differences seen among different groups of immigrants and non-immigrants. Foreign born men smoke to a greater extent than Swedish born men. Women from European countries but outside of Sweden smoke more than Swedish women, whereas women born outside of Europe smoke less than Swedish women. The prevalence of alcohol related diseases mirrors attitudes and habits of use of alcohol in immigrants' countries of origin. Finnish immigrants are more often inpatients due to alcohol related diseases than Swedish men, whereas immigrants from the Middle East region are less often inpatients in comparison to Swedes.

Mechanisms having to do with the immigration process in itself and how immigration issues are handled in Sweden

Since the middle of 1970s, immigration to Sweden has been dominated by refugees and their families. People who have fled from their homes have almost always lived under severe stress before they left their countries. A large proportion of refugees have endured violence, often torture or other human rights violations. In the 1970s and 1980s, one out of four refugees from Latin America reported that they have been tortured. Among Kurdish refugees, 40% reported on systematic violence. The flight in itself equates to hardship and suffering. Families are often split apart for a longer period. After the arrival to a new country, a new period of uncertainty and insecurity awaits. These experiences may cause Post Traumatic Stress Syndrome (PTSD). In a literature review in the Lancet in 2005, it was reported that almost 10% of adult refugees and 7-17% of their children suffered from PTSD.

During the asylum process, adult refugees have limited access to health care. Only emergencies or healthcare that cannot wait is accepted for subsidised health care. However, there are no such limitations for refugee children.

The dominating health problems among refugees are psychiatric problems and different psychosomatic symptoms. It is about three times more frequent for asylum seekers than among the rest of population to be inpatients after having attempted suicide. Asylum seeking children are considerably overrepresented among children in Child Psychiatric Care.



Support from relatives and friends are important for mental health among refugees, during the first years in the new country. New contacts are often established among members of the same origin. Studies have shown that it is of considerable risk for mental health to be referred to a place where it is hard to make contacts with members of the same origin.

Integration Mechanisms in Sweden after the immigrant has been granted citizenship

Immigrants are in a vulnerable social position. They are unfamiliar with the social system and too often exposed to discrimination more often than others. They are more often unemployed; they work in a poor environment, both from physical and psychosocial aspects. Immigrants from outside of Europe have more often less favourable material living conditions than immigrants from European countries.

Discrimination in Sweden affects the living conditions of immigrants. Discrimination at work places leads to lower income and unemployment. Discrimination in the housing market leads to immigrants being referred to areas with low social status. This is more pronounced among immigrants from non-European countries. These groups are more often exposed to violence or threats as a result of living in low status areas.

Discrimination might affect health indirectly through poor living conditions. Repeated experiences of discrimination might also have a more direct influence on health. It can be seen as a chronic stressor where the immigrant is always prepared to encounter and react to discrimination. Immigrants reporting discrimination are twice as often reporting deteriorated mental health. Some studies have also suggested a relationship between discrimination and psychosis. In Sweden, immigrants are treated in hospitals for psychosis two to three times more often than others. According to studies, this is linked to socioeconomic factors such as low income, single parents and living in low status areas. These factors, in turn, have probably strong links to discrimination in society.

The mortality from accidents is about the same for children and adolescents with immigrant and non-immigrant background, although the patterns look different. Children with immigrant backgrounds are less likely to be hurt by motor accidents or by accidents related to leisure activities. On the other hand, burn injuries are more common among children with immigrant background. This probably reflects differences in material living conditions.

We know comparatively little about health needs among immigrants. Knowledge is mainly based on register data from administrative health care registers and research reports on specific issues. Some key points are:

- Health situation differs profoundly between different ethnic and socio-economic groups
- Immigrants under utilize the health care system
- There is definitely limited access to healthcare among refugees, especially those waiting permission to stay or those who have illegal status
- There is a strong correlation between health and socio-economic status for both immigrants and Swedish-born people.



3. Policy agenda

Immigration has been an issue for the past forty years in Sweden. In the 1960s there was an upsurge in the Swedish economy that led to a tremendous increase in labour immigration, partly due to an active recruitment of people from Scandinavia, but also from Italy, Greece and Former Yugoslavia.

The major issue within migration policy today, perhaps even within the entire domestic policy, is probably the growing residential segregation between those with Swedish origin and those with foreign but also Swedish-born with very low income and lack of material and cultural resources.

Since the economic decline in the 1970s, and especially from mid-1980s onwards, there has been a slow change towards a growing hardship for many foreign-born people. From 1985 and onwards the government launched a number of reforms which affected migration.

- Europe rather than the Third World became the focus of Swedish foreign policy.
- Unemployment rates quadrupled during the first years of 1990s- from 2% to 8%.
- Welfare schemes were cut down in order to achieve balance in budgets at national, regional and municipality levels.
- Immigrants faced dramatic changes in attitudes and in living conditions in general.

3.1. Policy agenda

It is stated above that immigrants have access to the same public health care system as other people and that public health policies integrate immigrant health issues. However, many of immigrants' health problems pose special challenges to the health care system. The most obvious is perhaps how health care personnel should deal with people with differing cultures and languages.

Stewardship

Policies to deal with immigrant health issues are strongly focused on the social determinants of health. It should be clear that many of the challenges with immigrant health issues are not ethnic or cultural but result from lack of economic and cultural resources needed to participate in the Swedish society, a problem shared by many marginalised Swedish born people. Therefore, immigrant related public health policies should involve strategies to tackle inequities in health and the distribution of health determinants within the entire population.

One important part of such a public health policy is to build coalitions between actors at the regional, local and national levels with the common objective to reduce inequities in health. For the past three years, a key coalition exists between local public health professionals and professionals at the regional level in order to exchange experiences and coordinate collaboration in the field of public health.



The problems of marginalisation and social exclusion are clustering in the larger cities. Therefore, public health strategies differ in different parts of the region. It should come as no surprise that strategies towards social exclusion are more prominent in the main cities. Such strategies are characterised by initiatives aiming at integration and breaking barriers to citizens' participation in society.

An important obstacle to efficient stewardship is the limited possibilities for monitoring and evaluating the effects of such initiatives. Thus, there is a lack of sufficient and valid data on the development of immigrants' health.

Service delivery

Health systems should deliver services to citizens in order to improve or maintain their health status. In general, the Health Care system delivers good quality services at a comparatively low cost. However, there is growing evidence that lower socioeconomic groups have less access to everyday health care. The National Board of Health and Welfare produced a report on, geographical and socioeconomic differences in availability to health care and consequences from treatments and investigations (Socialstyrelsen 2009). Mortality in preventable diagnoses is more than four times higher among lower educated men than among well educated women. Well educated people visit surgeries more often than lower educated ones. Since many immigrants hold a low social position, this pattern of service inequality applies to immigrant groups coupled with extra barriers due to lack of communicative skills among health care personnel including lack of cultural knowledge, and inability to speak other languages etc. It is unclear to what extent this is the situation in the Region of Västra Götaland since there is very little data available on this subject matter.

Financing

Health care and public health programmes are financed through taxation but providers can be private. During the last decade there has been a growing policy trend towards the freedom to choose health care providers. However, there is an ongoing debate that such extension of individuals' right might compromise equal opportunities for everyone to access health care. The key argument is that people with more resources will be able to obtain the best health care possible and by creating a pseudo system that in the long run will influence the distribution of health care providers in the region. The regional political management has tried to prevent such a bias by financially supporting health care and public health initiatives in areas with limited economic and cultural resources. This reform was launched in autumn 2009.

Resource generation

There are no mandatory training or medical education programmes to increase skills and knowledge about health of immigrants. However, many health care professionals working in areas with high number of immigrants are devoted to their work and are in tune with this



distinction. There are opportunities for education on the subject matter available on a voluntary basis (both medical and sociological). There are several ongoing programmes aiming at involving immigrants, with their competences, to render health care and disease prevention programmes more effective.

4. Good practices and projects

As stated above, migrants share many of the socioeconomic health determinants and risks with Swedish-born people with low economic and/or cultural resources. In order to meet multicultural health problems, a project to create a new local hospital in Angered - a multicultural area in Gothenburg, Sweden - was started in February 2007⁶. Existing city hospitals in Gothenburg are thought to be insufficient in meeting growing demands for specialist care in large multicultural areas in North-East of the city. Demographic and lifestyle characteristics of the population in these areas are different from the rest of Gothenburg. However, statistics and other information obtained by different agencies and bodies may be fragmented and unclear because they reflect specific limitations of the respective organizations and therefore do not present the entire picture of the population as a whole. A comprehensive analysis of the need for health care, including general health status, disease profile and perception of health care was therefore necessary to plan a new type of local hospital that would be tailored to the specific needs of the local population.

Various characteristics of the catchment area population were collected and analyzed using a number of information sources: statistical data by government agencies (Statistics Sweden, The National Board of Health and Welfare, Swedish National Institute of Public Health, Swedish National Agency for Education), municipal bodies (City of Göteborg, Health care Board), questionnaires on utilization of emergency departments as primary point of care and review of research publications. Furthermore, a number of individual and focus group interviews with representatives of Sahlgrenska University Hospital, communal health care establishments, schools, and elderly care institutions were conducted to augment statistical data with personal experiences, and reflections from the people on the ground.

The population of North-East of Gothenburg was found to differ from the rest of the city in a number of characteristics. Up to 50% were born abroad, the majority of them outside Europe. There were a substantial number of refugees suffering from stress associated with previous traumatic experiences that interfered with integration into the Swedish society. Consequently, the social deprivation index and the proportion of unemployed and welfare-takers, especially among women, were substantially greater than the national and county average, and higher than in the rest of the city. The characteristic lifestyle features included low physical activity and high prevalence of smoking. Despite the fact that the average age of the residents in the North-

⁶ This part on good practices is written by Mrs Olga Panfilova, researcher and epidemiologist, and Ms Marianne Olsson, project director, affiliated with Local Government Research Institute (KFi), Angereds Närsjukhus, Gothenburg (Göteborg), Region Västra Götaland.



East was the lowest in comparison with other areas in Gothenburg, the morbidity and mortality rates were higher, especially with regard to cardiovascular diseases, chronic obstructive pulmonary disease, lung cancer, and alcoholism.

Despite equal access to health care for all inhabitants of Gothenburg, the local medical services were found to be suboptimal: the primary care centers were understaffed and the patients had to travel to emergency departments of the big city hospitals. To meet the population needs identified by the analysis, the following areas became prioritized in this local hospital (Angereds Närsjukhus): cardiovascular diseases and diabetes, chronic obstructive pulmonary disease, pediatric care, musculoskeletal diseases associated with chronic pain, and mental health. In our opinion, the results highlight the need for comprehensive data collection from various sources and its subsequent integration in order to plan for a high standard of treatment for existing diseases as well as for promotion of health and wellbeing. Therefore, epidemiology and preventive medicine should be integral part of the total care provision.

5. Conclusions

There are clearly a number of issues. Perhaps the most urgent is a strategic issue – what kind of initiatives would be efficient to reduce the exclusionary effects from residential segregation? If the conceptual model is adequate, then it implies that social determinants of health “upstream the individual” must be approached and the mechanisms behind institution-generated migration must be made transparent. However, this is a tremendous challenge, requiring skills and knowledge which are rarely found within a sole region. This implies that collaboration and exchange of experiences and knowledge between regions throughout Europe is of fundamental importance. Even if health of migrants will depend on the unique societal context in which migrants live, the mechanisms underpinning the problems often share the same characteristics. Thus, Joint efforts are needed in order to tackle one of the biggest challenges to reducing inequalities in health between but also within regions in Europe.

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World Health Organization
Regional Office for Europe
Regions for Health Network



Migrants and Health Care: Responses by European Regions (MIGHRER)

Complete reference material

XII. Regional report Veneto

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Summary

Veneto Region, as Italy, is characterized by a late immigration. At the end of 2007 the immigrants were representing the 8.4% of the total population: 52% were men and mostly young or in working age. In fact in 2007 about the 18,6% on the total new born in Veneto were children of foreigners and the 23,3% have at least one foreigner parent. The Veneto population is expected to increase and this growth matches significant changes in the distribution for age classes.

In Veneto has been realized a three-year plan 2007-2009 for the immigration sector that includes social integration insisted to the relationships through immigration and development, the legal migratory, the rights, the duties and the social opportunities, and on the participation to the regional policies of the Local Governments, immigrants organizations, associations, the productive sector and the sector of job to encourage the living together. A success factor of this strategy is the creation of a net of synergies and collaborations with local organizations, Caritas, Italian Red Cross, Hospital, Institutional Organizations and the development of a sense of responsibility in all professionals and services.

It's important also to underline the concept of reciprocity between the hospital society and the immigrant that includes that the hospital society applies to remove the obstacles that the immigrant people meet, and on the other hand the migrant citizen must follow the duties provided by the Italian law.

In this direction many projects and experiences have been realized as the international project Migrant Friendly Hospitals in defence of the maternal-infantile health, or the juvenile age and second generation initiative with the activation of specific surgeries inside the Local Health and Social Trust of Padua that provides paediatric visit, dermatology visit, and many other services for minors. A particular example is related with irregular Chinese people that have few contacts with health service and insufficient knowledge to the social-sanitary services. For this reason a strategy to help the access of these persons specially of the female components and the teenagers to the public health services has been realized by the involvement and reinforcement of a young Chinese as cultural mediator.

1. A view of the National and Regional Health System

1.1. The National Health System

The Italian National Health System (SSN) is identified as the most important and complex institution of national sanitary system and is defined as the complex of functions, of structures, of services and of activities intended to the promotion and to the maintenance of the physic and psychic health of all population, without distinction from individual or social conditions and according to the procedures that secure the equality of the citizens to the service.

The SSN is together of organizations and organs that converge to the achievement of the tutelage objectives of the citizens health.



The SSN is financed from the general taxation and from the direct incomings of the Local Health Trusts, derived from the payment of tickets (out of pocket contributes of citizens to the expense) and from the paid services.

Through the SSN is put in the practise the art. 32 of Italian Constitution that stress the right to the health of all citizens.

The institutional order of SSN is articulated in three levels:

- a central or State level;
- a regional level with important role in organizing health structures;
- a local level (peripheral), where participate Local Governments and health services are provided by the Local Health Trusts.

The strategic objectives of SSN,coherently with the principles, are:

- uniform and appropriate distribution of the Essential Level of Assistance (LEA)
- the organization of the Regional Health Services (SSR)
- the strengthening of the promotion of health
- the renovation of care system
- the promotion of continuous quality improvement
- the qualification of innovation
- the participation of citizens

The SSN is characterized from a system of health planning, that is regulated from art. 1 of DLgs 502/1992,that is articulated to the National Health Plan (PSN) and to the Regional Health Plans (PSR). The three years Plans indicates:

- priority areas of intervention, to a progressive reduction of the social and territorial inequality to health;
- the LEA and the corresponding funds;
- the principal project to be realized through the functional and operative integration of the local health and social services;
- the basic educational objectives and the continuous medical education requirements;
- the criteria and the indicators for monitoring processes and results;
- the guidelines and the relative diagnostic-therapeutic pathways.



1.2. Structural organization at the regional level in Veneto

The Region promotes the quality and the integration of the health and the social care in particular for: efficacy and efficiency; equity and accessibility to all citizens; appropriateness.

The organization at the regional level includes several structures:

- Council of the Health Policies - for health planning, health promotion, public health, etc.
- Council of the Social Policies - for social services planning for the minors, the old people and the disabled, etc.
- Council of Migrant Policies
- Council of the Public Job Policies and Sports - for sport and free time planning, local police and security
- Council of Budget - for human rights and equal opportunities
- Council of Education and Training Policies - for education, the right to education, active policies for work
- Council of Economy, of Development, of Research and Innovation - for the cooperation, productive districts and local development

The Region is organized in Directions, Services and Offices for the various Departments.

1.3. Organizations

Regional no profit Companies, Agencies and private Societies exercise public functions or are private partners.

Local Health and Social Trust

The Local Health and Social Trusts (AUSSL) are the organizations which provide at the local level social and health services.

The AUSSL cooperate among them for large areas (province) programmes through specific agreements that include different subjects and with integrative agreements at the regional levels. It is, therefore, possible to develop common ideas, to introduce innovative activities, to coordinate the activities in specific health sectors, in the personnel training and to make contracts with the Universities and with the other Hospital Trusts.

Regional Council of Immigration

The Regional Council of Immigration, founded with the Regional Law n. 9/1990, has a role in:

- defining the three-year plan and the annual programming;
- monitoring the phenomenon of immigration and the social problems and economic consequences;



- studying the criteria for distributing resources to the municipalities and the immigrants organizations;
- promoting the collaboration between the migrant associations and with other interested organizations;
- evaluating the needs and the demand concerning education, culture, social services, housing, etc.

Regional Observatories and Guarantee Organs

- Regional Committee - Regional Committee for Communications (Re.Co.Com.) and the Bioethics Committee
- Regional Commissions - Regional Commission for the Equal Opportunities, Regional Commission for Handicraft, Special Commissar for the Touristic Activities and Promotion
- Regional Observatories - Regional Observatory of the Contracts, Regional Observatory for the Security, Regional Observatory of Mobility, Regional Observatory of Immigration with carries to find the dates, the research on specific problems.
- Regional Consult for Immigration - includes representatives of the immigrant associations.
- Regional Table of Coordination for the Immigration - includes all the social parts and the system of local autonomies.
- Immigrate Informative Network - is a regional programme of information with the aim of creating a professional community able to exchange and to disseminate information, practical solutions, good practices, researches, etc. in order to help the immigrants integration at the social-working Veneto tissue. The Immigrate Information Network works in collaboration with the Regional Observatory for Immigration.
- Regional Register of Immigration - of associations, of the companies, of the NGOs that operate continuously with the immigrants.

1.4. Intersectorial actions for the health of the migrants between public and private institutions

Among them:

- Table on Immigration - coordinated by the Immigration Service of Local Health Trust of Padua with the local institutions and organizations (Local Companies, Prefettura, Diocese, Police, Italian Red Cross, Associations and Cooperatives,) which meet every month from 2004.



- Protocol of agreement between the Municipality of Padua, Social Interventions and the Local Health Trust of Padua for the health programmes in favour of the under eighteen that are in Veneto alone (psyco-physical evaluation nearby the paediatric services at a district level).
- Protocol of agreement for the using of the net of services for asylum applicants "Progetto rondine" between the Municipality of Padua and Local Health Trust of Padua for Immigrants with the aim of offering health assistance to applicants for asylum which are evaluated from the Ministry of the Interior.
- Convention with Diocese for healthcare (Caritas, Popular Kitchen).
- Convection between the Centre Help to Life and Local Health Trust of Padua in favour of the women and children under eighteen.
- Convection between the Centre Veneto Wife Project and Local Health Trust of Padua for the cases of maltreatments of children and women.
- Protocol of agreement between the Local Health and Social Trust of Padua and the Operative Unity of Microbiology and Virology of the Hospital Company for the diagnosis and the prevention of infectious diseases.
- Surveillance system for the control of tuberculosis (Regional Law n. 42/2004). The system of surveillance of tuberculosis in Veneto is based on the notification and on a special flow presented from a regional file that contains, besides the same information of notification's file, also data on risk's factors and cases of the localization at the lungs, the relative data about the treatment and the result of the therapy.
- The Immigration Service of the AUSSL of Padua produced a guide about the norms on health assistance to the immigrants (regular immigrants waiting for permission; permission for health reasons, pregnant women, assistance for prisoners, students, extra-EU priests, invalids, person temporary present in Italy, temporary assistance for the under eighteen, TEAM document, permission for medical care, visas and permission).

1.5. The health of the migrants

After many years of constant decline, from the end of 80` in Veneto we are registering a rise of Tuberculosis which is based on social and health factors of a growing importance. The Veneto Region reorganized the surveillance system for TBC, which involves different partners and is based on:

- a Functional Dispensary in every Local Health and Social Trust, which is the fulcrum of the clinical and epidemiologic activities and the reference centre for gathering information;
- the rationalization of the microbiology laboratories net;



- a software for the management of the cases, of the latent infections and of the epidemiologic investigations, able to follow the clinical and epidemiologic development and to share data between the different structures;
- new guidelines.

A three-year plan 2007-2009 for the immigration sector in Veneto has the following general objectives:

- accepting the pillar of the territorial immigration and the social integration insisted on the relationships through immigration and development, the legal migratory, the rights, the duties and the social opportunities, through the interregional cooperation and through the Region and territory;
- confirming the Table Unique and the Immigration Consultation which are the instruments of the regional policies for participation and cooperation between the Local Governments, immigrants organizations, associations, the productive sector and the labour sector to encourage the living together between the autochthon population and the immigrants.

The reception pact contained into the Three-year plan 2007-2009 of the Region of Veneto provides the reciprocity between the receiving community and the immigrant, in particular:

- the receiving community, according with the national law, promote the measures to remove the obstacles that the foreigners meet, especially in finding home, linguistic difficulties, or for their social integration;
- the migrant citizen must follow the duties provided by the Italian law (art. 2 p subsection 8 Unique Text), the rules of the living together, and the values of the receiving community.

The services offered to the migrants include:

- the access to drugs, the rehabilitation services, the mental health also for the minors, the dental health, sanitary emergency, the drug-dependence, are regulated with same procedures as for the Italian citizen, also at the case of the irregular people;
- in the case of irregular person with healthcare document (SPT), the doctors can prescribe the essential cure using the stamp of STP;
- in the case of EU foreigner that have the TEAM, released from its Countries, the pharmaceutical assistance and the primary care will be prescribed by the medical doctors of SSN.

The private assurance gives right for the assistance by the SSN (according to the directive from the Minister of Health of 3/8/2007) if:

- it is valid in Italy,
- it provide for the integral cover of the health risks,
- the annual duration with the date of release and the expiring date,



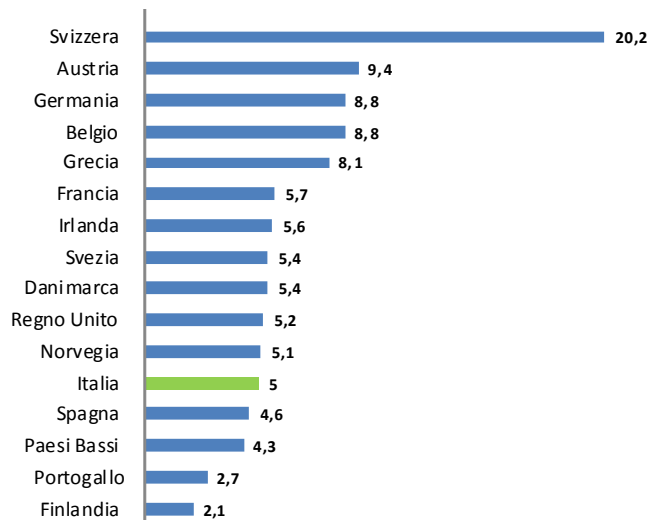
- it is clear on the cover of other members of the family and the parental degree,
- it mentions the address (n. tel/fax) of the responsible for the payments,
- it is translated in Italian.

2. The migration phenomenon

2.1. Immigration in Italy

It is well-known that Italy is a country of late immigration and itself, until not many decades ago, produced emigration towards various world countries. European countries most involved by the Italian migrant fluxes were Switzerland, that currently has the 20.2% of resident foreign population and the 23.8% of foreigner people who born there, Belgium and Germany with about 9% of resident foreign population and the 12-13% of foreign people born there (Figure 1). Italy is in the last places with the 5% as for resident and as for born foreign people.

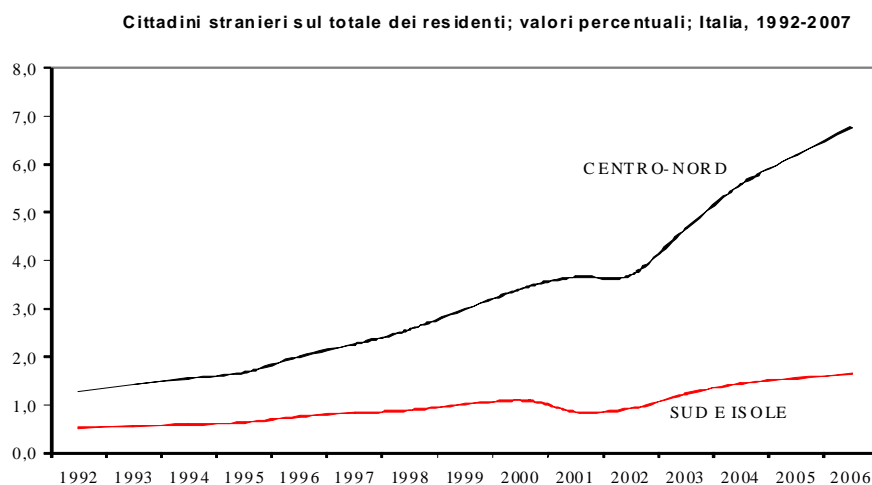
Figure 1. Percentage values of resident foreign population in European Countries - ISTAT data presented in 2008



Italy has now become itself immigration land and the ISTAT data confirm that the bigger concentration of foreign people is in central and northern Italy. By this trend we can hypothesize that the central and northern regions will be the youngest and most prolific, while the southern Italy and the Islands will become the oldest and less prolific (Figure 2).



Figure 2. Graphic trend of the percentage values of foreign citizens 1992-2007 on the total of the resident people in Italy - ISTAT data published in 2008



Fonte: elaborazioni su dati Istat.

2.2. Data about the migratory flows in Italy

According to estimates made known by the National Institute of Statistics (ISTAT, January 2009) in Italy there are more than 60 millions of resident people. Foreign people living in Italy, at 1st January 2009, were about 3 millions 900 thousand, with an increase of 462 thousand units more than at 1st January 2008. According to ISTAT estimates the foreign people resident in Italy was the 6,5% of the total population (5.8% in 2007).

The migratory balance, even if lower than that of 2007, remains very positive, confirming the features of attractiveness of Italy for new-community and extra community citizens.

The appraisal for births is 576 thousand units that is about 12 thousand births more than in 2007.

This phenomenon is mainly due to two factors: birth-rate recovery by Italian mothers and growing contribution by foreign mothers.

Table 1. ISTAT estimates about comparison of births in Italy in 1999 and in 2008 by foreigner mothers

1999	29,000 births equivalent to 5.4% of total	-	-
2008	88,000 births equivalent to 15.3% of total	3.4% with Italian partner	11.9% with foreign partner

Table 2. Foreign nationalities mostly represented in Italy at 1st January 2009 - ISTAT sources

Romanian	772,000 residents	Equivalent to 40% of foreign presences in Italy
Albanian	438,000 residents	
Moroccan	401,000 residents	

Table 3. Foreign people distribution on the Italian national territory - ISTAT data at January 2009

North	62%
Centre	25%
South-Islands	12%

Table 4. Average age of foreign people in Italy - ISTAT data at January 2009

North	30.5 years
Centre	32.2 years
South-Islands	32.8 years

2.3. Data about migrants in Veneto

Demographic characteristics

From the "2009 Foreign Immigration in Veneto Report" (by the Regional Department of Migration Policies) at 31/12/2007 the resident population in Veneto is composed by 4,832,340 people, of whom 403.985 foreigners, representing the 8.4% of the total (Figure 3).

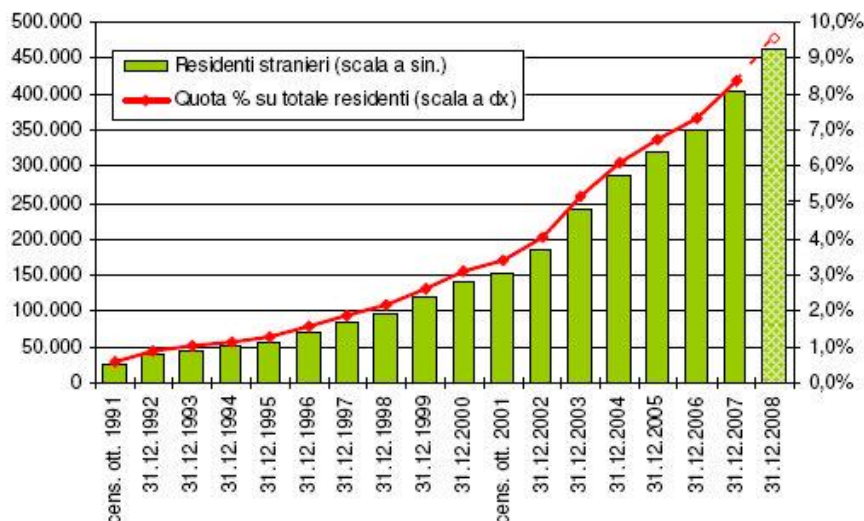
The migrants are:

- Gender - men 210,364 (52%) and women 193,621 (48%). The gender gap on the whole is attenuated, but inhomogeneities insist for some national groups.
- Age - above all children, people in working age (many between the 25 and 45 years) and young people, with an average age of 29 years, in opposition to the 43/44 years of the whole population.
- Areas of origin (Figure 4) - 55% European (about 76% from States extra European Union), 24% African, 6% Asian; % American.



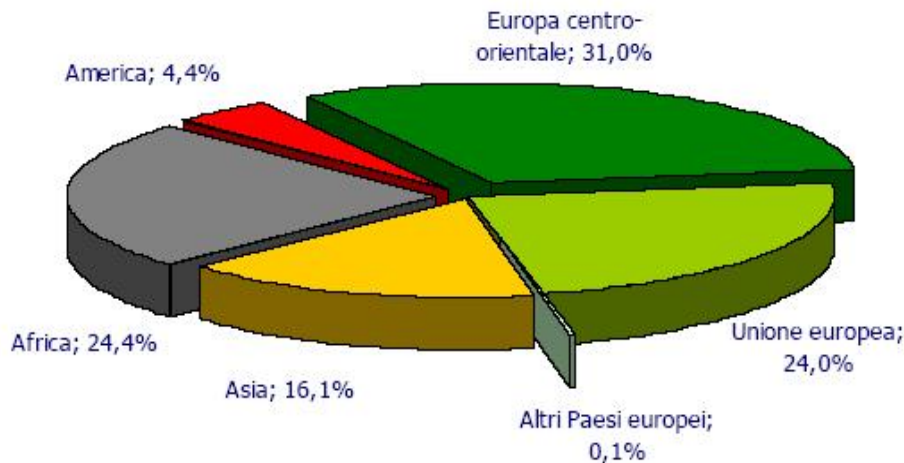
Figure 3.

Popolazione straniera residente ed incidenza % sul totale della popolazione residente in Veneto (1991-2008)



Fonte: elab. Osservatorio Immigrazione Regione Veneto su dati Istat; stima Veneto Lavoro per il 2008

Figure 4.



Fonte: elab. Oss. Imm. Regione Veneto su dati Istat (Bilancio demografico cittadini stranieri 2007 - <http://demo.istat.it/>)



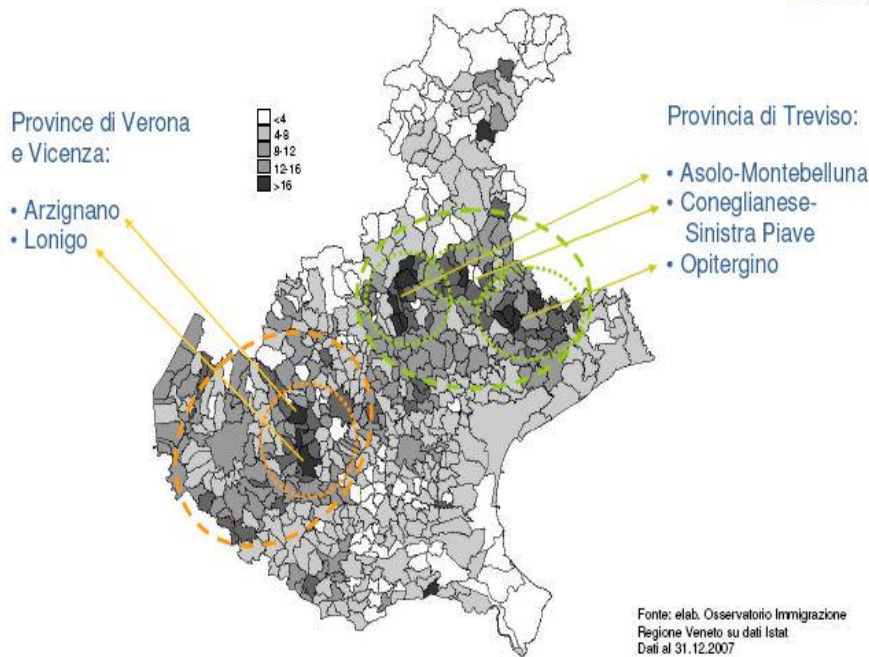
From data by the Regional Observatory on Immigration in 2009 it results that, in comparison with 2006, Veneto is the fourth Italian region for the presence of foreign residents with an increase of the 15% due to: transfers from abroad (92,000 new subscriptions); new born by foreign citizens in Italy (about 8,800).

In 2007 about 8,800 (the 18.6% on the total new borns in Veneto) are children of foreigners (1/6) and 11,000 (the 23.3%) have at least one foreigner parent.

In the provinces of Treviso (especially in the areas of Oderzo, Conegliano - left side Piave and Asolo - Montebelluna), Vicenza (alongside the road Lonigo-Arignano) and Verona live about 12-16% of foreigners and more. In Arignano and Lonigo they are 19% and in Pieve di Soligo 17% (Figure 5).

Figure 5. Incidence of foreign citizens on the total residents in the Veneto towns

Incidenza % di cittadini stranieri sul totale dei residenti nei comuni del Veneto.



It is important to note that in every territory, especially in expanded contexts, the conformation and the evolution of the foreign population is particular; indeed birth levels, arrivals from abroad, cancellations, minors share, etc. are factors strongly influenced by other elements and is therefore unthinkable they assume the same valence in the whole regional territory.

In Veneto the incidence of the foreigner birth rate on the total birth rate is 18.6%; Treviso with the 21.9%, Vicenza with the 21.7% and Verona with the 19.7% are the provinces with the highest incidence (Table 5).



Table 5. Incidence of the foreign children births on the total of the Veneto Provinces in 2007

	Totale			di cui: stranieri			Inc. % stranieri su totale	Con almeno un genitore straniero (% su tot. nati)
	Maschi	Femmine	Totale	Maschi	Femmine	Totale		
Verona	4.718	4.453	9.171	957	852	1.809	19,7%	25,3%
Vicenza	4.587	4.385	8.972	1.023	926	1.949	21,7%	26,1%
Belluno	898	778	1.676	98	70	168	10,0%	15,2%
Treviso	4.846	4.548	9.394	1.093	961	2.054	21,9%	26,4%
Venezia	3.897	3.654	7.551	537	505	1.042	13,8%	18,3%
Padova	4.475	4.342	8.817	768	711	1.479	16,8%	21,4%
Rovigo	925	914	1.839	154	169	323	17,6%	21,5%
Veneto	24.346	23.074	47.420	4.630	4.194	8.824	18,6%	23,3%

Fonte: elab. Osservatorio Immigrazione Regione Veneto su dati Istat (Rilevazione degli iscritti in anagrafe per nascita-
<http://demo.istat.it/altridati/IscrittiNascita/index.html>)

Countries of origin

According to the Regional Observatory on Immigration, at the end of 2007 the Rumanian migrants were the largest group (Table 6). The increase, as regards the previous year, has been remarkable (+59%), but mostly ascribe to the enlargement effect that has determined a real "race" to anagrafic subscriptions. Romania has become in 2006 (and confirmed in 2007) the first State for the provenance of foreign residents in Veneto, exceeding the other historical nationalities of immigration in Veneto, like the Albanian and the Moroccan. We cannot exclude, in the near future, a progressive attenuation of the Romanian provenance, considered the benefits that this country can get by its recent entrance in the European Union.

Following Morocco (12%) and Albania (9%), two nationalities always very numerous and that, despite the recorded big grown, they are not able to keep the pace with the first classified.

The Former Yugoslavia Republics (especially Serbia-Montenegro and Macedonia) continue to have a big importance, even because favoured by the geographic closeness of the Italian-Slovenian border with Veneto and by a consolidated net of transnational movements.

China is the main extra European country for the provenance of migratory fluxes towards Veneto. At the end of 2007, there are about 21.500 Chinese people regularly inscribed in the registry offices (about 5% of the regional total), the double of the ones inscribed at end 2003. This demonstrating the particular vivacity that today distinguishes this group.

Then, Moldova, Macedonia, Bangladesh, Ghana, India and others.

On the whole, however, even with the consolidating of some specific nationalities, the foreign presence in Veneto continues to be rather heterogeneous and in some respects indented.



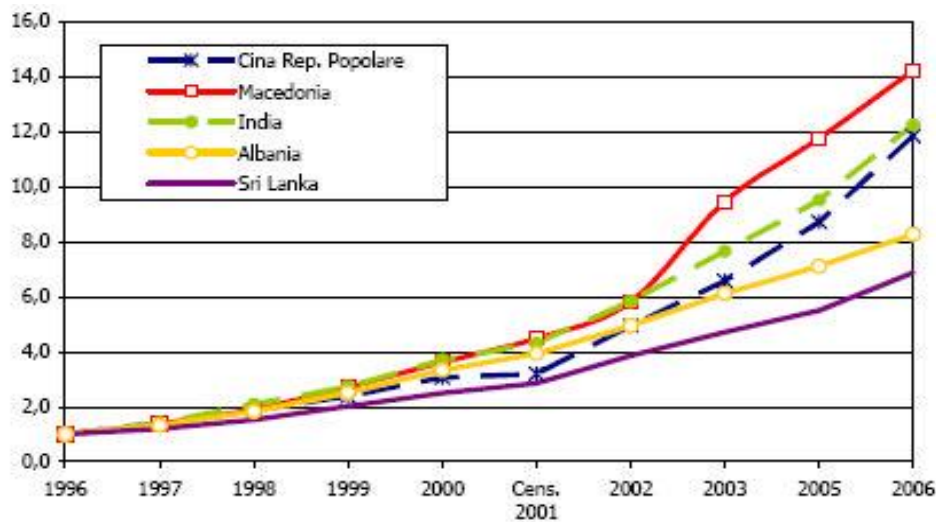
Table 6.

1997	2003	2005	2006	2007					
Marocco	14.680	Marocco	35.201	Marocco	43.682	Romania	48.207	Romania	76.861
Jugoslavia*	10.719	Romania	27.347	Romania	43.093	Marocco	46.781	Marocco	49.653
Ghana	5.848	Albania	26.352	Albania	33.318	Albania	35.654	Albania	37.798
Albania	5.725	Serbia e Montenegro	16.493	Serbia e Montenegro	21.468	Serbia e Montenegro	22.415	Serbia e Montenegro	23.655
Croazia	3.907	Cina	10.602	Cina	16.418	Cina	19.112	Cina	21.558
Senegal	2.839	Macedonia	10.381	Macedonia	13.696	Macedonia	15.610	Moldova	19.407
Romania	2.689	Ghana	9.159	Moldova	13.473	Moldavia	15.560	Macedonia	16.551
Nigeria	2.495	Bangladesh	7.195	Bangladesh	10.746	Bangladesh	12.340	Bangladesh	13.659
Cina	2.286	Moldavia	7.174	Ghana	10.258	Ghana	10.645	Ghana	11.143
Germania	2.105	Nigeria	6.716	Nigeria	8.671	India	9.663	India	10.725
Altri	24.875	Altri	65.814	Altri	105.977	Altri	114.728	Altri	122.975
TOTALE	83.172	TOTALE	240.434	TOTALE	320.793	TOTALE	350.215	TOTALE	403.985

In the period 1996-2006 and still today, the fluxes of immigration from Moldova, Romania and Ukraine are increasing. Between the extra European countries, Bangladesh is the only one that records very high growing levels.

As seen until 2006, between the countries at average growing dynamics we find some with a long migratory tradition. Two are eastern European (Albania e Macedonia), three Asian (China, India and Sri Lanka) and on the whole show a structural size of the growth, bound overall to the progressive stabilization on the territory (Figure 6).

Figure 6.



Fonte: elab. Osservatorio Immigrazione Regione Veneto su dati Istat



Forecast for the future

ISTAT periodically updates the forecasts on the future of the national and regional population. From a population a bit less than 4.8 millions, in 2007, we can hypothesize the exceeding of 5 millions in ten years. The forecasts for the year 2037, that is in thirty years, are articulated in three different "sceneries":

- high - 6 millions
- medium - 5.6 millions, the most likely
- low - 5.2 millions

In all the three scenarios the Veneto population is expected to increase and the migratory balance is going to have a mayor role. The foreign population, both for the migratory fluxes and for a positive natural balance, is intended to increase quickly; however this growth matches significant changes in the distribution for age classes.

The average age of foreigners will increase significantly, from the current 29 years to the 35 in 2027 and 38 in 2037.

In 2027 foreigners in Veneto will be about 1 million, that is 18% in all. For some age classes around 40 years the incidence could arrive at 30%. Like the Italian population, the foreign one is intended to get old.

Education

In the Veneto schools pupils represent an important element for strengthening the whole scholastic population. In the last ten years, students with non-Italian citizenship have become about 76 thousand in the school year 2008/2009, while they were 9,000 in the school year 1998/1999 (data at 15 January 2009). In these years, the scholastic population would have grown about 3% instead of 13% (Figure 7).

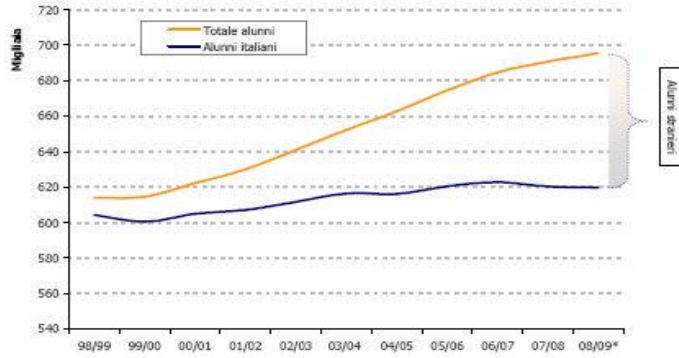


Figure 7.

Quale andamento della popolazione scolastica senza gli alunni stranieri?



Alunni iscritti nelle scuole del Veneto (statali e paritarie) negli anni scolastici 1998/99-2008/09*



* dati al 15 gennaio 2009
Fonte: elab. Osservatorio Immigrazione Regione Veneto su dati Mbur fino all'a.s. 2007/08 e Ufficio Scolastico Regionale per il Veneto/ARIS per l'a.s. 2008/09

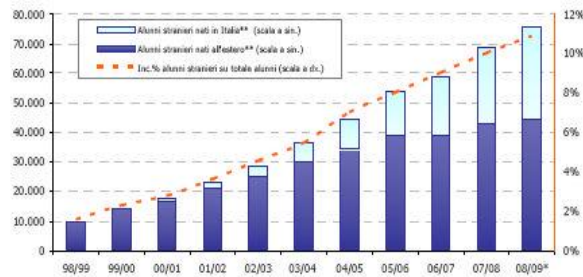
The share of the foreign pupils is growing on the total of the scholastic population, increasing from 2% in 1998 to 11% in January 2009. Effect of the stabilization process of the migrant families, the share of the foreign pupils born in Italy has increased from 28% in the scholastic year 2005/2006 to 42% in the month of January of the scholastic year 2008/2009 (Figure 8).

Figure 8.

Cresce il peso degli alunni stranieri a scuola: più iscritti, più bambini nati in Italia



Alunni stranieri iscritti nelle scuole del Veneto (statali e paritarie) negli anni scolastici 1998/99-2008/09*



* dati al 15 gennaio 2009; ** stima Veneto Lavoro per la quota di alunni stranieri nati in Italia relativa agli anni scolastici antecedenti al 2005/06
Fonte: elab. Osservatorio Immigrazione Regione Veneto su dati Mbur e Ufficio Scolastico Regionale per il Veneto/ARIS



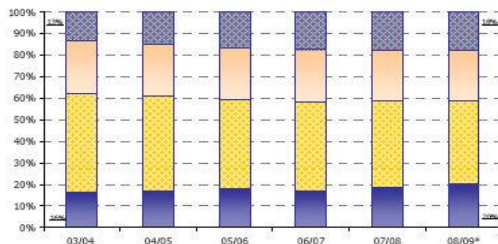
In the last years, despite of the still pre-eminent concentration of foreign children and boys in the primary school (39 % in 2009) and I grade secondary school (23%), there is a bigger increase for the inscribed in the childhood school (20%) and in the II grade secondary school (18%) (Figure 9).

Figure 9.

Nuovi ingressi e progressione a scuola: aumenta la concentrazione di alunni stranieri nelle scuole dell'Infanzia e Secondaria di II grado



Distribuzione degli alunni stranieri per ordine di scuola. Anni scolastici 2003/04-2008/09*



Alunni stranieri nelle scuole del Veneto per tipo di ordinamento

A.S.	Infanzia	Primaria	Secondaria I grado	Secondaria II grado	Totale
02/03	5.666	12.411	7.102	3.469	28.648
03/04	5.974	16.725	8.983	4.734	36.416
04/05	7.644	19.491	10.849	6.541	44.525
05/06	9.738	22.290	13.036	8.816	53.880
06/07	9.906	24.408	14.402	10.212	58.928
07/08	12.887	27.596	15.893	12.112	68.488
08/09*	15.290	29.414	17.580	13.444	75.728

* dati al 15 gennaio 2009
Fonte: e.i.i.b., Osservatorio Integrato Regione Veneto su dati ISTAT Scolastico Regionale per il Veneto (ARIS)

The importance of foreign students grows in all the scholastic systems with a global incidence of the 11% in all (Figure 10).

Figure 10.

Il peso degli stranieri aumenta in tutti gli ordinamenti



Alunni nelle scuole del Veneto per tipo di ordinamento. Anno scolastico 2008/09*

Ordine	Totale alunni	Alunni stranieri	Inc.% stranieri su Tot.
dell'Infanzia	134.465	15.290	11%
Primaria	228.706	29.414	13%
Sec. I grado	137.725	17.580	13%
Sec. II grado	194.635	13.444	7%
Totale	695.531	75.728	11%



Foreign students enrol mainly in the vocational (44% in 2009) and technical institutes (41%), while, in spite of the Italian students trend, a smaller share prefer a high school education (15%). The incidence of the foreigner on the total of the enrolled in institutes for vocational education has considerably grown, increasing from 9% in 2005 to 14% in 2009 (Figure 11).

Figure 11.

Cresce la concentrazione e il peso degli studenti stranieri negli istituti professionali: preferenze, compensazione o segregazione? Sono il 3% nei licei, l'8% negli istituti tecnici, il 14% negli istituti professionali



**Studenti iscritti nelle scuole secondarie di II grado.
Anno scolastico 2008/09***

Tipo istruzione		Italiani	Stranieri	Totale
Istruzione liceale e artistica		78.556	2.058	80.614
di cui	Liceo Scientifico	35.104	659	35.763
	Istituto e Scuola Magistrali	15.260	411	15.671
	Liceo Classico	19.308	327	19.635
Istruzione professionale		37.231	5.879	43.110
di cui	I.P. Industria e Artigianato	13.293	1.867	15.160
	I.P. Commerciale	10.257	1.343	11.600
Istruzione tecnica		65.404	5.507	70.911
di cui	I.T. Commerciale	28.598	2.256	30.854
	I.T. Industriale	23.043	1.039	24.082

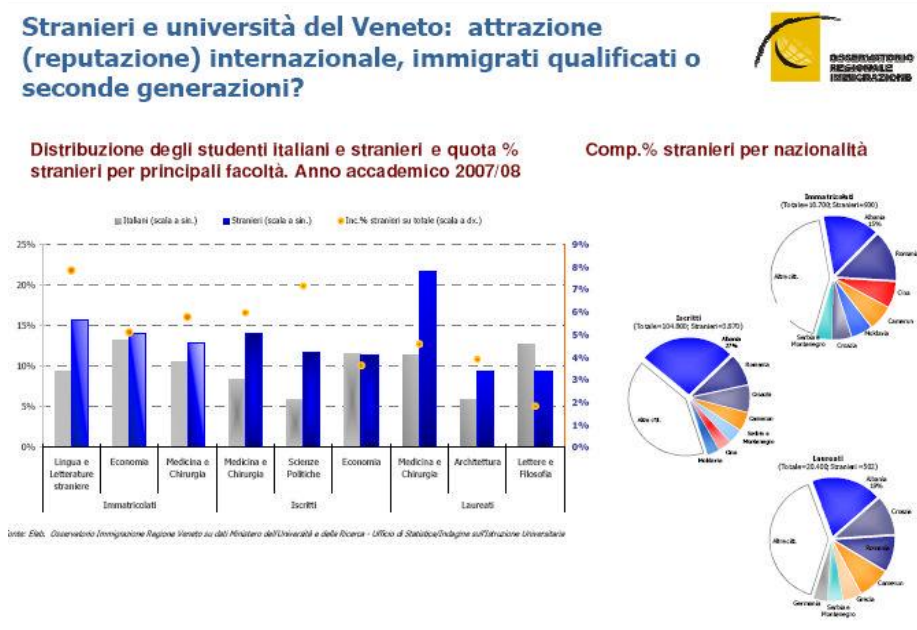
In the academic year 2007/2008 the weight of foreign students in the Veneto universities has been: 4% inscribed, 5% 1st year students, 2.5% graduated.

The 60% of the inscribed consists in the prevailing presence of young Albanians, followed by the Romanians, Croatian, Cameroon, Serbians, Montenegrin, Chinese and Moldavian.

Medicine and Surgery, Political Sciences, Economics and Languages and Foreign Literature represent the most appreciated Faculties grouping above all about half of the foreigners inscribed in the Veneto universities (Figure 12).



Figure 12.



3. Policy agenda

Health is an important resource not only for single individuals, but even for the whole community and it has to be reached and maintained daily with precise and aimed operative strategies.

Health is a basic state for the satisfaction and the physical, mental and social wellness of individuals and it is an important element for the contribution to the economic and social progress. To be harmonically in equilibrium it is not sufficient detect the absence of disease. (WHO Declaration 1948).

So the health concept is no more a unique and well definable concept but it becomes a concept open to the multiplicity of factors that compose it: genetic, biologic, psychological, social, spiritual. From here it begins the necessity to express common guidelines based on the scientific evidence that could be used by the governments to create health policies specific for their own country, and meanwhile inserted in a more large international context. From one side institutions are called to analyse, to improve and to sustain better social - economics and health conditions, from another side the single persons have to assume more the control of their own health status and become responsible of their own life style.

The mission of every professional man/service that operates for the public health is also to create opportunities for making nets and good relationship with relapse on sanitary governance; much more when we talk about the defence of the community health bound to the immigration reality.

The Service for Immigration (Struttura Alta Professionalità Immigrazione - SAPI) of the Local Health and Social Trust 16 of Padua (SAPI - AUSSL 16) is an example of social and health structure that coordinates, in the sphere of the defence of the health of regular and irregular



foreigners, the sanitary and social - sanitary problems connected. Its aim is the health of the individual through the listening and the social - health information, but also the defence of public health.

The management has favoured relations between different health professionals of the Health Trust, the hospital, the social providers and the voluntary organizations, the Municipalities, in a coordinated system of actions and interventions for the defence of public health. This has brought to the creation of a net of synergies and collaborations with local organizations, Diocese of Padua (Popular Kitchens and Caritas), Italian Red Cross, Hospital, Institutional Organizations, and with the activation of a Table for the Immigration where participated the Police Headquarters and the Prefecture of Padua.

The population assisted by the Local Health and Social Trust (AUSSL) 16 of Padua is of 409,994 persons and the immigrants assisted in 2007, including the Foreigners Temporarily Present (STP) were 36,838 people (Figure 13).

Figure 13. Foreigners assisted by AUSSL 16 of Padua, years 2002-2007. Data ULSS 16 - 2008

The foreigners resident in the city of Padua (211,936 inhabitants) at October 1st 2008 were 24,775 (9% of the total population), of whom 12,156 man and 12,169 women. To these we have to add the clandestine, of whom we do not have the real numbers.

The irregular/clandestine foreigners and the homeless, coming from other regional provinces can find hot food in the Popular Kitchen, subsidized by the Municipality and by the Diocese; they can also find various health and social - health services, activated by the institutions and not, given by the Caritas, the Municipality or by Cooperatives and Associations (contracted and of voluntary service), Sanitary Societies and Italian Red Cross.



4. Projects and good practices

Based on the highlighted needs and thanks to the professionalism of many subjects on the net, some projects, shared between the SAPI - AUSSL 16 of Padua with other Partners, are activated with the creation of precise agreement Protocols.

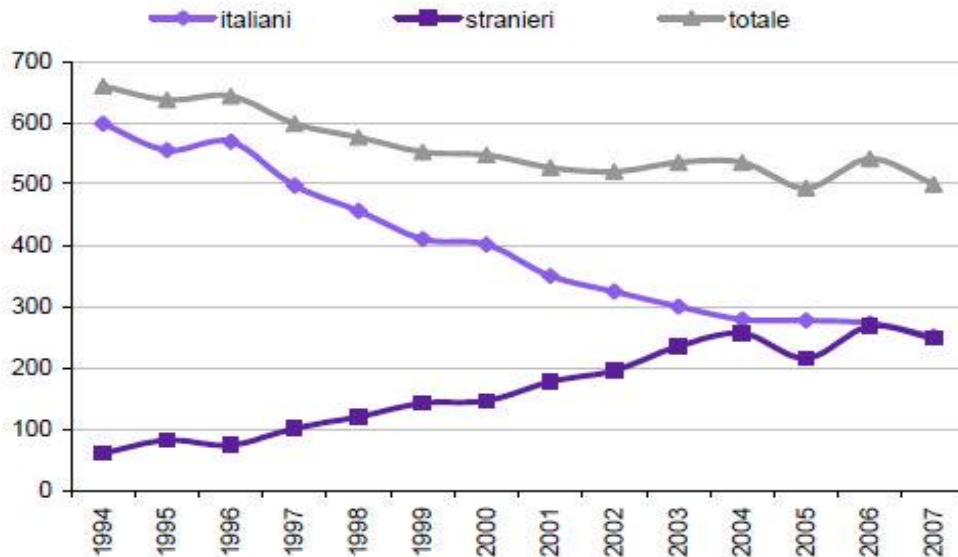
Migrant Friendly Hospitals

For what concerns the defence of the maternal-infantile health, inside the international project "Migrant Friendly Hospitals" there is the activation of a specific dermatology surgery, addressed to the immigrated women coming from extra EU Countries, irregular and nomads, at the Poliambulatorio of AULSS 16, in close synergy with the Microbiology and Virology Unit of the Hospital, for the diseases control, skin infestations and sexual transmission diseases.

TBC

For the active and passive prevention of the tuberculosis, local services are activated since the year 2000. A formal protocol has been signed in February 2007 for the management and overseeing of tuberculosis cases which is consistent with the New guidelines for the tuberculosis control in the Veneto Region (Delibera of the Giunta Regionale n. 2602 of 7 August 2007 - Regione Veneto) (Figure 14).

Figure 14. Tuberculosis in the Veneto Region data at 21/12/2007



Data from the Servizio Sanità Pubblica e screening Direzione Prevenzione - Regione Veneto - 2008.



The juvenile age and second generation

There is a Protocol with the Municipality of Padua for the health care to the "not accompanied teenagers" that provide for the activation of specific surgeries inside the Local Health and Social Trust of Padua. For these minors, in charge of the Social Interventions of the Municipality of Padua, are provided: paediatric visit, dermatology visit, chest radiography, X ray photograph of the wrist, check for contagious diseases, hematochemical exams, some vaccinations.

For the minors assisted by Communities of "Accoglienza", some Projects are in progress concerning the childhood, the adolescence and the family. An example is represented by the Regional Project "Scholastic and Social - Sanitary Integration, for migrant women and minors".

The problem of second generation minors, but also that of not accompanied alone minors, cases of which we know through "Spazio Ascolto" has involved and is involving the Service for Immigration in thinking to aimed interventions for the sanitary defence, but social defence too, especially considering the teenager phase of these subjects. It is well known that the relocation with the sense of loss and the consequential eradication can imply a suffering condition, made more pregnant in the not accompanied alone teenager, who, besides he has to face the strong elements of modification bound the change of country, he has also to deal with the inner personal conflicts (as body changes, sexuality) and inter personal conflicts typical of adolescence (as school, far away family, friendship).

The second generation boys of different ages, come in Italy very young following their parents or born in Italy by immigrant parents, enclose in themselves the synthesis of two worlds that must cohabit and integrate inside them too. In the multi-ethnic society, second generation minors witness the wish for of their family for territorial stabilization and Veneto is one of the most chosen regions.

Children born in Italy by foreign parents become the junction segment that well represent and reflects the passage happened from a temporary immigration to a lasting one, in many cases definitive which brings all the problems of the second generations.

If these two typologies of boys and girls, who will make the future Italian society, don't have since now the opportunities of integration, with scholastic and social exploitation, and inside the family, like a bridge, a link between the here and the elsewhere, the before and after, it is not hard to hypothesize in a near future an increase of "young Italians" with structural personality frailty and with physical repercussions.

The Service for Immigration of the Local Health and Social Trust 16 of Padua in the school

The planning of initiatives arranged and shared with the scholastic Headmastership of every order and grade, happens through the monthly appointment represented by the Inter Institutional Table on Immigration (operative since 2004), that afterwards analyses the results in terms of efficacy.



The activity of the Inter Institutional Table on immigration has been presented during the National Seminar of Training, made in collaboration with the Ministry of Education, the Ministry of University and of Research and the Regional Scholastic Bureau for Veneto (MIUR) in May 2009 in Abano Terme (Padova).

The project "The mutilation of female genital and the human rights t the migrant communities"

With the increment and the stabilization of the African families in Italy, is emerged the necessity to active the prevention of the female genital mutilations and the assistance for the women that they have suffered this practise at the countries of origin. This traditional practise is diffused in 28 African countries and in some of Arabic and Asiatic countries. Today around 130 millions of girls and women are submitted to this tradition.

The Italian law n. 7 of 9 January 2006 has taken in consideration this problem and through the adoption of varied measures, has provided different projects coordinated and financed by the Department of Equal Opportunities and realized in cooperation with non governative organizations and the migrant associations, local administration, relative to three areas: the research, the campaign of information and sensibility and the formation.

The project "Mutilation of female genital and human rights at the migrant communities" with the integrate activities of research, sensibility and education has been realized between may 2008 and may 2009, by AIDOS, in collaboration with ADUSU- Association for human rights and development of Padua and Opened Culture of Trieste, with the help of SAPI - AUSSL 16 that included all the public Health Trusts of Veneto.

The activities of this project provide the regional coordination, the realization of the qualitative research of the phenomenon in Veneto, the sensibility and information, formative possibilities, the realization of the final summit.

The educational method used was highly interactive. The referee had the role of director during the process of learning, leaving all the necessary space of the participants to learn from the experience of each others. The methodology included theory and practice, to stimulate the participants to think above the themes of their interests (activities) that each of them can take more confidence in promoting the women's rights and the changes of social and individual attitude. The participants received all the necessary material and the bibliography.

The participants to this course were health professionals daily involved with women coming from the Countries where the female mutilation is used.

The Service for Immigration of the Local Health and Social Trust 16 of Padua "Listening space for the foreigners"

The SAPI - AUSSL 16 is running the project "Listening Space for foreigners" which is offered to all the foreigners citizens regular and irregular with consultation, information and health orientation. It is open from Monday to Friday morning and two afternoons at the week, with two operators, and acts as:



- Valve for the emergency of the hospitals, overwhelmed by the informative requests and the inappropriate services, helping to direct towards the other health structures when the cases are not emergency;
- Thermometer of reading at the time of the changes of health needs of the foreigners, specially the irregulars, through the analyses of the requests of information coming as the requests of information above the care's procedure, obstetric-gynaecologic, paediatrics and vaccination, those relative at the very serious illness as the oncologic illness and the admission to hospital, for the transplantations of the organs, fisiokinesitherapeutics and riabilitatives ecc.;
- Precious observatory at the taking way of the unknown needs and try to give answers that are well received by the users.

An example

A particular example is related with irregular Chinese people in 2006. The large presence of Chinese people in Padua, particularly the families with children under 18 years old and their insufficient knowledge to the social-sanitary services, was a serious problem for the Service for Immigration and valid strategy to help the access of these persons specially of the female components and the teenagers to the public health services was necessary.

The involvement of a young Chinese as cultural mediator, in particular for the gynaecologic area, increased in one year the percentage of users from 2.8% to 18.5%. The main requests were related with the conditions of "foreign temporary present" and the use of the health document for a limited period, that the women can use during the pregnancy and during the first six months of the new coming, except the access to obstetric-gynaecologist visits, regarding the practice IVG, paediatrics visits and vaccinations.

One after the other have seen the first presents of pregnant women sheltered nearby the obstetrics departments, received with surprise by the sanitary personal as they have seen the few presents at the past. After the birth the report continuous with the multiethnic paediatric department.

This allowed to create nets, to compare, to consolidate good relations at the name of the governance of the immigration inside the Local Health Trust and not only, owing to the invitations versus the other Services or Departments (the collaborations that exists between multiethnic obstetric-gynaecologist service and the paediatric service of SAPI - AUSSL 16, with Red Cross, the Popular Kitchen, the Caritas, the Services of Local Administration the Offices of Registration of Municipality of Padua, the Police, the Unities of Emergency, are added the offices of Consulates, the Embassies and the specialist hospitals departments, in particular the Division of Infectious Diseases).

World Health Organization
Regional Office for Europe
Regions for Health Network



Migrants and Health Care: Responses by European Regions (MIGHRER)

Complete reference material

XIII. Regional report Wales

Denise Puckett¹



¹ Welsh Assembly Government



Summary

In Wales the migration is the main reason for continuing population growth. There is a consensus across Government, House of Lords, researchers that migration has an overall positive impact on the economy.

Someone who has or intends to change his or her country of usual residence for a period of at least a year is defined as an international migrants: so the migration phenomenon in Wales include Students from EU and extra EU, migrant workers, refugees and asylum seekers, other migrants extra EU and from EU. The main nationalities are Asian 48% and African 30%.

The Wales refugee council estimates the refugees currently living in Wales are less than 0.4% of the Welsh population, most of them have settled in Cardiff, Newport and Swansea. When Welsh became an official reception area for asylum seekers in 2001, the number of refugees increased.

The status and rights of migrants and refugees are set out under international laws, in particular the 1951 Convention relating to the status of refugees. Powers and responsibilities relating to migration have not been devolved to the Welsh Assembly Government. Since 1999 the UK Government has introduced policy and legislation about migration in the Immigration and Asylum Act (1999) which introduce significant changes to the way migrants and asylum seekers are supported in UK.

The Welsh Assembly Government's strategic agenda is based on the principle that all citizens are empowered to determine their own lives and to shape the communities in which they live. The strategy is underpinned by the principles of social justice, sustainability and inclusivity for all people in Wales. The refugees Inclusion Strategy is one of the ways in which these principles will be implemented.

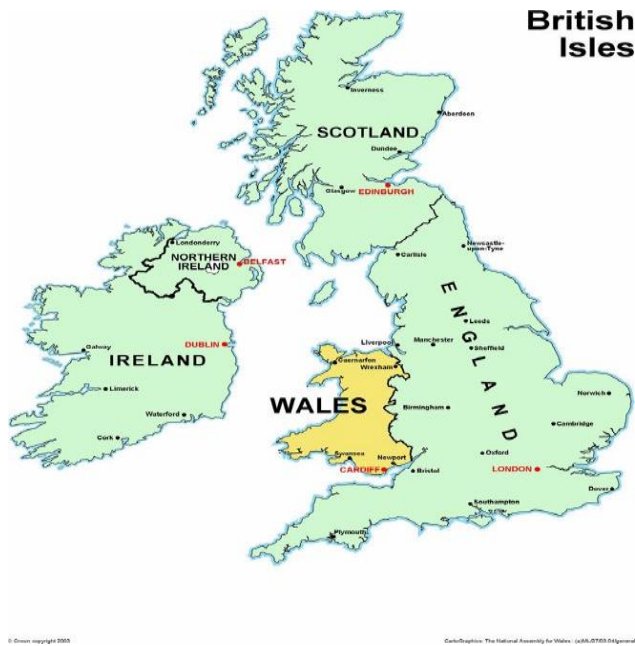
In Wales there are a lot of specific project and services for migrants. For example the "Welcome to Wales pack", targeted to migrant workers, to ensure them about their rights and responsibilities, and to help them fit in with the local community. In particular there are many practices and projects for refugees connected by the national strategies "UK-wide programmes to support refugee inclusion": the "Sunrise" is a a scheme created to facilitate smoother and quicker integration of refugees into the UK with a personal integration plan covering long-term integration objectives; the "Gateway" is a resettlement programme that aims to bring modest numbers of refugees into the UK who would not otherwise have the means to make the journey; the "Time together" project provides the work of pairs volunteer mentors with refugees to help them to achieve goals in education and employment and to integrate the communities their live in. A very important service for refugees is the "Refugee Integration and Employment service (RIES)", the UK border agency is redirecting the available budget for refugee integration to make available a standard set of integrations services for all new refugees through a regional asylum system.



1. Context and terminology

1.1. Context

Wales has a population of 2.9 million: around 5% of the population of the United Kingdom (UK) covering over 20,000 square km. Wales is 250 km from North to South. One million of the population live in rural areas, two million in urban areas.



Wales is officially a country with two languages - English and Welsh; almost everyone can speak English, and 21% of the population speak Welsh.

Wales is one of the newest self-governing countries in Europe. The National Assembly has 60 elected Members. The Government of Wales Act 2006 has given the National Assembly for Wales powers to make its own legislation on devolved matters such as health, education, social services, local government.

The National Health Service (NHS) was 60 years old last year - it was designed and introduced by Aneurin Bevan who was Welsh. Health care is free at the point of delivery for everyone, including failed asylum seekers. NHS health care covers all aspects of primary care, secondary care and community care.

1.2. Terminology

The Welsh Assembly Government published the Refugee Inclusion Strategy in June 2008. This strategy made clear distinctions between the terminology used to define refugees, asylum seekers and migrants in Wales. These definitions are provided below.



Refugee inclusion and integration

Refugee inclusion involves removing barriers which prevent refugees from becoming fully active members of society, who participate in, and contribute to, the economic, social, cultural, civil and political life of the country. The objective of refugee inclusion is the establishment of mutual and responsible relationships between refugees and their communities, civil society and government.

Refugees will make individual choices about the degree to which they wish to integrate into Welsh society. Refugee integration takes place when individual refugees become active members of society.

Asylum seekers and refugees

An asylum seeker is a person who is fleeing persecution in his/her homeland, has arrived in another country, made themselves known to the authorities and exercised the legal right to apply for asylum.

Under the 1951 United Nations Convention relating to the Status of Refugees, a refugee is a person who

“owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country ...” (United Nations High Commissioner for Refugees, 1951).

The UK Government recognises an asylum seeker as a refugee when s/he satisfies the above definition.

Within this policy, the term “refugee” also refers to those who have not been recognised as refugees, but have been granted indefinite leave to remain (ILR), humanitarian protection (HP) or discretionary leave (DL) following their asylum claim.

Receiving communities

The communities into which refugees settle are called receiving communities. This term can refer to the range of different communities - whether the immediate local community, a community of interest or broader society.

Migration

Migration is the movement of people from one state or locality to another. International migration includes the movement of refugees, displaced persons, uprooted people as well as economic migrants. A distinction is often made between forced migration and voluntary migration.



Forced migration

Forced migration refers to the movements of refugees and internally displaced people (people displaced by conflicts) as well as people displaced by natural or environmental disasters, chemical or nuclear disasters, famine, or development projects.

Trafficking

Article 3(a) of the United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention against Transnational Organized Crime (United Nations, 2000) defines trafficking in persons, for the purpose of the protocol, as:

“Trafficking in persons shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs”.

Migrants

The Commission on Human Rights considers the term “migrant”, in article 1.1 (a) of the Convention on Human Rights, should be understood as covering all cases where the decision to migrate is taken freely by the individual concerned, for reasons of “personal convenience” and without intervention of an external compelling factor (UN Economic and Social Council, 1998).

From this definition, it follows the term migrant does not include refugees, displaced persons or others forced or compelled to leave their homes. Migrants make choices about when to leave and where to go, even though those choices are sometimes extremely constrained.

Migrant workers

The UN Convention on the Rights of Migrants defines a migrant worker as a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national



2. Health systems overview, national situation

2.1. Health system functions - national overview

The National Health Service (NHS) is the name frequently used to describe the publicly-funded health care service in the United Kingdom excluding Northern Ireland. The NHS is mostly funded through general taxes and national insurance contributions.

Each healthcare system in Wales, England, Scotland and Northern Ireland operates independently, and is funded by, and politically accountable to its own government.

Collectively, the NHS was the third largest employer in the entire world in 2009, employing more than one in twenty employed people in the United Kingdom [2].

Three services for England and Wales, Scotland and Northern Ireland were originally established by separate pieces of legislation and commenced on 5 July 1948. In 1969, five years after the creation of the Welsh Office, in 1964, responsibility for public health services in Wales was split from the Department of Health in London that had previously been responsible for health in both England and Wales.

Responsibility for NHS Wales and NHS Scotland transferred from the Welsh Office and Scottish Office to the Welsh Department of Health and Social Services and the Scottish Government Health Department, following devolution in 1999.

There is no discrimination when a patient resident in one country of the United Kingdom requires treatment in another. The consequential financial matters and paperwork of such cross-border working are dealt with between the organisations involved and there is generally no personal involvement by the patient comparable to that which might occur when a resident of one European Union member country receives treatment in another.

Single Equality Scheme

The Single Equality Scheme (SES) will enable the Assembly Government to tackle equality, diversity and human rights issues across all equality strands. It will help to identify where people might face multiple barriers in their everyday lives.

The scheme builds on the three former equality schemes for gender, race and disability. It also focuses on the additional strands of religion and belief and non belief; age, sexual orientation and transgender issues. The scheme is firmly grounded in the principles of human rights: freedom; respect; equality and diversity.

The Scheme will run from 31 March 2009 until 31 March 2012. It will be monitoring and publishing progress made on a six monthly basis.



Impact Assessment

As with all public authorities in the UK, the Welsh Assembly Government must, by law, complete Equality Impact Assessments on policies and practices in respect of the general and specific duties for race and disability. In developing its Single Equality Scheme, the Welsh Assembly Government has committed to undertake impact assessment for all of the equality strands - age; disability; gender and transgender; race; religion or belief and non-belief; sexual orientation and human rights.

2.2. Structural Organisation at Regional Level HS Wales - (Welsh: *Gwasanaeth Iechyd Gwladol Cymru (GIG Cymru)*)

NHS Wales provides public healthcare in Wales and employs over 90,000 staff, making it Wales's biggest employer. The Minister for Health and Social Services is the person within the Welsh Assembly Government who holds cabinet responsibilities for both health and social care in Wales.

A map of the NHS Structure in Wales can be seen in Figure 1.

In 2009, Wales abolished the internal market, commission/contracting system and now has:

- Seven LHBs that plan and arrange provision of all health services.
 - o Each Local Health Board (LHB) has a widely-representative board of 22 people including general practitioners (GPs) and other health professionals, members of the local authority, a patient, a carer and others.
 - o LHBs are responsible for determining the health and well-being needs of their local population, and commissioning services from NHS Trusts and others to meet these needs. Around three quarters of the health budget is allocated directly to LHBs for this purpose. Health Commission Wales (an arm of the Welsh Assembly Government) is responsible for commissioning specialist health services for the resident population of Wales.
- A public health Trust, Public Health Wales.
- Two NHS Trusts that provide ambulance services and specialist cancer services.

Primary care services

Primary care services are provided by family doctors (also known as general practitioners or GPs), opticians, dentists, pharmacists, and other healthcare professionals.

There are more than 1,900 family doctors in Wales, more than 1,000 dentists, and some 600 opticians. Family doctors are the first point of call, referring people to hospitals or specialist treatment when necessary.



Other healthcare staff working in the community include: specialist community public health nursing; midwives; community nurses; physiotherapists; occupational and speech therapists; and practice nurses.

Secondary care

Secondary care refers to care in hospitals and services provided by ambulance services.

Tertiary care

Tertiary care refers to specialised care provided at some of the larger hospitals or through specialist hospitals treating particular types of illness such as cancer.

Community care

In addition to the above, community care services are provided in partnership with local social services. Community care services are usually defined as those services which are provided to patients in their own homes.

They include a range of primary care services provided by nurses, midwives, health visitors and services from other professionals such as occupational therapists.

NHS Direct Wales

NHS Direct Wales offers open access telephone and web-based information. Citizens call for nurse triage and advice if they are feeling ill and are unsure what to do, or for health information on a particular condition such as diabetes or asthma. Advisers can also give citizens information relevant to where they live, such as the nearest doctor, pharmacist, dentist or support group, as well as information on citizens rights as a patient, waiting lists times and any benefits available to them.

Citizens can call NHS Direct Wales on 0845 46 47 and speak to an adviser in English, Welsh or one of over 120 languages via a telephone translation and interpretation service. Citizens need to state in English the language they would prefer to use and an interpreter will be found.

On the website, citizens can find information about NHS Direct Wales in 28 languages. These include Albanian, Arabic, Bengali, Cantonese, Croatian, Czech, Farsi, French, German, Greek, Gujarati, Hindi, Italian, Japanese, Kurdish (Sorani), Mandarin, Polish, Portuguese, Punjabi, Russian, Serbian, Somali, Spanish, Swahili, Thai, Turkish, Urdu, and Vietnamese.

Minicom and Type Talk help NHS Direct Wales to make the service available for anyone with a hearing impairment. The textphone number is 0845 606 4647. Information can also be sent in Braille or on audiotape.



Community Health Councils

Community Health Councils (CHC) are the only statutory lay organisations with rights to information about, access to, and consultation with all National Health Service (NHS) organisations.

CHCs represent the interests of the public in the health service in their district. They give people an independent voice in their local NHS and the services it provides.

They are concerned with all aspects of the health service: they help people get the services they need by offering advice and information, they listen to what the public has to say about the quality of health services and they help, advise and support people who wish to make complaints about health services.

The Board of Community Health Councils in Wales ([external link](#)) provides a forum for CHCs for the exchange of information and ideas. It also:

- represents the collective views and interests of patients, the public and CHCs in Wales to the NHS, the National Assembly for Wales, other bodies and the media;
- raises issues of concern in relation to patients and the NHS at a national level;
- raises the profile of CHCs nationally;
- provides a training programme for staff and members;
- co-ordinates national research into issues of patient concern;
- acts as a source of central advice and information for CHCs.

National Advisory Board

The National Advisory Board (NAB) was established in April 2009 as part of the NHS Reforms in Wales.

The board is responsible for providing independent advice to the Minister for Health and Social Services to help inform her decisions on setting priorities for the NHS.

Chaired by the Minister, this board will hold its meetings in public wherever possible, with its board papers published. Members of the public are invited to attend the meetings.

Health Inspectorate Wales (HIW)

The Healthcare Commission promotes improvement in the quality of the National Health Service (NHS) and independent healthcare. It has a wide range of responsibilities, all aimed at improving the quality of healthcare. It has a statutory duty to assess the performance of healthcare organisations, award annual performance ratings for the NHS and coordinate reviews of healthcare by others.



National Leadership and Innovation Agency for Healthcare (NLIAH)

The National Leadership and Innovation Agency for Healthcare (NLIAH) was launched in March 2005. Its purpose is to provide a national strategic resource to support NHS Wales in delivering the Designed for Life agenda by building leadership capacity and capability to secure continuous service improvement underpinned by technology, innovation, leading-edge thinking and best practice.

NLIAH has a wide-ranging work programme that enables it to meet and contribute to the Designed for Life 2006 milestones, including:

- delivery of new and innovative models of clinical leadership;
- undertaking modernisations assessments across health communities;
- developing and introducing a new process for collecting and disseminating best practice and ensuring its uptake.

National Institute for Health and Clinical Excellence (NICE)

The National Institute for Clinical Excellence (NICE) was originally established in April 1999 to promote clinical excellence and the effective use of resources in the health service in England and Wales.

Following the Arms Length Bodies Review undertaken by the Department of Health in 2004, NICE merged with the former English Health Development Agency to become the National Institute for Health and Clinical Excellence (also known as NICE), and was re-established on 1 April 2005 as an England-only Special Health Authority.

The Welsh Assembly Government has an agreement in place with NICE covering the Institute's technology appraisals, clinical guidelines and interventional procedure guidance, which all continue to apply in Wales.

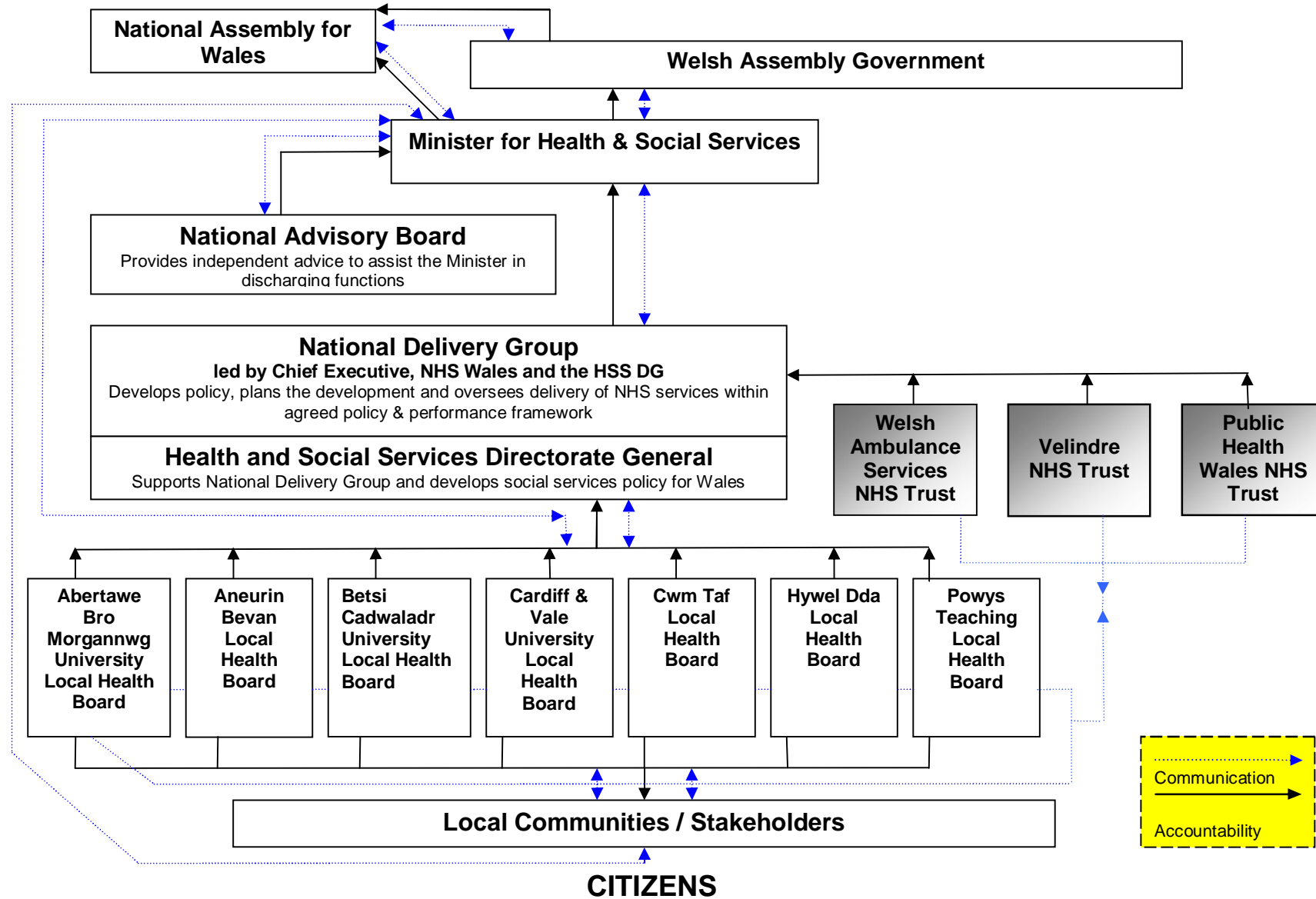
Wales Office of Research and Development

The Wales Office of Research and Development for Health and Social Care (WORD) develops policy on research and development (R&D), commissions and funds R&D activity and contract manages projects and initiatives to reflect the health and social care priorities of the Welsh Assembly Government.

Local Authorities

There are 22 local authorities that among other services provide social services, housing and environmental health services.

Figure 1. NHS Structure - Wales





2.3. Intersectoral actions

Refugee Inclusion Strategy

The Refugee Inclusion Strategy sets out the Welsh Assembly Government's vision of refugee inclusion in Wales.

Refugee inclusion takes place when a refugee becomes a fully active member of society, participating in and contributing to the economic, social, cultural, civil and political life of the country.

The overall aim of the inclusion strategy is to support and enable refugees to rebuild their lives in Wales and make a full contribution to society.

The specific objectives contained within this strategy focus on three areas:

- services and their delivery;
- fulfilling potential; and
- community cohesion.

The Refugee Inclusion Strategy is part of the strategic approach being taken by the Welsh Assembly Government to realise its broader vision of a prosperous future for Wales that is free from racism and discrimination, where everyone is enabled to fulfil their potential, to have fair and equal access to services and participate fully in the political and civil life of the country.

The Refugee Inclusion Strategy provides the strategic framework for realising the aim of ensuring refugees are able to rebuild their lives in Wales and make a full contribution to society. Specifically, the purpose of the strategy is to:

- provide a clear strategic framework for all those working towards refugee inclusion in Wales; and
- co-ordinate the work of the Welsh Assembly Government and its partner organisations to maximise impact and resources.

The three year Implementation Action Plan will:

- set out the actions the Welsh Assembly Government and its partner organisations will take over the coming three years to achieve the objectives outlined in the Refugee Inclusion Strategy; and
- provide a framework for monitoring and evaluating achievements against objectives.

Principles underpinning the Refugee Inclusion Strategy

The strategy is underpinned by a number of fundamental principles:

- The Welsh Assembly Government welcomes refugees/asylum seekers to Wales. Refugees make an enormous contribution to the economic, social and cultural life of Wales.



- Refugee inclusion begins on day one of arrival in the UK and successful inclusion is closely related to the standard of reception procedures and people's experiences as asylum seekers.
- Refugees/asylum seekers are ordinary people in extraordinary circumstances who have the right to be treated with respect and dignity at all times.
- Refugee inclusion is about participation and partnership. The participation of refugees in decision-making, as well as monitoring and evaluating policy, is central to inclusion, as is the need to address concerns of non-refugee communities.
- Refugee inclusion does not imply assimilation. Assimilation suggests the abandonment of cultural difference and distinctiveness in favour of homogeneity. Inclusion, by contrast, implies a reciprocal and mutually respectful relationship, in which individuals with diverse backgrounds and histories are able to make distinctive contributions to society.
- Inclusion involves acknowledgement and respect for cultural differences with the objective of ensuring people can maintain aspects of their own cultural heritage while participating equitably in society. Inclusion, therefore, places responsibilities on refugees/asylum seekers and on established communities.
- There is enormous diversity amongst refugee/asylum seeker communities in Wales, in terms of gender, age, nationality, language, faith, culture and skills. The diversity refugees and asylum seekers bring to Wales is to be celebrated and the Welsh Assembly Government actively promotes equality of opportunity for all.
- The Welsh Assembly Government recognises the existence of racism, including institutional racism, and will challenge this and actively promote good relations between refugee and asylum seeker communities and receiving communities.
- For refugee inclusion to become a reality, it must be mainstreamed across the work of the Welsh Assembly Government and its partner organisations.
- **Housing:** a Refugee Housing Action Plan has been issued, guidance has been issued on refugee/asylum seeker housing provision and funding has been provided for refugee housing support.
- **Health:** guidance has been issued for health practitioners, which provides targeted funding and a system of monitoring delivery through Local Health Boards. A database of refugee health professionals has been established.
- **Education:** targeted funding has been provided to Local Education Authorities to support refugee inclusion in schools. A whole school approach to inclusive education will also be promoted by new guidance on the principles of minority ethnic achievement and through a good practice teaching aid.
- **Voluntary and community organisation initiatives:** a range of voluntary sector initiatives specifically aimed at promoting refugee inclusion have been funded. Voluntary



and community organisations working in this field are also eligible to apply for other Welsh Assembly Government grants.

Refugee inclusion has also been facilitated by Refugee Week Wales and several community initiatives, including those led by refugees.

Migrants Forum

The Migrants Forum is chaired by Dr Brian Gibbons AM, Minister for Social Justice and Local Government. The Forum is a multi agency group and the core membership consists of senior officials from across the Welsh Assembly Government and key representatives from external organisations.

The Migrants Forum sits within the wider strategic arena of national and regional groups. This includes the Migration Impacts Forum and the National Stakeholders Forum. The Migrants Forum will provide targeted information of national importance, as well as receive updates/information from the above groups. The Forum does not have any decision making powers.

The Forum will work to ensure a more strategic, co-ordinated and effective approach is taken to supporting the successful inclusion of migrants, their families and communities in all aspects of Welsh society

The All Wales Community Cohesion Project

The aim of the project is to promote more cohesive communities across Wales, with shared values and with equal opportunities in all areas of Welsh Society.

In partnership with the Welsh Association of Chief Police Officers, have initiated the All Wales Community Cohesion Project. This project will be guided by a steering group consisting of a number of key stakeholders including:

- Welsh Assembly Government
- Welsh Association of Chief Police Officers
- Welsh Local Government Association
- The Commission for Equality and Human Rights
- Faith Communities Forum
- Borders and Immigration Agency
- Home Office Crime Team

The project will seek to raise awareness of community cohesion issues in Wales, increase knowledge of good practice in relation to improving community cohesion in communities, and provide advice on mapping the changing make up of communities in Wales. This will allow the Welsh Assembly Government, local authorities and partners to respond to changing needs.



There are a number of phases of the project, they include:

- The development of advice for mapping and profiling of Welsh Communities;
- Looking at existing Community Cohesion work being conducted within the Welsh Assembly Government, Welsh Police Forces, Local Authorities and Voluntary and Community partners;
- Tackling the community cohesion aspects of extremism within Wales and across our borders with other nations;
- The creation and collation of a community cohesion toolkit for Wales which will reflect the good practice being conducted, and provide guidance to Local Authorities in relation to specific projects and schemes available;
- The preparation of an All Wales Community Cohesion Strategy and Implementation Plan.

Wales Strategic Migration Partnership (Asylum Seekers, Refugees and Migrants) (formerly the Welsh Consortium for Refugees, Asylum Seekers & Migrants)

The Welsh Consortium for Refugees, Asylum Seekers & Migrants was one of eleven regional consortia established across the UK in 2001 to facilitate the effective dispersal of asylum seekers across the UK.

Since April 2007, all the regional Consortia have evolved into Strategic Migration Partnerships as the remit of the partnerships evolved to include migrant workers as well as refugees and asylum seekers.

The WSMP (Asylum Seekers, Refugees & Migrants) plays a lead role working with a range of partners from the statutory, voluntary and community sectors in the development of strategic policies and initiatives on asylum seekers, refugees and migrants in Wales.

As part of their "enabling role", Strategic Migration Partnerships operate as the prime vehicle for consultation, liaison and partnership working between the UK Border Agency (UKBA) (formerly the Border & Immigration Agency) and other public, voluntary and private sector stakeholders in their respective regions and in Wales, Scotland and Northern Ireland, on migration issues.

The lead local authority of the WSMP (Asylum Seekers, Refugees & Migrants) is Newport City Council and as such Newport City Council signs an 'enabling grant agreement' on behalf of the WSMP with the UKBA.

The enabling role is defined as

"providing a regional (or in Scotland, Wales, or Northern Ireland - a National) advisory, development and consultation function for member organisations from the statutory, voluntary, community and private sectors - for the co-ordination and provision of advice, support and services for migrants."



Key Aims & Objectives

- Provide a regional (or in Scotland, Wales, or Northern Ireland - a national) multi-sector, multi-agency Strategic Migration Partnership structure to deliver the requirements of the enabling role.
- Facilitate and promote the effective contact, co-ordination and partnership working between the Strategic Migration Partnership and a range of organizations, including local authorities, police services, health authorities, employment and career services (including Jobcentre Plus), Government Regional Offices, the regional CBI/Employers Forum, the regional TUC, local and regional voluntary groups (including One Stop Service Providers), and the private sector (principally the UKBA contracted accommodation providers) - working across localities and service providers.
- To facilitate regional (or in Scotland, Wales, or Northern Ireland - National) strategic co-ordination discussions.
- To gather regional (or in Scotland, Wales, or Northern Ireland - national) data and trends, and monitor and evaluate the impact of asylum and other immigration policies on the dispersal process and provision of support and services for refugees, asylum seekers and migrants.
- To promote community safety and cohesion through a multi-agency approach.
- To identify and seek to address gaps in resources, service provision and delivery to refugees, asylum seekers and migrants.
- To ensure that local authority emergency planners and other relevant organisations are aware of the existence (and, where appropriate, placement) and additional needs of refugees, asylum seekers and migrants (some of whom will have limited or no understanding of English).
- To manage information regarding refugees, asylum seekers and migrants by translating for local and regional (or in Scotland, Wales, or Northern Ireland - national) use policies and current trends/thinking (including, where appropriate, those from devolved administrations in Scotland, Wales and Northern Ireland).
- To co-ordinate participation in and response to BIA consultation exercises regarding migration.
- To provide training and awareness regarding refugees, asylum seekers and migrants to local authorities and other organisations.

The WSMP (Asylum Seekers, Refugees & Migrants) is currently conducting a "mapping exercise" across Wales to ensure coordination on migration issues. This work is being carried out in partnership with the Welsh Local Government Association and the Welsh Assembly Government.



2.3. Health information system

Extrapolation of data in relation to migrants directly from health service data is not possible. Health data such as, hospital attendances, treatment, GP registrations and the Wales Health Survey may include information on ethnicity and country of origin but migration status cannot be identified from this.

The Welsh Assembly Government monitors the performance of the NHS through various measures and standards. One of the ways the Assembly Government achieves this is by issuing an Annual Operating Framework each year. The Annual Operating Framework (AOF) is designed to help organisations improve the health services they provide by setting out clearly what the Welsh Assembly Government requires them to do. It contains policy requirements, national targets, and efficiency and productivity measures that must be achieved and maintained during the year ahead.

NHS organisations in Wales, Local Health Boards, and NHS Trusts provide quarterly updates on how they are progressing and achieving these measures and targets during the year. The organisations provide a quarterly report called a balanced scorecard for the Welsh Assembly Government.

In July 2008¹ the UK Statistics Authority initiated a review of migration statistics. At that time the statistics were already being improved in response to previous reviews and the recommendations of a report from the House of Commons Treasury Committee. The purpose of the monitoring review was therefore to report on progress, the adequacy of the plans for improving the statistics, and the extent and effectiveness of co-operation across government to deliver the improvements. This review concludes that much useful work is being done to deliver moderate improvements in the short to medium term, while the longer term goal - for high quality migration statistics derived from an integrated statistical system that draws on administrative and survey/census data - will take some considerable time to realise, perhaps decades.

Statistical reports on migration include:

- Bulletin: Patterns of Migration in Wales
<http://wales.gov.uk/topics/statistics/headlines/pop-2007/hdw200602151/?lang=en>
- Bulletin: Patterns of Migration for Wales: Rest of the UK and International
<http://wales.gov.uk/topics/statistics/theme/population/migration/?lang=en>
- Wales's Population A Demographic Overview 2009 - This publication focuses mainly on population, but it does include a chapter on migration.
<http://wales.gov.uk/docs/statistics/2009/090326walespop09en.pdf> (pdf, 857 Kb)
- Migration data are also available on our StatsWales website:
<http://www.statswales.wales.gov.uk/ReportFolders/reportFolders.aspx>



Importance of migration statistics

International migration is currently the largest component of population change in the United Kingdom - since the late 1990s it has exceeded the net effect of births and deaths and it increased substantially following the expansion of the European Union. However the statistical concept of migration also includes the movement of people within the UK. Such internal movements can have a substantial influence on the changing level and composition of the population in local areas. Accurate measurement of the net flows of people, both into and around the country, is thus essential to obtaining reliable population estimates. These estimates are at the heart of decisions around policy development. (Source: Migration Statistics the Way Ahead, national Statistics Office, July 2009)

3. Regulations and legal framework

3.1. International and European legislation

The status and rights of refugees are set out under international laws, in particular the 1951 Convention relating to the Status of Refugees. Refugees and asylum seekers are also protected under other international agreements, including the Universal Declaration of Human Rights.

The Welsh Assembly Government is committed to the principles set out in the 1951 Convention and to upholding its responsibilities under the Human Rights Act.

3.2. United Kingdom legislation and policy

Powers and responsibilities relating to immigration and asylum have not been devolved to the Welsh Assembly Government and, thus, remain the responsibility of the Home Office. Since 1999, the UK government has introduced policy and legislation which have brought about a number of changes.

The Immigration and Asylum Act 1999

The Immigration and Asylum Act 1999 introduced significant changes to the way asylum seekers are supported in the UK, including dispersal. Part VI of the act, provides for the dispersal of individuals who are seeking asylum and applying for accommodation and subsistence support to particular areas of the UK, on a no-choice basis. The provision does not apply to asylum applicants who are self-supporting or apply for subsistence only support.

Prior to the act coming into force, asylum seekers generally remained in the area where they arrived, the majority living in London and the south east of England.



Controlling our Borders: making migration work for Britain

In February 2005, the UK Government set out a five-year asylum and immigration strategy, *Controlling our Borders: making migration work for Britain* (Home Office, 2005a). The aim of the strategy is to build on previous reforms, which have strengthened border control, reduced the level of asylum applications and increased the numbers of removals (Home Office, 2005a).

The strategy is being implemented through the Immigration, Asylum and Nationality Act 2006 and through policy initiatives, such as the New Asylum Model (NAM) and Managed Migration. A number of changes have taken place as a result of *Controlling our Borders* which include the terms on which refugee status is granted and the processes involved in assessing claims for asylum.

- Section 71(1) of the Race Relations Act 1976 (as amended) which places a duty on Welsh Ministers (and other bodies specified in Schedule 1A of the Race Relations Act 1976) when carrying out their functions to have due regard to the need to eliminate unlawful racial discrimination and promote equality of opportunity and good relations between persons of different racial groups.
- Section 77(1) of the Government of Wales Act (GOWA) 2006 places a duty on Welsh Ministers to make appropriate arrangements with a view to securing their functions are exercised with due regard to the principle there should be equality of opportunity for all people.
- Section 70 of GOWA 2006 allows Welsh Ministers to give financial assistance (whether by way of grant, loan or guarantee) to any person engaged in any activity which Welsh Ministers consider will secure, or help to secure, the attainment of any objective which they aim to attain in the exercise of any of their functions.
- Section 71 of GOWA 2006 allows Welsh Ministers to do anything which is calculated to facilitate, or is conducive or incidental to, the exercise of any of their other functions.

The Welsh Ministers have powers to make regulations setting out charges for the provision of treatment (i.e. exemptions to the general principle that NHS services are free at the point of delivery (section 1(3) National Health Service (Wales) Act 2006). The relevant regulations are the National Health Service (Charges for Overseas Visitors) Regulations 1989. These Regulations were made pre-devolution, however, the function of making regulations in this regard are now vested in the Welsh Ministers. The regime at present provides for overseas visitors to be charged save where certain exceptions apply.

The NHS in Wales exists primarily to provide health services for people who live in Wales. Access to health service treatment is based on ordinary residence in the United Kingdom. Anyone who is not ordinarily resident in the UK and who requires hospital treatment is subject to the NHS (Charges to Overseas Visitors) Regulations 1989 ("the 1989 Regulations"), which apply in England and Wales.

The 1989 Regulations place a responsibility on NHS Trusts to establish whether a person is ordinarily resident; exempt from charges under one of the exemption categories in the Regulations; or liable for charges. Some of the exemptions relate to services themselves, such



as treatment provided in an accident and emergency department, or treatment for certain specified diseases. Others exemptions relate to individual circumstances and international agreements. Mrs Hart said in May 2008 that she intended to make the change and has since been consulting with the NHS and church leaders on the proposals.

The Health Minister said: "I have made clear that the aim of these changes is to ensure that people who are in need of healthcare receive it. I believe the mark of a civilised society is the way in which it treats its people, particularly the sick and dying".

Allow failed asylum seekers to receive hospital services free of charge until they return to their country of origin.

The arrangements for missionary workers to receive hospital services free of charge.

Allow the spouse or civil partner and any children under the age of 16 (or under 19 if still at school or college) of crown servants posted overseas, members of Her Majesty's armed forces, employees of the Commonwealth War Graves Commission and the British Council, persons working overseas whose employment is funded in part by the UK Government and in part by the government of another country, missionaries and victims of human trafficking to be exempt in their own right even when the spouse or civil partner or child are not living permanently with the overseas exempt visitor.

3.2. Amendments

Regulation 2(a): Failed Asylum Seekers

Currently the 1989 Regulations only allow an overseas visitor who has been accepted as a refugee or whose application to stay as a refugee has not yet been determined, to be entitled to free NHS treatment. Failed asylum seekers can complete a course of treatment which was started while their application was still under consideration, but for any new treatment can be charged.

For some failed asylum seekers, the Home Office are often not able to return them to their home country because it is not safe to do so. Often they become destitute whilst they remain in the UK because not all failed asylum seekers receive financial support and so they are not always in a position to pay for NHS treatment.

The amendment to the 1989 Regulations contained in regulation 2(a) of the proposed draft Regulations will mean that all failed asylum seekers will be entitled to free NHS treatment until their point of departure to their country of origin.

To place this amendment in context, there were 1,434 applications for asylum in Wales in 2007 and 652 applications refused.

In 2008 there were 1,725 applications for asylum in Wales and 530 applications were refused.



Regulation 2(b): Missionaries

An amendment to the 1989 Regulations in 2004 placed a 5 year limit on how long a UK citizen could spend working outside the UK. After that time, they would no longer be exempt from charges if they returned to the UK in need of hospital treatment. A considerable number of missionary organisations contacted the Department of Health to argue that the nature of missionary work made it a special case.

The amendment contained in regulation 2(b) of the proposed draft Regulations will mean a missionary worker who has worked abroad for more than 5 years will be entitled to free NHS treatment if they return to the UK.

Regulation 2(b): Human Trafficking

The 1989 Regulations were amended in 2008 to extend the exemption from charges to overseas visitors to overseas visitors who are victims of human trafficking. The proposed Regulations remove and then reinsert this provision in a different place in the 1989 Regulations but this is purely a drafting point in the interest of clarity.

Regulation 2(c): Spouse, Civil Partner or child

An amendment to the 1989 Regulations in 2004 meant that family members of crown servants posted overseas, members of Her Majesty's armed forces, employees of the Commonwealth War Graves Commission and the British Council and persons working overseas whose employment is funded in part by the UK Government and in part by the government of another country are all exempt from charges as long as the exempt person was with the family member in the UK at the time of treatment.

A number of Government Departments highlighted that this was not always possible e.g. wives of soldiers deployed abroad routinely return to the UK to give birth, but under the current arrangement would be liable to be charged because their husbands could not be with them in the UK.

An amendment contained in regulation 2 (c) of the draft Regulations will mean that the spouse or civil partner and any children under the age of 16 (or under 19 if still at school or college) of crown servants posted overseas, members of Her Majesty's armed forces, employees of the Commonwealth War Graves Commission and the British Council, persons working overseas whose employment is funded in part by the UK Government and in part by the government of another country, missionaries and victims of human trafficking will be exempt in their own right even when the spouse, civil partner or child are not living on a permanent basis with the overseas visitor in the UK.



Regulation 3: Countries

The countries or territories of Bulgaria, the Czech Republic, Hungary, Malta, Poland, Romania and the Slovak Republic, which are now part of the EU, were party to individual bilateral healthcare agreements with the UK and therefore listed in Schedule 2 of the 1989 Regulations which lists the countries or territories in respect of which the UK government has entered into a reciprocal agreement. Since EU healthcare Regulations take precedence over bilateral agreements, and in general offer more extended eligibility for access to free healthcare, these countries need to be removed from the list in Schedule 2 as they have become part of the European Union.

4. The migrant phenomena in Wales

4.1. General characteristics and extent of the migration phenomenon in the region

The issue of migration is of increasing importance in the context of social and economic change in Wales. With an ageing population coupled with only slightly more births than deaths in recent years, migration is the main reason for continuing population growth.

Total International Migration (TIM) is estimated by combining data from the International Passenger Survey (IPS) and Home Office data on asylum seekers and visitor switches with estimates of migration between the Republic of Ireland and Wales from the Irish Labour Force survey. Prior to 1992, international migration estimates are only available using data from the IPS alone.

Cross-border migration refers to people moving within the UK to or from Wales. The UK does not have a compulsory system to record the movements of its citizens, therefore when measuring migration within the UK, data from the National Health Service Central Register (NHSCR) is used as a proxy. The register records movements of patients when they move former health authority area.

Internal Migration refers to the movement of people within Wales, for example, from one local authority to another. Each Health Authority holds a register of patients registered with its GPs, called the Patient Register Data System (PRDS). Combining every patient register in England and Wales and comparing with the register from the previous year identifies people who have changed their postcode. An internal migrant is then defined as a person who has changed their area of residence between one year and the next.

The Office of National Statistics (ONS) is currently undertaking a significant program of work on improving population and migration estimates. Further information on this program of work is provided in the Quality Section.

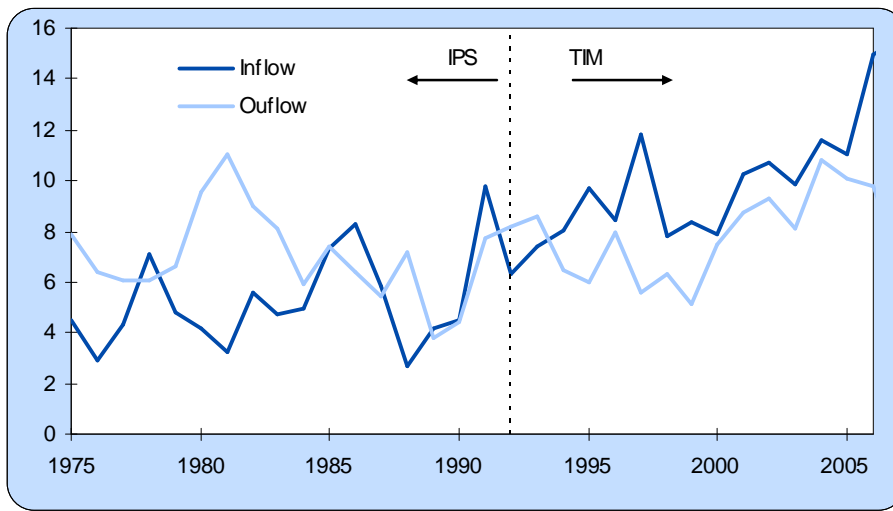


International Migration

Someone who has or intends to change his or her country of usual residence for a period of at least a year is defined as an international migrants. This section examines international migration flows between Wales and the rest of the World (excluding the rest of the UK) from 1975 to 2007, which can be seen in the chart below.

Figure 2. International migration flows, Wales, 1975 to 2007

Thousands



Source: Prior to 1992: International Passenger Survey. 1992 onwards: Total

International Migration data (IPS combined with asylum seekers and persons admitted as short term visitors who subsequently granted an extension of stay for other reasons. Also includes migration between Wales and the Irish Republic).

It is not clear how many refugees are currently living in Wales due to the lack of reliable official data. Estimates of the refugee population in Wales have, however, been published. The Welsh Refugee Council, for example, estimates there are just over 10,000 refugees currently living in Wales, less than 0.4% of the Welsh population².

Prior to 2001, relatively low numbers of refugees decided to settle in Wales compared to some parts of the UK, with 3,565 refugees in Wales in 1997. When Wales became an official reception area for asylum seekers in 2001, the numbers of refugees increased as a relatively high number of those given leave to remain choose to settle here. Most refugees have settled in Cardiff, Newport and Swansea, with smaller numbers in Wrexham and smaller numbers again living outside these areas.

² Based on 2001 census.



Types of migrant in Wales include:

- students - EU Countries 6,775 - other International Students 11,335 (Education and Lifelong Learning Statistics Unit 2008)
- a number of Migrant Workers on the Workers Registration Scheme for Wales between May 2004 - Mar 2008 21,900 - the estimated real figure is 135,000 (Statistics for Wales Jul 2008)
- a number of employed residents who were born outside the UK
- Non-Accession EU Countries 17,200 - rest of the world 8,300 (Statistics for Wales Jul 2008)
- Not defined as Migrants in the UK - Refugees 10,000 - Asylum Seekers 2,500 (Sept 2007) (Refugee Inclusion Strategy WAG - June 2008)
- Internal Migration - Wales & UK

4.2. Composition of migrant flow

- In the first quarter of 2008, a reduction in inflow was seen - the first since 2004
- +14,000 residents from the A8 countries between 2004-2007 also +16,000 from the rest of the World over same period.
- In both cases 90% of working age
- Only 3% were over statutory retirement age.
- In 2007, the average number of people entering Wales for 12 months or more is 15,000, the average number of people leaving Wales for 12 months or more is 10,000 (ONS 2007)



Figure 3.

**Residents of Wales who were born outside the UK
- Rest of the World (2007)**

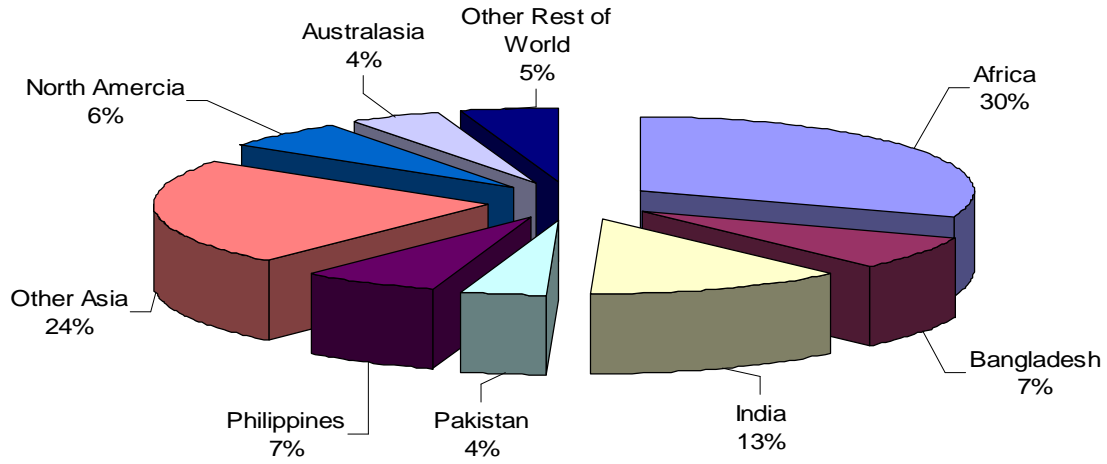


Figure 4.

**Worker registration Scheme Approvals In
Wales up to Q1 2008 by country of origin (A8)**

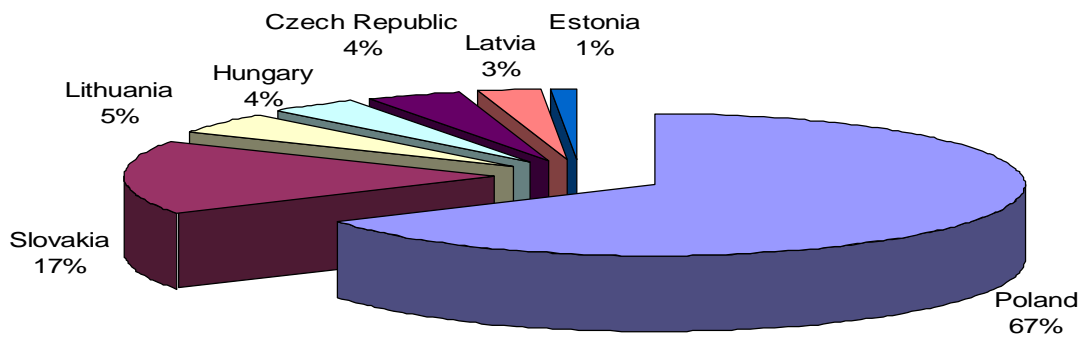
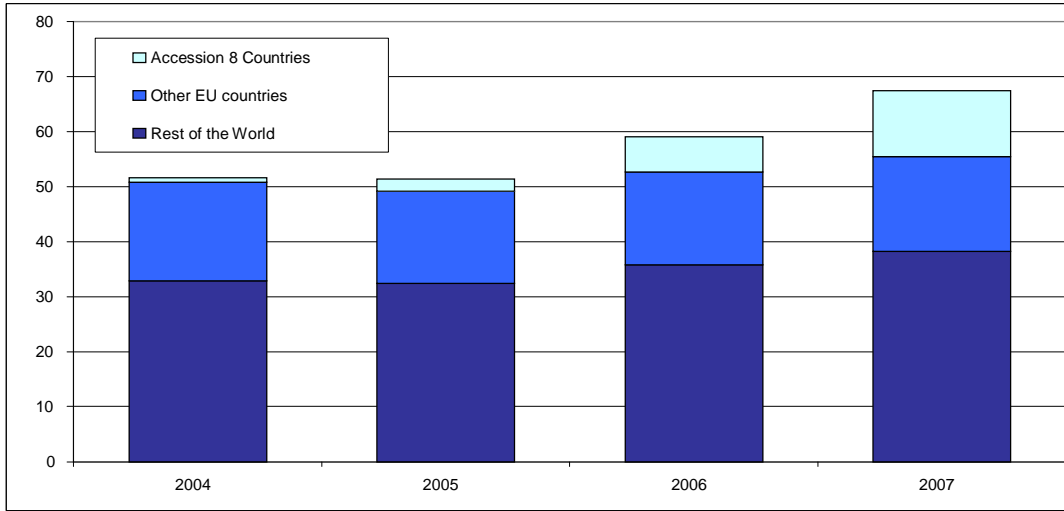




Figure 5. Number of employed residents in Wales born outside the UK (thousands)



Numbers of migrant workers - 2008

Flintshire	1,730
Newport	2,995
Wrexham	3,780
Cardiff	2,720
Carmarthenshire	3,405

Figure 6. Top 5 locations for migrant workers shown as % of total population

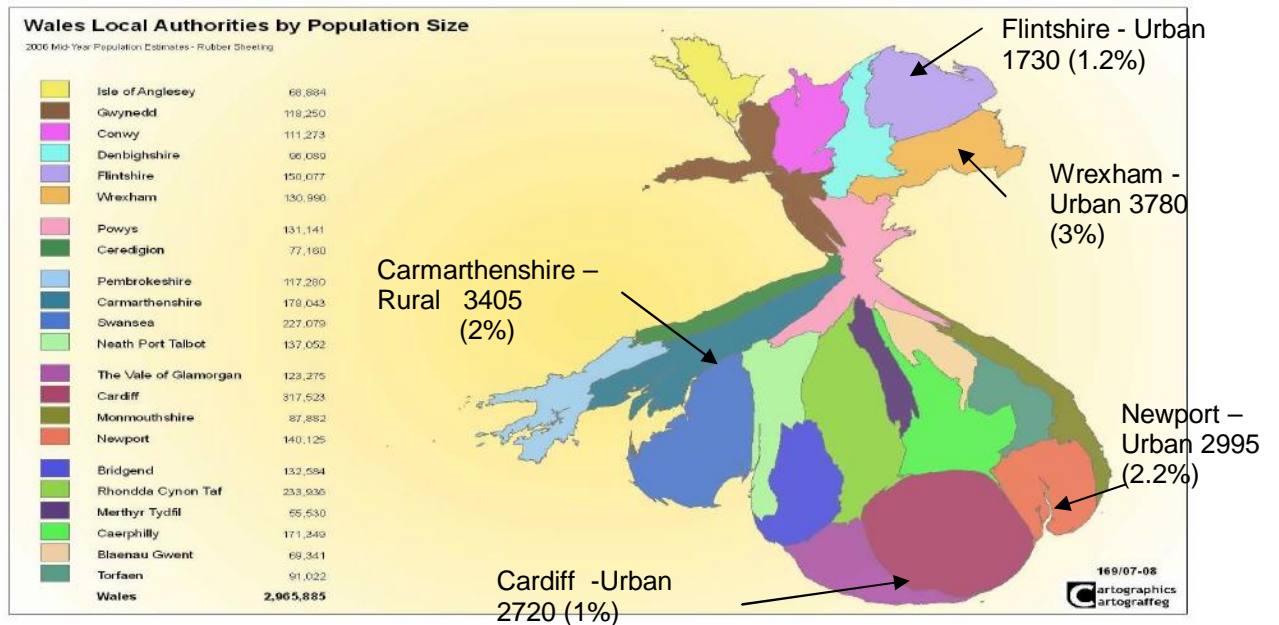




Table 1. Migration indicators by local authority, from mid 2004-05 to mid 2006-07

	Internal migration (a)		International migration (b)		International migration	All migration
	In	Out	In	Out		
Isle of Anglesey	6,800	5,900	400	500	4	65
Gwynedd	13,900	13,600	1,300	900	6	84
Conwy	13,600	11,900	800	900	5	82
Denbighshire	13,300	11,200	800	700	5	90
Flintshire	13,200	13,300	900	800	4	63
Wrexham	10,800	9,900	1,300	900	5	58
Powys	16,300	13,500	900	900	5	80
Ceredigion	15,500	14,700	1,600	900	11	141
Pembrokeshire	11,800	10,000	1,000	800	5	67
Carmarthenshire	18,300	14,300	1,200	1,300	5	66
Swansea	22,700	22,200	4,600	2,600	11	76
Neath Port Talbot	11,500	9,900	400	800	3	55
The Vale of Glamorgan	14,600	12,800	2,100	1,800	11	85
Cardiff	45,400	46,700	13,700	7,700	23	119
Monmouthshire	12,200	11,200	600	700	5	94
Newport	13,700	14,200	1,800	1,800	9	75
Bridgend	11,600	9,100	700	700	4	56
Rhondda Cynon Taf	16,200	16,300	2,300	2,200	6	53
Merthyr Tydfil	3,700	3,800	200	300	3	48
Caerphilly	12,600	12,100	600	1,200	3	51
Blaenau Gwent	4,700	4,400	200	300	2	46
Torfaen	6,700	6,700	200	400	2	51

Source: Office for National Statistics

Asylum seeker profile

The Welsh Assembly Government recognises immigration and asylum matters are not devolved matters. There are, however, a wide range of ways in which asylum seekers come into contact with services which are devolved such as health, housing, social services and education. Some of these services make no practical distinction between asylum seekers and refugees in terms of delivery. The Welsh Assembly Government considers it appropriate, therefore, to consider issues relating to the interaction of asylum seekers with devolved services. Many of the actions set out in this strategy, and in the Implementation Action Plan, relate to both asylum seekers and refugees, while some are specific to one or other groups.



Figures from the Home Office (2007a) indicate there are 2,500 asylum seekers dispersed by National Asylum Support Service (NASS) in Wales, less than 0.1% of the population³. The asylum seeker population falls under two distinct sub-groups:

- people who receive National Asylum Support Service accommodation and support and have been dispersed to Wales on a no-choice basis; or
- people who receive subsistence only National Asylum Support Service support, have chosen to live in Wales and found their own accommodation.

In March 2004, 95% of people seeking asylum in Wales received National Asylum Support Service accommodation and support (Welsh Assembly Government, 2005a).

Asylum seekers living in Wales originate from over 60 countries and speak over 40 different languages⁴. Refugee movement is dependent on world events. The countries of origin of asylum seekers change over time. In April 2006, the top ten nations of origin of refugees in Wales were: Pakistan, Somalia, Iran, Turkey, Iraq, Congo (Democratic Republic) Afghanistan, Sudan, Zimbabwe, and Algeria (Welsh Consortium for Refugees and Asylum Seekers, 2007).

Profile of receiving communities

Asylum seekers are dispersed to National Asylum Support Service accommodation located in Cardiff (49%), Newport (17%), Swansea (33%) and Wrexham (1%) (see table one below).

Table 2. Regional distribution of asylum seekers (including dependants) in dispersed accommodation by local authority, as at September 2007

Dispersal Area	
Cardiff	1,225
Newport	415
Swansea	820
Wrexham	35
<i>Total</i>	<i>2,500</i>

Source: Home Office (September 2007)

Recent Home Office research (Anie et al, 2005) found local authorities in England with a high proportion of asylum seekers also have high proportions of vacant housing stock and residents who are not working, are dependent on state benefits or who are in low paid work. Hynes (2006) found a significant relationship between dispersal locations, the 88 most deprived local

³ Based on the 2001 census.

⁴ Based on WCRAS information on asylum seekers (June – November 2005). Includes people in NASS accommodation as well as on subsistence only support.



authority districts in England and areas with high levels of employment deprivation. At the outset of dispersal nearly 80%⁵ of dispersal locations were in areas of multiple deprivation. Three years later just over 70% of dispersal locations were in deprived districts (June 2004).

The context of dispersal in Wales, however, appears to differ from the English context. Of the 2,359 asylum seekers living in Wales in 2004, only 35% (n=826) live in Communities First areas⁶.

The dispersal of asylum seekers to areas of multiple deprivation impacts on the success of inclusion policy. Anie et al (2005), for example, found a significant association between characteristics related to greater levels of deprivation within receiving communities and an increased likelihood of poor relations with asylum seekers.

4.3. Migrant impact in social and economic standards

There is a consensus across Government, House of Lords, researchers etc that migration has an overall positive impact on the economy. (Source: Sleepwalking to Segregation, Finney & Simpson).

NHS services across Wales and the UK have benefited from a workforce inclusive of workers from overseas, 38% of all Doctors in the UK qualified abroad. (source: Bell M, Ford I, McDougall D 2008).

4.4. Migrant social determinants of health and healthcare needs

Information on the health issues living in Wales is limited, however there certain issues which are common to migrant workers, asylum seekers and refugees, these include:

- Lack of awareness regarding benefits and entitlements, including access to infrastructures of public services;
- Differing experiences of accessing public services in home countries;
- Differences in languages, cultures, beliefs, lifestyle and practices;
- Level of English and Welsh language and literacy;
- Education levels - migrants often have higher education attainment levels than employment / non-employment reflects;
- Experience of hostility, discrimination, stereotyping, racism, media and public perception.

⁵ Percentage as of June 2001.

⁶ Based on data collected by the National Asylum Support Service (includes the number of supported asylum seekers in Wales in receipt of subsistence only and accommodation support) aggregated by the Statistical Directorate (Welsh Assembly Government) from Lower Layer Super Output Areas to Communities First areas.



5. Policy agenda

The Welsh Assembly Government's strategic agenda is set out in *One Wales: a progressive agenda for the government of Wales* (Welsh Assembly Government, 2007a). The strategy outlines the agenda to achieve the Welsh Assembly Government's vision of a fair and just Wales, in which all citizens are empowered to determine their own lives and to shape the communities in which they live.

The strategy is underpinned by the principles of social justice, sustainability and inclusivity for all people in Wales and recognises that if some individuals and groups are discriminated against arbitrarily, this damages their life chances. The strategy aims to foster cohesive, plural and just communities where people, regardless of physical ability, gender, sexual orientation, race, creed or language, can feel valued.

The Refugee Inclusion Strategy is one of the ways in which these principles will be implemented. The principles outlined in *One Wales* will also be implemented through the Single Equality Scheme (SES). The scheme, which is being developed in anticipation of the proposed Single Equality Bill, will encompass all seven equality strands (age, disability, gender, transgender, faith/religion, race and sexual orientation) and set the broad direction for equality, diversity and human rights in Wales.

To ensure the Welsh Assembly Government fulfils its responsibilities under International, European and UK legislation and to achieve the successful implementation of UK-wide and Welsh policy, the Welsh Assembly Government will:

- Maintain close dialogue and work with its partners in Wales and the UK to ensure key UK and EU programmes relating to refugee inclusion are delivered appropriately in Wales.
- Seek opportunities to engage in the European Commission's programmes to promote the social and economic inclusion of refugees.
- Encourage local authorities across Wales to consider the potential for introducing the Gateway programme.
- Mainstream refugee inclusion across the work of the Welsh Assembly Government.
- Ensure the work of the Welsh Assembly Government is co-ordinated across departments.
- Continue to maintain close dialogue with the UK government, the Scottish Government and the Northern Ireland Executive on refugee inclusion, through bodies such as the National Asylum Support Forum, to share good practice and maximise impact and resources.



5.1. Health and Social Care Strategies

Designed for Life - A World Class Health Service for Wales

Launched in May 2005, Designed for Life describes the kind of health and social care services the people of Wales can expect by 2015 and how these can be developed.

Standards 2009-2014 Service Development Directives for Epilepsy

This document is an important element in discharging the Welsh Assembly Government's commitment to improving the management of Chronic Conditions.

Service Improvement Plan 2008-2011

The purpose of this Service Improvement Plan is to help clarify the actions needed to implement the Chronic Conditions Management Model and Framework

Delivering Emergency Care Services

This strategy is aimed at those people who need access to health and social care that is not planned.

Fulfilled Lives, Supportive Communities

The Strategy sets out the policy direction for social services for the next 10 years.

6. Good practices and projects

6.1. Welcome to Wales Pack for Migrant Workers

Our Welcome to Wales Pack for Migrant Workers provides a wealth of information about living and working in Wales. The aim is to ensure that migrant workers who come to this country are fully aware of their rights and responsibilities, and to help them fit in with the local community.

- Community Cohesion Initiatives
- British Council 'Open Cities' project
- Cultural Awareness
- Multi-agency forums
- Adult Mental Health Race Equality Action Plans
- Single Equality Scheme
- Inclusion Unit - Social Justice & Local Government
- Research



- Health ASERT Programme
- Ministerial Led Migrant Forum
- 'Open Door' project
- Migrant Worker events
- ESOL Classes

6.2. UK-wide programmes to support refugee inclusion

Integration Matters

The UK Government refugee integration strategy, *Integration Matters: a national strategy for refugee integration* (Home Office, 2005d) aims to enable refugees to begin the process of integration swiftly and to support them in doing so. The strategy seeks to help as many refugees as possible to take up citizenship of the UK if they wish, while recognising that some will return to their countries of origin if circumstances change.

The UK national strategy for refugee integration focuses on England. The strategy does, however, include UK-wide initiatives such as the Strategic Upgrade of National Refugee Integration Services (Sunrise), the Gateway Protection Programme (Gateway) and the Time Together Project.

Sunrise

The key objective of the Sunrise scheme is to facilitate smoother and quicker integration of refugees into the UK enabling them to meet their full potential and contribute to the community as soon as possible. Under the scheme, each new refugee who chooses to participate works with a caseworker to manage the transition from asylum seeker to refugee and produce a Personal Integration Plan covering longer-term integration objectives.

Following a successful pilot, the Home Office has decided to roll out the provision of the Sunrise scheme on a UK-wide basis from April 2008. Refugee integration services will be procured from the voluntary sector by the Home Office in consultation with the devolved authorities in Northern Ireland, Scotland and Wales.

Gateway

Gateway is a resettlement programme that aims to bring modest numbers of refugees into the UK who would not otherwise have the means to make the journey. Resettlement is one of the three long-term solutions the Office of the United Nations High Commissioner for Refugees (UNHCR) works for on behalf of refugees.



Time Together

The Time Together Project, run by the national charity TimeBank, pairs volunteer mentors with refugees, for five hours a month, to help them achieve their goals in education and employment and to integrate into the communities they live in.

Time Together has been running in Cardiff since April 2006. Cardiff is the only city in Wales covered by the project and there are no plans for the project to be expanded.

Refugee Integration and Employment Service (RIES)

The UK Border Agency is redirecting the available budget for refugee integration to make available a standard set of integration services for all new refugees through a regional asylum system.

In the past, the then Border and Immigration Agency funded numerous organisations and projects to carry out integration activities but there was little consistency in availability and not enough focus on key integration outcomes. The Sunrise pilots introduced in Integration Matters: a national strategy for refugee integration, provide a more consistent level of integration support but only to approximately 20% of new refugees.

The Refugee Integration and Employment Service will be available to all new refugees and will focus on employment as a key driver to successful integration outcomes. The service will also provide practical advice on issues such as housing and education.

The RIES will offer a 12 month service, made up of the following three elements:

- an advice and support service offering assistance to new refugees in addressing initial critical needs;
- an employment advice service helping refugees enter sustained employment at the earliest opportunity; and
- a mentoring service offering the opportunity for refugees to be matched with a mentor from the receiving community.

7. Conclusions

In conclusion, migrants arriving in Wales experience similar health and well-being issues as the rest of the UK. The health and well-being of migrant is affected a range of characteristics including, age, gender, ethnicity, their background, culture, reasons for migration, the receiving community and their lifestyle.

With the UK in recession, rising unemployment and increases to education fees, there is already evidence to show that Eastern European workers and international students are arriving in significantly smaller numbers, (Source: W Somerville & M Simpson, Migration Policy Unit, Mar 2009), however the overall impact of the recession on Wales immigration population is likely to be small. (EHRC Mar 2009).



The challenges faced by migrants to Wales continue as will the work across Wales to face these, and work with communities to overcome the challenges faced.

Challenges

- Access to interpreters and translation facilities
- Many migrant workers return home for healthcare treatment
- Availability of accurate data
- Access to Primary Care
- Inappropriate attendance at A&E
- Maternity & Child Services
- Planning & Commissioning of Services for unknown population
- Access to information
- Lack of Health & Safety training by Employers
- Mental Health
- Sickle cell & Thalassaemia
- Higher prevalence of heart disease in some ethnic groups
- Chronic Diseases
- Diabetes
- Obesity rates among children
- Poor Housing effect on health
- Gang Masters Licensing Act 2005 - only covers Agriculture, horticulture and food, drink and shellfish processing and packing - however Gang-masters moving to other sectors - 34 are registered in Wales



Appendix

Regulations and legal framework

National Health Service (Charges to Overseas Visitors) (Amendment) (Wales) Regulations 2009

These Regulations amend the National Health Service (Charges to Overseas Visitors) Regulations 1989 ("the principal Regulations"), which provide for the making and recovery of charges in respect of certain services provided under the National Health Service (Wales) Act 2006 to certain persons not ordinarily resident in the United Kingdom (overseas visitors).

Regulation 2(a) amends regulation 4(1)(c) of the principal Regulations and provides that an asylum seeker whose application for asylum has failed will not be [charged]. Regulation 2(b) amends regulation 4(1) of the principal Regulations so as to extend the exemption from charges to overseas visitors, to an overseas visitor who is a missionary. Regulation 2(c) substitutes regulation 4(4) of the principal Regulations so as to provide that the spouse, civil partner or child of an overseas visitor to whom sub-paragraph (g), (h), (i), (j), (q) or (r) of paragraph (1) of regulation 4 of the principal Regulations applies is also exempt from charges. However, in all other remaining cases, it continues to be a requirement that the spouse, civil partner or child of an overseas visitor also lives on a permanent basis with the overseas visitor in the United Kingdom in order to be exempt from charges.

Regulation 3 omits certain countries from the list in Schedule 2 to the principal Regulations, as these countries have now become part of the European Union and therefore overseas visitors from those countries will be dealt with under regulations 4(1)(m), 4A(1) and 5 of the principal Regulations

Race Relations (Amendment) Act 2000

The race equality duty gives us the following responsibilities:

- Eliminate unlawful discrimination.
- Promote equality of opportunity.
- Promote good relations between people of different racial groups.

Specific duties:

- A series of specific duties has also been created which require public authorities to establish a proactive approach to race equality. This includes preparation of a Race Equality Scheme which sets out the Assembly's arrangements for:
 - o Listing all functions, policies and proposed policies assessed as relevant to the general duty.



- Assessing and consulting on the likely impact of proposed policies on the promotion of race equality.
- Monitoring policies for adverse impact on the promotion of race equality.
- Publishing the results of assessments, consultation and monitoring.
- Ensuring that the public have access to information and services provided by the Assembly.
- Training staff in connection with the general and specific duties; and
- Reviewing the assessment of functions, policies and proposed policies every 3 years.

There are also employment related specific duties.

Disability Discrimination Act 2005

The disability equality duty gives us the following responsibilities:

- Eliminate unlawful discrimination.
- Eliminate harassment of disabled people that is related to their disabilities.
- Promote equality of opportunity between disabled people and others.
- Take steps to take account of disabled people's disabilities, even where that involves treating them more favourably than others.
- Promote positive attitudes towards disabled people.
- Encourage participation by disabled people in public life.

Specific duties:

- The specific duties require listed public authorities to publish disability equality schemes that set out how they will carry out their general duty, monitor, and report on progress and how they have involved disabled people in developing their scheme.

Sex Discrimination Act 1975 (as amended by the Equality Act 2006)

The gender equality duty gives us the following responsibilities:

- Eliminate unlawful sex discrimination.
- Eliminate harassment.
- Promote equality of opportunity between men and women.



The Equality Bill

Background

In February 2005, the United Kingdom Government set up the Discrimination Law Review to look at inconsistencies in the discrimination law framework and to consider how best to achieve a clearer and more streamlined equality legislation that results in better outcomes for those who experience disadvantage.

A Framework for Fairness: Proposals for a Single Equality Bill for Great Britain was published in June 2007. This was quickly followed by *A Framework for a Fairer Future - the Equality Bill* and *The Equality Bill - Government Response to the Consultation*, both published by the Government Equalities Office.

Effect of the new law

The single bill will replace the 116 different pieces of equality legislation in force, including 35 acts, 52 statutory instruments, 13 codes of practice and 16 European Commission directives. The aim is that the new equality law will harmonise and strengthen UK discrimination law. When brought into force, it will establish the protected characteristics of age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

It will also give definitions of direct discrimination, discrimination arising from disability, indirect discrimination, harassment and victimisation.

The new law will also:

- Place a new duty on certain public authorities when carrying out their functions and on other persons when carrying out public functions to have due regard of the need to eliminate prohibited conduct; the need to advance equality of opportunity between persons who share a relevant protected characteristic and those who do not; and the need to foster good relations between people who share a relevant protected characteristic and people who do not. The practical effect is that listed public authorities will have to consider how their policies, programmes and service delivery will affect people with the protected characteristics.
- Allow an employer or service provider or other organisation to take positive action so as to enable existing or potential employees or customers to overcome or minimise disadvantage arising from a protected characteristic; and
- Enable an employment tribunal to make a recommendation to a respondent who has lost a discrimination claim to take certain steps to remedy matters not just for the benefit of the individual claimant (who may have already left the organisation concerned) but also the wider workforce.



Human Rights Act (1998)

The main source of human rights law in the UK is the Human Rights Act and it incorporates most of the rights that are contained in the European Convention on Human Rights into UK law.

Some of the rights to consider:

- Article 2: The right to life
- Article 8: The right to respect for private and family life, home and correspondence
- Article 4 (1) The right to be free from slavery
- Article 7: No punishment without law
- Article 4 (2): The right to be free from forced labour
- Article 5: The right to liberty
- Article 6: The right to a fair trial
- Article 9: The right to freedom of thought, conscience and religion
- Article 10: The right to freedom of expression
- Article 11: The right to freedom of assembly and association
- Article 12: The right to marry and found a family
- Article 2: Protocol 2: The right to education

More about human rights can be found on the British Institute for Human Rights website:
<http://www.bih.org.uk/>



UN Human Rights Treaties that apply in the UK

The UK Government has signed up to a number of UN human rights treaties expressing its commitment to giving fundamental rights and freedoms to society. When undertaking the Inclusive Policy Making process you should consider if and how these guiding principles drawn from each treaty can be reflected in the policies and practices of the Welsh Assembly Government.

Key considerations

The International Covenant on Civil and Political Rights

- All peoples have the right to freely determine their political status and freely pursue their economic, social and cultural development.
- Right for men and women to the enjoyment of all civil and political rights
- No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment
- Everyone has the right to liberty and security of person.
- Everyone shall have the right to freedom of thought, conscience and religion.
- Everyone shall have the right to freedom of expression.

The International Covenant on Economic, Social and Cultural Rights

- Recognize the right to work, which includes the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts.
- Recognize the right of everyone to social security, including social insurance.
- Recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

The Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment

- Reaffirming that torture and other cruel, inhuman or degrading treatment or punishment are prohibited and constitute serious violations of human rights
- Strengthening the protection of people deprived of their liberty

The Convention on the Elimination of Discrimination Against Women

- To embody the principle of the equality of men and women in their national constitutions or other appropriate legislation.
- To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions.
- To ensure equal rights between men and women and eliminate discrimination against women in the fields of education, employment and health care.



The Convention on the Elimination of Racial Discrimination

- Condemn racial discrimination and undertake to eliminate racial discrimination in all its forms and promote understanding among all races.
- Condemn racial segregation and apartheid
- Combat prejudices which lead to racial discrimination particularly in the fields of teaching, education, culture and information.

The Convention on the Rights of the Child

- Ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.
- Ensure the child such protection and care as is necessary for his or her well-being
- Respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community.
- Recognize that every child has the inherent right to life and ensure to the maximum extent possible the survival and development of the child.
- Ensure that children have the right to freedom of expression
- Recognize the right of the child to education
- Recognize that a mentally or physically disabled child should enjoy a full and decent life.

The Convention on the Rights of Persons with Disabilities (CRPD) (the UK has signed but not yet ratified this Convention)

- To promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities
- Reaffirm the need for persons with disabilities to be guaranteed their full enjoyment without discrimination.
- Recognizing that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.
- Emphasizing the importance of mainstreaming disability issues.
- Recognizing the importance for persons with disabilities to have freedom to make their own choices and to have the opportunity to be actively involved in decision making processes about policies and programmes.
- To raise awareness throughout society, including at the family level, regarding persons with disabilities.
- To combat stereotypes, prejudices and harmful practices relating to persons with disabilities and to promote positive perceptions of persons with disabilities.



- Recognize the right of persons with disabilities to work, on an equal basis with others; this includes the right to the opportunity to gain a living by work freely chosen or accepted in a labour market and work environment that is open, inclusive and accessible to persons with disabilities.
 - Ensure that persons with disabilities enjoy equal access to education, culture, recreation and sport.
-

More information about the UN human rights treaties can be found on the Office of the High Commissioner for Human Rights website:

<http://www.ohchr.org/EN/Pages/WelcomePage.aspx>

External websites relevant to migrants and community cohesion

- Institute of Community Cohesion (iCoCo)
The Institute is a partnership between academic, statutory and non governmental bodies and provides information on the background of community cohesion, best practice, research and toolkits.
<http://www.cohesioninstitute.org.uk/home>
- IDeA (Improvement and Development Agency)
The IDeA works for local government improvement so councils can serve people and places better. The website provides best practice and toolkits.
<http://www.idea.gov.uk/idk/core/page.do?pageId=1>
- Communities and Local Government (CLG)
Communities and Local Government have responsibility for all race equality and community cohesion related issues in England.
<http://www.communities.gov.uk/corporate/>
- Institute for Public Policy Research (IPPR)
The IPPR seeks to promote social justice, democratic participation, and economic and environmental sustainability in government policy and have a research team dedicated to Migration, Equalities and Citizenship research.
<http://www.ippr.org/>
- Joseph Rowntree Foundation (JFR)
Social policy research and development charity. JFR research programme includes Immigration and Inclusion.
<http://www.jrf.org.uk/>
- Home Office Research, Development and Statistics (RDS)
Research and statistics from the Home Office on crime, policing, justice, immigration, drugs and race equality.
<http://www.homeoffice.gov.uk/rds/>



- Equality and Human Rights Commission
The Commission is a statutory body established under the Equality Act 2006. It champions equality and human rights for all.
<http://www.equalityhumanrights.com/>
- Neighbourhood Renewal Unit (NRU)
The Neighbourhood Renewal Unit is part of CLG and takes forward community cohesion work through their Neighbourhood Renewal Policies and Programmes.
<http://www.communities.gov.uk/communities/>
- Centre for Migration Policy Research (CMPR)
The Centre for Migration Policy Research (CMPR) is an inter-disciplinary Research Centre based at Swansea University.
<http://www.swan.ac.uk/cmpr/>
- The Interfaith Network for the UK
The Inter Faith Network for the UK promotes good relations between people of different faiths in the UK
<http://www.interfaith.org.uk/>
- UK Evaluation Society (UKES)
UKES promotes and improves the theory, practice, understanding and utilisation of evaluation and it's contribution to public knowledge.
<http://www.evaluation.org.uk/>
- Welsh Local Government Association
The Welsh Local Government Association (WLGA) represents the interests of local authorities in Wales. The website has Equalities and Social Justice publications section.
<http://www.wlga.gov.uk/>
- Wales Strategic Migration Partnership
The Partnership plays a lead role working with a range of partners from the statutory, voluntary and community sector in the development of strategic policies and initiatives on asylum seekers, refugees and migrants in Wales.
http://www.newport.gov.uk/_dc/index.cfm?fuseaction=refugeesasylum.homepage
- Borders and Immigration Agency
The Border and Immigration Agency is an executive agency of the Home Office responsible for controlling our borders and managing immigration in the UK.
<http://www.bia.homeoffice.gov.uk/>
- Wrexham County Borough Council
Wrexham County Borough Council provides information on One Wrexham, a new initiative being led by the Council to promote good relationships between everyone who resides or works in the County Borough.
http://www.wrexham.gov.uk/english/council/one_wrexham/



- Local Government Data Unit
The Local Government Data Unit aims to meet the data needs of local and central government in Wales by ensuring that they are better informed about the characteristics of the services and activities of local authorities and of the environment in which they operate.
<http://www.dataunitwales.gov.uk/Home.asp?lang=en>
- Office for National Statistics
Provides data on economy, population and society at national and local level.
<http://www.statistics.gov.uk/hub/index.html>
- Muslim Council of Wales
An umbrella organisation of mosques, Muslim associations and institutions; information about their objectives, activities, news, and publications.
<http://www.muslimcouncilwales.org.uk/>
- The FAN Groups
Neighbourhood groups to promote community cohesion and to help people integrate.
<http://www.thefangroups.org/>

World Health Organization
Regional Office for Europe
Regions for Health Network



Migrants and Health Care:
Responses by European Regions
(MIGHRER)

Complete reference material

**XIV. WHO and the health of migrants
in the European Region**

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Summary

Migration processes and determinants of health such as employment, education, health system access and social exclusion are intrinsically linked. Migrants-particularly those experiencing socioeconomic disadvantage and other adverse conditions-can face a range of factors that negatively influence health. The WHO Constitution explicitly underlines the commitment of the Organization's 193 Member States to the "highest attainable standard of health as a fundamental right of every human being without distinction of race, religion, political belief, economic or social condition". The health of disadvantaged groups has long been, and continues to be, a cross-cutting priority for the Organization.

Building on WHO's longstanding commitment to tackling health inequities and the determinants of health, as well as previous work on migrant health, at the 61st World Health Assembly, delegates adopted Resolution WHA61.17 on the Health of Migrants. Resolution 61.17 urges Member States and WHO to promote the inclusion of migrants' health in regional health strategies; to develop/support assessments and studies and share best practices; to strengthen service providers' and health professionals' capacity to respond to migrant needs; to engage in bi- and multi-lateral cooperation; and to establish a technical network to further research and enhance cooperation capacity. It recalls the relevance of other resolutions on the migration of health professionals and the importance of strengthening health systems in developing countries.

It is estimated that 72 million of the world's estimated 200 million international migrants live in the 53 Member States of the WHO European Region. WHO's Regional Office for Europe is collaborating with and contributing to the work of stakeholders through integrating activities on migration health into programme areas including: human resources for health, occupational health, reproductive health and rights, social determinants of health, emergency room services, financing, communicable diseases including HIV/AIDS and TB, and child and adolescent health and development, and its support to networks including the Regions for Health Network and the Healthy Cities Network. This chapter provides some details on work carried out in two of these areas: occupational health and reproductive health.

The Tallinn Charter, endorsed at the European Ministerial Conference for Strengthening Health Systems, and work conducted by the WHO European Office for Investment for Health and Development on how health systems can improve the health of socio-economically disadvantaged groups, emphasize the importance on a health system-wide approach, rather than advancing with isolated projects that target these groups only in relation to specific diseases and for a time-limited period. As the demographics of European Member States change, increased capacity to serve migrant populations can be a feature of how health systems evolve to meet population needs at national, regional and sub-national levels.



1. The context for WHO action on migrant health

1.1. A long-standing commitment to health equity and action on the determinants of health

The World Health Organization (WHO) is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.

The WHO Constitution explicitly underlines the commitment of the Organization's 193 Member States to the "highest attainable standard of health as a fundamental right of every human being without distinction of race, religion, political belief, economic or social condition". Article 2 further defines one of the Organization's functions as "promot[ing], in co-operation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene" (WHO, 2006). As such, WHO is committed to equity in health and action on wider determinants of health. This commitment has been reflected in the Organization's support for:

- primary health care, as evident in the World Health Report 2008 published on the thirtieth anniversary of the international conference of Alma-Ata;
- the Millennium Development Goals;
- the principles of "Health for All" (Resolution WHA30.43);
- processes resulting in the Ottawa Charter on Health Promotion and the Bangkok Charter for Health Promotion in a Globalized World (resolution WHA60.24); and
- the Commission on Social Determinants of Health, the recommendations of which will be debated at the 62nd World Health Assembly in May 2009.

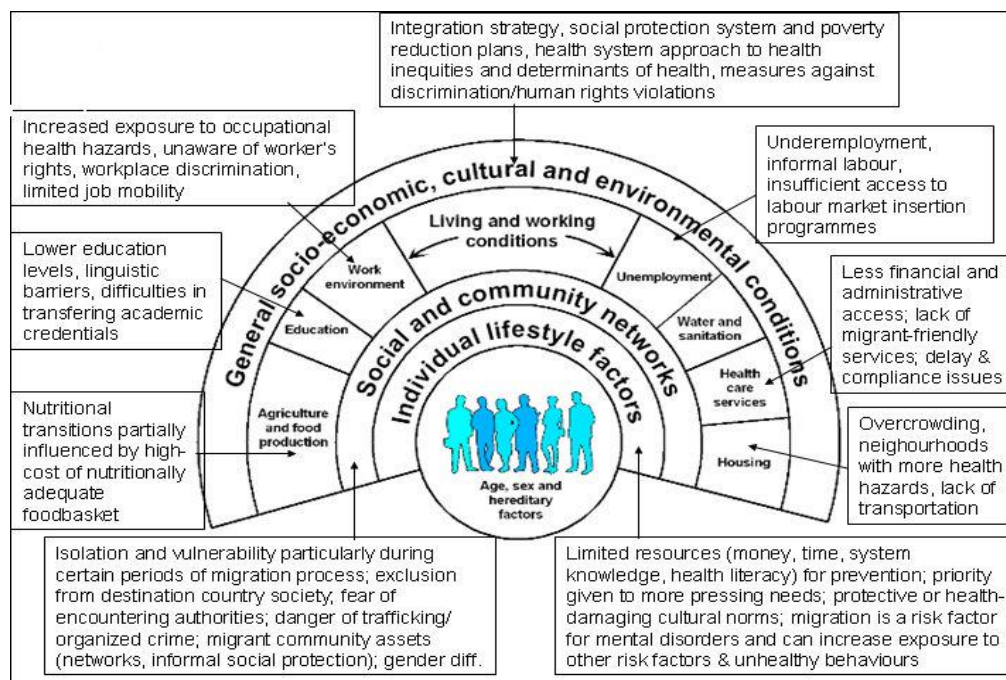
The health of disadvantaged groups has long been, and continues to be, a cross-cutting priority for the Organization. Strategic Objective 7 of the WHO Medium-Term Strategic Plan (2008-2013) is: "To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches" (WHO, 2008). In parallel, equity and concern for the most vulnerable populations is reflected across the other Objectives. Recently, the importance for this cross-cutting approach has been emphasized by Executive Board Resolution EB124.R6 of January 2009, which calls for the scaling up of measures to promote addressing social determinants of health to reduce health inequities in all areas of the Organization's work, especially priority public health programmes (WHO, 2009).

Migration processes and determinants of health such as employment, education, health system access and social exclusion are intrinsically linked. Migrants-particularly those experiencing socioeconomic disadvantage and other adverse conditions-can face a range of factors that negatively influence health, as demonstrated in Figure 1. In light of these, WHO has accounted



for the specific needs of migrant populations in diverse programmatic areas throughout the years, working together with Member State governments and other international organizations and intergovernmental bodies.

Figure 1. Determinants of the health of socially excluded migrant populations



Source: Koller T, adapted from Dahlgren and Whitehead (1991) and inspired by the presentation from Dr Nani Nair, TB Regional Advisor at 15-16 September 2005 WHO/SEARO Consultation on the Social Determinants of Health.

1.2. Resolution WHA61.17 on the health of migrants

Building on WHO's longstanding commitment to tackling health inequities and the determinants of health, as well as previous work on migrant health, at the 61st World Health Assembly, delegates adopted Resolution WHA61.17 on the Health of Migrants (WHO, 2008). The Resolution calls for Member States:

- to promote migrant-sensitive health policies;
- to promote equitable access to health promotion, disease prevention and care for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality or race;
- to establish health information systems in order to assess and analyse trends in migrants' health, disaggregating health information by relevant categories;
- to devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery;



- to gather, document and share information and best practices for meeting migrants' health needs in countries of origin or return, transit and destination;
- to raise health service providers' and professionals' cultural and gender sensitivity to migrants' health issues;
- to train health professionals to deal with the health issues associated with population movements;
- to promote bilateral and multilateral cooperation on migrants' health among countries involved in the whole migratory process;
- to contribute to the reduction of the global deficit of health professionals and its consequences on the sustainability of health systems and the attainment of the Millennium Development Goals.

The Resolution requests WHO to promote migrants' health on the international health agenda in collaboration with other relevant international organizations; to explore policy options and approaches for improving the health of migrants; to analyse the major challenges to health associated with migration; to support the development of regional and national assessments on migrants' health and the inclusion of migrants' health in health strategies; to help collect and disseminate migrant health data; to strengthen service providers' and health professionals' capacity to respond to migrant needs; to engage in bi- and multi-lateral cooperation; and to establish a technical network to further research and enhance cooperation capacity. It recalls the relevance of other resolutions on the migration of health professionals and the importance of strengthening health systems in developing countries. Furthermore, it asks that a report on resolution implementation be submitted to the Sixty-third World Health Assembly (2010).

2. WHO action on migrant health in the European Region

It is estimated that 72 million² of the world's estimated 200 million international migrants live in the 53 Member States of the WHO European Region (IOM, 2008). In the Region, the migration process contributes to economic development and helps to counterbalance an aging population in destination countries. Through remittances, the migration process also contributes to poverty reduction and informal social protection in countries of origin, both in and beyond the Region.

The Portuguese Presidency's Health and Migration in the EU Conference, the Council of Europe (including through multiple recommendations and the Bratislava Declaration), the European Commission, IOM, NGOs, academia and sister UN agencies have all worked to advance knowledge to improve migrant health in the European Region. WHO's Regional Office for Europe is contributing to this work through integrating activities or foci on migration health into a broad range of programmes, including: human resources for health (looking at the migration of health professionals), occupational health, reproductive health and rights, social

² Calculation made by IOM based on 2005 data. Source: 10 July 2008 author's communication with IOM Brussels.



determinants of health, emergency room services, financing, communicable diseases including HIV/AIDS and TB, and child and adolescent health and development. WHO is also working on migrant health through its support to networks including the Regions for Health Network (the focus on this book) and the Healthy Cities Network.

A cross-cutting working group on migrant health was launched in December 2008. It aims to improve coordination and synergies for delivering on Resolution 61.17, both across the Regional Office for Europe and with HQ, and with the aim of acting as one cohesive body when engaging partners on issues related to migrant health.

The sections that follow provide examples of how two specific areas of work-occupational health and reproductive health and rights-are addressing migrant health.

2.1. Occupational health

In Europe, occupational accident rates are about twice as high for migrant workers as for native workers. Migrant workers tend to be employed in high-risk sectors. They face language and cultural barriers, and require specific occupational health and safety communication, instructions and training approaches. Many migrant workers overwork and are particularly prone to occupational injuries and work-related diseases (European Agency for Safety and Health and Work, 2007). They may have low levels of integration and face barriers in accessing social security and health services. Furthermore, they may not be familiar with their obligations and the obligations of their employers in preventing occupational diseases and injuries (Kim, Ivanov, 2007).

The WHO Regional Office for Europe is implementing the WHO Global Plan of Action on Workers Health (Resolution WHA60.26). The Plan calls to improve the health of all workers, through: devising and implementing policy instruments on worker's health; protecting and promoting health at the workplace; improving the performance of and access to occupational health services; providing and communicating evidence for action and practice; and incorporating worker's health into other policies (WHO, 2007). The Plan identified migrant workers as one of the vulnerable groups for priority action. As such, the WHO European Centre for Environment and Health has applied a public health approach to migrant labour health to identify key action areas. These are (Kim, Ivanov, 2007):

- Establish linkages between employment, health and migration policies. Such linkages should stimulate synergistic intersectoral actions to prevent and mitigate unfavourable health effects on international labour migration and to promote migrant worker health. For example, health impacts assessment should address how migration policies may affect migrant labourer employment and health status.
- Ensure collaboration between countries exporting and importing labour force. Such collaboration should better prepare potential migrant workers to meet their health needs while working abroad, with emphasis on health and safety training, and access to health services. It is also necessary to consider the issues of medical follow up and compensation in case of occupational diseases contracted during working abroad.



- Ensure coverage of all workers, including migrant workers, with basic occupational health services. Such services need to be adapted to the specific needs of migrant workers, in terms of language and culture. They should establish a preventative culture at the workplace and should encourage dialogues and participation of migrant workers in activities regarding their health, including promotion of healthy lifestyle and protection from non-occupational health hazards.
- Establish information systems on migrant workers' health. Workforce mobility require information systems that allow for health surveillance of migrant workers. Over-sampling of immigrant populations in national surveys on working conditions should be encouraged to correct under-reporting. There is also need to evaluate the impact of systemic misclassification of employee status and job titles on estimates of migrant workers' health status and safety risks. Race, ethnicity and country of origin should be included in existing occupational health surveillance systems.
- Ratify and implement the relevant UN Conventions on migrant workers. UN International Convention on the Protection of the Rights of all Migrant Workers and Members of Their Families and the ILO Migrant Workers Convention No. 143 provide good basis for protection of the health of migrant workers. Their ratification will stimulate closing the gaps in the national legislation that prevent migrant workers from meeting their health needs.
- Strengthen research on migrant workers health. There is a need to better understand the determinants of migrant workers' health before, during and after migration. Community based participatory research would be the most effective approach. Research on migrant workers' health should focus on interventions, should provide skills for the migrants' community and should communicate findings back to the community. Priority research questions would include: (1) what factors make migrant workers more vulnerable to occupational injury and illness; (2) what are the language, literacy and cultural barriers to health and safety education and action among migrant workers and employers; (3) what are the gaps in knowledge about migrant workers among the general workforce.

This analysis was taken into account in the process of drafting the European Work Plan for Implementation of Resolution WHA60.26 for 2009-2012. The European Work Plan specifically calls for the preparation of situation analyses and recommendations for migrant workers, and the carrying out of international studies and develop methodologies and tools for health impact assessment of employment policies, for example labour migration. The analysis was also presented at the EU Portuguese Presidency conference on health and migration in September 2007, and has been taken into consideration in the conference conclusions and follow-up.

To support Member State action in this area, a network for migrant workers' health has been established, involving WHO Collaborating Centres and national contact points in Albania, Greece, Hungary, and Slovenia. The WHO Regional Office works closely with ILO, European



Agency for Safety and Health and Work, the International Commission on Occupational Health and other international associations to improve the health of all workers, including migrant labourers.

2.2. Reproductive health and rights

Universal access to reproductive health by 2015 is one of the MDG 5 targets. As such, sexual and reproductive health and rights (SRH&R) of migrants, including refugees and asylum seekers, is relevant to the health agenda in many countries of the European Region. The WHO Regional Office for Europe reproductive health and research programme aims to decrease the health inequities in migrant and refugee women through: (1) researching the health needs of migrant women in Europe; (2) removing legal, financial, religious, racial and language barriers to services; (3) promoting protection from female genital mutilation and other harmful practices.

The WHO Regional Office for Europe counts on the contributions of collaborating centres for advancing this work. Sexuality education in a multicultural Europe is analyzed and further standards developed by the WHO Collaborating Center on Sexual and Reproductive Health at the Federal Centre for Health Education (BZgA) in Cologne, Germany. Select relevant activities of the WHO Collaborating Center for Research on Sexual and Reproductive Health at the International Centre for Reproductive Health (ICRH) in Ghent, Belgium, are outlined below (ICRH, 2009).

The research initiative on sexual and reproductive health and rights of asylum seeking and refugee women (ASRW) in the EU

Supported by the European Refugee Fund and conducted in 2004-05, the study revealed a lack of EU and national policies explicitly recognizing the sexual and reproductive rights of ASRW, as well as access barriers resulting in limited or no access to the broad range of SRH services. The study identified the need to address challenges including lack of information among service providers about ASRW rights; lack of culturally appropriate care; linguistic barriers; patient mistrust; and difficulties in navigating the health system.

The project "Hidden Violence is a Silent Rape" on sexual and gender-based violence among refugees, asylum seekers and undocumented migrants

This community-based participatory research project, conducted in Belgium, the Netherlands and the United Kingdom during 2006-2008, found that young female and male refugees, asylum seekers and undocumented migrants are extremely vulnerable to several types of gender-based violence. It found that preventing victimization will require participatory multi-disciplinary and multi-stakeholder interventions working on three levels:



- individual (e.g., behavioural change and enhancement of social capital);
- interpersonal, organizational, community (e.g., general awareness raising, social networks and active participation in host society);
- public policy (more preventive legislative framework and protection of rights).

Project outcomes have included reports of findings, a prevention tool, and awareness-raising activities. An example of the latter was an international seminar (held February 2008) in Ghent, Belgium, which brought together 150 target group members and stakeholders to formulate practice and policy recommendations in a Call for Action.

European Network for the Promotion of Sexual and Reproductive Health and Rights of Refugees, Asylum Seekers and Undocumented Migrants (EN-HERA!)

The network was launched in November 2008 at an international seminar in Ghent. It builds on previous work funded by the European Refugee Fund and coordinated by ICRH. As of February 2009, the network includes 36 members. Achievements thus far include: a framework for the identification of good practices in the field of SRH&R for refugees, asylum seekers and undocumented migrants, a literature review and a common research agenda.

The project "Frame of Reference for the Prevention of Sexual and Gender-based Violence against and among young refugees, asylum seekers and unaccompanied minors in the European Reception and Asylum sector"

Funded by the EC, this community-based participatory research project aims to develop a frame of reference consisting of a Code of Conduct, a Standard Operating Procedure, and a training manual focusing on prevention of and response to sexual and gender-based violence within the European asylum and reception sector. Project participants include academic, civil society, policy and community stakeholders in Belgium, the Netherlands, Ireland, Spain, Greece, Portugal, Malta and Hungary. The project timeframe is December 2008 to December 2010, and an international seminar is scheduled for November 2010 to present results.

The project "Improving Female Genital Mutilation (FGM)-law enforcement in Europe: dissemination of lessons learned and capacity building of actors in (para)legal fields"

Financed by the EC for the June 2007 - June 2009 period, the project aims to enhance implementation of criminal and child protection laws on FGM in the EU. Questionnaires were sent to all EU countries to update the review of the criminal and child protection laws on FGM, and the review was subsequently expanded and disseminated. Project partners from Belgium, France, Spain, Sweden and UK have collaborated for workshops (October 2008, February 2009) to build the capacities in FGM law enforcement for the following stakeholders: child protection officers, social workers, police, prosecutors, and others.



EuroNet-FGM

The WHO Collaborating Centre is a member of the International Steering Committee and the National Committee of Belgium for EuroNet-FGM, a network that aims to improve the health of female immigrants in Europe and to address FGM in Europe by finding a global solution and establishing a lobby aimed at eradicating the practice on all continents and in all regions. Currently, EuroNet is working on the development of national action plans against FGM in 15 EU Member States of the European Union. Funded by the EC Daphne Programme, members of EuroNet coordinated events to present the national action plans to fight FGM.

3. Migrant health in the context of health system strengthening

The definition for health systems used in the Tallinn Charter, endorsed at the European Ministerial Conference for Strengthening Health Systems, is: "The ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health" (WHO Regional Office for Europe, 2008). The Tallinn Charter emphasizes that health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health. Health systems can act on the determinants of migrant health, through specific actions that relate to each of the four functions of health systems: stewardship, service delivery, resource generation and financing.

Work conducted by the WHO European Office for Investment for Health and Development on how health systems can improve the health of socio-economically disadvantaged groups emphasized the importance on a system-wide approach, rather than advancing with isolated projects that target these groups only in relation to specific diseases and for a time-limited period. Questions such as the following can be posed with reference to each function: For service delivery, strengthening primary health care to address migrant health is a priority. Are services culturally and gender-sensitive? Do they account for adverse living conditions influencing, for instance, treatment compliance? Do information systems monitor health inequities, including by migrant status? For financing, are migrants incorporated into national health insurance schemes? Is research being conducted on how remittances can be used to strengthen health systems in countries of origin? For resource generation, is migrant health featured in pre-service and continuing education opportunities for health professionals? Are there standardized processes for the training and accreditation of cultural mediators? Is the international recruitment of health workers guided by ethical considerations and cross-country solidarity, resulting in reciprocal arrangements with regards to health workers? For stewardship, is there a cross-government approach to reducing health inequities across the socioeconomic gradient? Is the health sector equipped with the skills and institutional mechanisms necessary to map policies of other sectors, assess health impacts, and cooperate for health dimensions to be incorporated? (Koller, 2009).

As the demographics of European Member States change, increased capacity to serve migrant populations can be a feature of how health systems evolve to meet population needs at national, regional and sub-national levels.



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Regional Office for Europe
Regions for Health Network



Migrants and Health Care:
Responses by European Regions
(MIGHRER)

Complete reference material

**XV. PICUM: Platform for International
Cooperation on Undocumented Migrants**

Eve Geddie¹

¹ PICUM: Platform for International Cooperation on Undocumented Migrants.



1. PICUM's research on "Access to Health Care for Undocumented Migrants"

PICUM is a non-governmental organisation that aims to promote respect for the human rights of undocumented migrants in Europe. It was founded as an initiative of grassroots organisations during the post-Tampere EU building process to mobilise civil society support for undocumented migrants at a European level and voice their human rights concerns within the development of the European Union's migration policy. From the beginning, PICUM's focus developed from the themes important to those working with undocumented migrants at local level and its work remains based on issues occurring in the field.

While it has been estimated that there may be from 5 to 8 million undocumented migrants in Europe, they largely remain invisible in the eyes of policy makers. This situation puts enormous strain on local actors such as NGOs, health care and educational professionals, and local authorities, who often work with limited resources to defend undocumented migrants' fundamental rights, including the right to health care, education and training, fair working conditions, and housing. These local actors are confronted on a daily basis with situations confirming that irregular legal status is an obstacle for a sizeable part of the population in accessing basic social services. Professional groups experience clashes between what their professional ethics tell them to do and the incriminatory discourse regarding undocumented migrants.

PICUM promotes respect for the basic social rights of undocumented migrants. A key activity of the organisation is to monitor and report on the situation facing undocumented migrants in Europe to ensure that violations of their fundamental human rights, so often hidden and ignored, are extensively reported so the situation can be addressed and improved. PICUM remains the only organisation solely dedicated to guaranteeing dignity, equality and non-discrimination for undocumented migrants at EU level.

Access to health care for undocumented migrants is a key concern for PICUM and a fundamental tenet on which its network has developed. Since 2001, PICUM has monitored and reported on the issue of health care access, raised awareness among policy makers and built the capacities of NGOs and health care professionals working to provide urgent assistance to undocumented migrants the field. PICUM actively promotes and disseminates the values and practices underlying the protection of the human rights of undocumented migrants and encourages policy makers to include undocumented migrants in social and integration policies on the national and European levels.

From 2005-2007, PICUM completed a two-year project which aimed to build cooperation between local actors to improve access to health care for undocumented migrants residing in Europe. While undocumented migrants constitute considerable part of Europe's migrant population, they remain invisible in the eyes of policy makers and few social strategies address their needs. Public and private actors working on the local level find that access to health care is the most pressing problem for undocumented migrants. Lack of access to health care for this



vulnerable group has serious public health consequences and the situation places an enormous burden on health care staff, social workers, local administrations and grass root workers left to deal with the urgent problems arising from incongruous and inhumane social policies.

In response to this situation, PICUM targeted the thematic priorities as defined in the EU's Second Joint Report on Social Inclusion (2004) which stated "access to decent social services such as health care is recognized as crucial in the fight against social exclusion". Emphasising the extreme exclusion facing undocumented migrants as a consequence of their inability to access health care, PICUM received funding from the European Commission under the Community Action Programme which sought support the implementation of the Open Method of Coordination (OMC), in particular the development and implementation of the National Action Plans on Social Inclusion.

Nineteen partners, including NGOs, health care providers and local authorities, from eleven EU member states participated in the project to combat undocumented migrants' social exclusion by trying to improve access to health care for undocumented migrants in Europe through research and advocacy activities. Throughout the project, PICUM actively supported and gave visibility to local efforts to address this issue and brought local expertise to the national and European level. A key aim was to increase awareness among a wide range of actors regarding undocumented migrants' inalienable right to the highest standard of health without discrimination of any kind. With the support of the project partners, best practices involving cooperation between civil society, health care providers and local authorities were identified and disseminated.

This paper will outline how PICUM's project created a knowledge base regarding undocumented migrants lack of access to health care in the EU, explain the cooperative process by which the project was carried out, the identification and dissemination of good practices, strategies to promote the social inclusion of undocumented migrants were developed and how anti-discrimination and human rights arguments were promoted.

2. Knowledge base regarding undocumented migrants' lack of access to health care

The main purpose of PICUM's research was to give visibility to various problems associated with the existing lack of or insufficient access to health care for undocumented migrants residing in Europe. The project allowed for a mapping of the situation in eleven EU member states regarding access to health care for undocumented migrants in terms of law and practice with illustrations of good practices. The results formed the basis of the country reports incorporated into the final project publication "Access to health care for undocumented migrants in Europe". Launched in November 2007 in both English and French language versions, this report remains a sound reference for NGOs and health care providers advocating for undocumented migrants' rights to access health care at national and European level.

PICUM's project report presents the situation regarding access to health care for undocumented migrants in terms of law and practice through eleven country profiles corresponding to the different member states participating in this study. During the first year of the two-year project,



field trips and research interviews were carried out. In the second year, the information was assimilated into report format. Each country profile provides an overview of the situation in practice, highlighting the most common problems and obstacles preventing undocumented migrants from accessing health care and importantly, illustrates the role of civil society and local actors in this field. Concerning the legal framework, information is provided on: i) the general health care system; ii) the specific legal entitlements of undocumented migrants to access fully or partially publicly subsidized health care; iii) the procedures and financing of the different systems put in place by EU member states to give a response to undocumented migrants' health care needs.

Information was gathered by PICUM's researcher through a series of field trips and working meetings were organized to obtain feed-back from all the partners. Through these activities, PICUM could ascertain whether the data obtained during the field-trips clearly identified existing the gaps and dilemmas and furthermore, that the research was relevant, useful and practice-related. The workshops were a useful tool to brief project partners regarding the proceedings and also enabled project staff to identify and discuss additional issues arising throughout the course of the research. Regular meetings with a selection of academic advisors occurred throughout the two-year process and external experts were invited to participate in working meetings and provide ongoing input.

3. Collaboration among civil society, health care providers and local authorities

Nineteen partners from 11 EU member states participated in the project. An innovative element of this project, and a key element of its success, was that it involved the active collaboration of an interdisciplinary range of actors involved in the support of undocumented migrants, the provision of health care and the implementation of health legislation at the local level, namely NGOs, health care providers and local authorities.

PICUM's project marked the first EU wide collaboration of civil society groups, healthcare service providers and local authorities to engage with policy makers to improve undocumented migrants' access to health care. PICUM ensured the involvement of these target groups in each stage of the project and involved other groups such as researchers and undocumented migrants themselves, to share experiences and discuss ways to address the problems associated with insufficient access to health care services for undocumented migrants. Each group had their own experiences and problems arising from the inadequate access to care for undocumented migrants' and any strategy to improve the situation would have to involve their close collaboration.

Among health care providers, throughout Europe we found that those who are more "undocumented migrant friendly", i.e. are more willing to render service to undocumented migrants, tend to become more overloaded. Highly concerned about undocumented migrants' health care needs, health providers are increasingly involved in advocating for undocumented migrants' rights. They are normally listened to by health authorities and they have a great persuasive power.



Many local authorities in charge of implementing the law lack information about undocumented migrants' entitlements and were found to illegitimately deny or refuse to recognize undocumented migrants' right to access publicly subsidized health care. PICUM's research found that in many countries there was a high decentralization of competences from the central government to the regional and local entities. There are also many gaps between what the law says and its implementation. The procedures concerning implementation of the law are often complicated; there are many conditions, sometimes many administrations involved and a lot of bureaucracy.

NGOs are a very relevant actor in this field since as they provide direct health care as well as health care-related assistance to undocumented migrants. Given the gaps and failures of the health care system, there is enormous pressure on NGOs and charities, particularly in countries where legislation is rather restrictive. These organizations make a tremendous effort to fill the gaps and correct the failures of the state system and on many occasions feel obliged to constantly improvise solutions. They do this under difficult conditions since they often lack human, technical and financial resources and, in some countries, they face pressure from public authorities given the repressive culture. In addition, there are a high number of undocumented migrants reliant on them. In some countries their task is essential since NGOs and religious hospitals are the only providers of health care to undocumented migrants.

The existing lack or insufficient access to health care for undocumented migrants was found to have very much boosted networking among these actors at the local level. PICUM was keen to support and multiply such initiatives, especially those involving collaboration among a diverse set of actors. Through the course of the research, PICUM found numerous examples of both formal and informal methods of cooperation. Many NGOs, hospitals and individual health care providers had created informal networks to maintain regular contact, organize meetings to exchange information on problem resolution or planning targeted actions to advocate for undocumented migrants' right to access health care. Public administrators and authorities are often involved in these informal networks as well. Even the police will sometimes agree to avoid a particular NGO or hospital to enable undocumented migrants' access care. There are also frequent examples of formal methods of cooperation such as partnerships at the local level involving cooperation of NGOs, health care providers, as well as hospitals and local authorities with responsibility for public health. Most of these partnerships seek to facilitate access to health care at the local level for undocumented migrants in general or for particularly vulnerable groups of undocumented migrants.

4. Identification and dissemination of good practices

As a network of organisations working to guarantee the basic social rights of undocumented migrants, PICUM has long been aware of the tremendous efforts of civil society to fill the gaps existing in national health care systems to address the crisis caused by current policies and guarantee minimum respect for undocumented migrants' human dignity. To cope with all the problems caused by insufficient access to healthcare for vulnerable migrants, good practices have been developed across Europe consisting of partnerships between NGOs representing



undocumented migrants, local authorities, and health care staff. Different models are being applied to ensure the access to health care (both on a preventive and curative level), or to ensure the effective implementation of the right to health. PICUM identified innovative practices, and promoted them both with European policy makers and with other local actors in Europe.

PICUM gathered exactly fifty services, initiatives and partnerships through this project. Having completed the legislative and policy frameworks of each of the eleven EU member states, a total of ninety interviews were conducted with local actors to discuss the effects of legislation upon services, the implementation of law at local and regional level, medical professionals' interpretation of legislation and terms, and finally, the existence of NGO pressure or mediation. Through this field research, PICUM could identify the main barriers impeding undocumented migrants' access to care and highlight initiatives which seek to bridge the cleavages occurring in specific localities or regions. The network was especially keen to highlight services and initiatives resulting from cooperation between authorities, providers and NGOs and not those in which NGOs were left alone to bridge the gaps and fulfil the state's obligation to guarantee health to all without discrimination.

A long term objective of the project was to inspire new strategies and actions to continue addressing the problems associated with insufficient access to health care for undocumented migrants in Europe. PICUM and other advocacy groups across Europe continue to use the findings of this research to convince the governments of EU member states to speak more, to do more, and to take on their responsibilities and comply with international human rights obligations instead of continuing to rely upon civil society as an alternative provider of health care for undocumented migrants.

5. Strategies to promote social inclusion of undocumented migrants

Since the Amsterdam Treaty, the fight against social exclusion is one of the objectives of the European Union. As the EU is currently unable to develop any binding legislation regarding social exclusion, it was agreed that Member States should co-ordinate their policies for combating poverty and social exclusion on the basis of an "Open Method of Co-ordination" (OMC). To follow up on the proceedings in different member states, national governments have to deliver "National Action Plans" (NAPs). In these plans each member state is supposed to analyse the situation in relation to poverty and social exclusion, and present the strategy and targets it has established for mostly a two-year period. The European Commission analyses these NAPs and writes a Joint Report about them, in which good and bad practices are indicated.

Even if undocumented migrants are among the most socially excluded groups in Europe today, almost no mention of their presence and marginalization has been made in the different NAPs on social inclusion so far. Certainly, some countries continue to deny undocumented migrants the access to basic social services such as health care. Others, whilst partially allowing the enjoyment of some of undocumented migrants' fundamental human rights, show great resistance to speak openly about their social policies towards undocumented migrants on the



European level. Given the fact that undocumented migrants remain invisible in the eyes of many policy makers, organisations working with undocumented migrants are encouraged to give visibility to the problems associated to the short entitlements and enormous obstacles found by them to access basic social services in Europe. These organisations also highlight the consequences in terms of social exclusion and the efforts made by local actors (NGOs, health care providers and local authorities) who often work with limited resources to ensure that the fundamental principles of social inclusion also apply to undocumented migrants.

The immediate aim of PICUM's partnership with local actors was to improve access to health care for undocumented migrants by establishing and promoting a system of reporting on the situation in the EU-member states in the framework of the Social Inclusion Strategy. To this end, PICUM established a system of reporting on the health-situation of undocumented migrants to enable local actors communicate their concerns the European policy level and engage in the EU's strategy to address social exclusion. The Open Method of Coordination (OMC) is a voluntary process to which all Member States have committed. It encourages a strategic and integrated approach to the issues of poverty and social exclusion by mobilising relevant actors. Amongst its main objectives is the "facilitation of access to resources, rights, goods and services for all", which includes policies which aim to provide access for all to healthcare appropriate to their situation.

PICUM developed a set of "reporting templates" intended as a model of a submission to the National Action Plan on Social Inclusion being drafted in each EU member state, the template was actively promoted by the project's staff and partners. These templates remain available for free download on PICUM's website². In addition, the project's partners received training and information on the European Social Inclusion Strategy and were encouraged to participate in an active European lobbying network to influence the National Action Plans. During field visits, PICUM's researcher also provided information and training on the European Social Inclusion Strategy to field partners.

6. Anti-discrimination and human rights

PICUM follows a rights-based approach and thus advocates for the use of international human rights principles of universality and non-discrimination as a framework for developing policies. PICUM promotes awareness of undocumented migrants' human rights and advocates for the development of policies which affect them to be fully coherent with the international human rights framework. While PICUM's research on health care access provided a useful mapping exercise regarding the situation in each EU member state regarding accessibility to health care services for undocumented migrants, it is essential to note that each national situation regarding accessibility to health care services for undocumented migrants was weighed against the international standard on the human right to health care rather than against other member states.

² <http://www.picum.org>



The European Union and its member states are obliged to uphold the human rights of those within their jurisdiction. While member states may control their borders, immigration and social policies must be coherent with their human rights obligations. Under human rights law, migrants without a valid residence permit should not face limitations of their fundamental rights on grounds of their immigration status. Any distinctions made against undocumented migrants seeking to realise their innate entitlement to health care, adequate housing, fair working conditions and education are thus in violation of the universal principles of human rights protection. The right to the highest attainable standard of health is a fundamental human right protected by international law. An important element of the right to health is that both health care and other essential conditions for health must be affordable to all without discrimination. Authorities are thus under obligation to ensure that policies and programmes consciously address the different needs of those suffering barriers in accessing care. As it is essential to the realisation of all other rights, PICUM recognises that guaranteeing the right to health care is an important first step in improving the living conditions of undocumented migrants in Europe.

PICUM's project used and promoted awareness of the right to health and widely disseminated the definition of health as provided by the UN International Covenant on Economic, Social and Cultural Rights. According to article 12(1), States Parties recognize: "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." The content of this provision has been further clarified by the Committee on Economic, Social and Cultural Rights (CESCR), established to monitor the implementation of the convention in its General Comment 14. Accordingly,

"States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal migrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy..."

Despite this, PICUM found that while no member state's legislation specifically forbids access to health care for undocumented migrants, access to publicly subsidized health care, either partially or fully, is not entirely guaranteed in Europe. In some countries, all health care (even emergency care) is provided only on a payment basis and treatments are generally unaffordable for undocumented migrants.

Through its focus on human rights and anti-discrimination argumentation, PICUM's project successfully mainstreamed the debate regarding the need to improve undocumented migrants' access to health care within several key policy debates at national and European level.

7. Conclusions

Improving access to health care for undocumented migrants continues to be an urgent priority in Europe today despite the tremendous efforts made by civil society to fill the gaps and guarantee the minimum respect for human dignity. Nonetheless there are still many undocumented migrants in Europe who do not access any kind of health care or access it at a very late and dangerous stage. By uniting relevant local actors working on the issue and ensuring their involvement throughout the implementation of this project, PICUM created a



knowledge base regarding the lack of health care facing undocumented migrants in the EU, gathered best practices involving cooperation between a diverse range of local actors and developed a set of recommendations drawing on key human rights, anti-discrimination and social inclusion arguments.

World Health Organization
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Migrants and Health Care:
Responses by European Regions
(MIGHRER)

Complete reference material

**XVI. International Organization for
Migration: selection of field programmes
on migrant health**

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Migration is a world wide phenomena and no country remains unaffected by international migration, whether as a source, transit or destination country. In 2008 the total number of international migrants is estimated at some 200 million persons (3% of the world population) (IOM, 2008). Migration trend is increasing considering that over the last 35 years the number of international migrants has more than doubled; by 2050 this number is expected to be 230 million.

As migration increase as health consequences on migrants and stable community become a great concerns too, leading to the need to apply timely and effective strategy to prevent and manage health consequences of migration.

1. Programmes at the “migrants approach” versus the “mobility system”

Health prevention has been defined to include many levels; however interventions at the individual level still predominate. The majority of programmes which aim to change health risky behaviour mostly locate problems at the individual level with less attention to roots and the socio-economic contexts in which behaviour is performed. Many programmes provide important guidance in formulating the design and evaluation of interventions and they can be of support at individual level. But they can be insufficient to have an impact on the whole phenomenon of health vulnerability of mobile populations. In other words, programmes that train educators in the workplace that distribute prevention materials, that perform medical screening, counselling and others are extremely important for an impact on the individual level. But they do not address the root causes of vulnerability and they do not impact the structural factors.

To tackle health vulnerability of mobile populations in the long term, the socio-economic and political factors that drive mobility should be addressed. This includes the uneven distribution of resources, unemployment, socio-economic insecurity, economic instability and political unrest (Macneil, Anderson, 1998; Campbell, Williams, 1999; Maloney, 2004). Programmes need to be implemented in tandem with efforts to protect basic human rights and improve governmental policies on living conditions and well-being that influence structural factors; the AIDS sectors has shown effective studies in this direction (Campbell, Williams, 1999; MacNeil, Anderson, 1998). To assure a comprehensive strategy when facing health in the context of migration, an important conceptual shift should be taken into consideration: moving from the migrant approach to mobility system. Individual is only the starting point, but his attitude is the result of several inputs related to the mobility context (IOM, 2004; Decosas et al., 1995; Kane et al., 1993); it is therefore essential to start looking at the context of mobility, as sketched in Figure 1.

Many studies have shown specifically how social determinants (Haour-Knipe, Rector, 1996; Martini, 2008a, 2008b) are amongst the most relevant factors which might impact the status of well being during migration. Thus policies facilitating integration of migrants would benefit in term of public health.

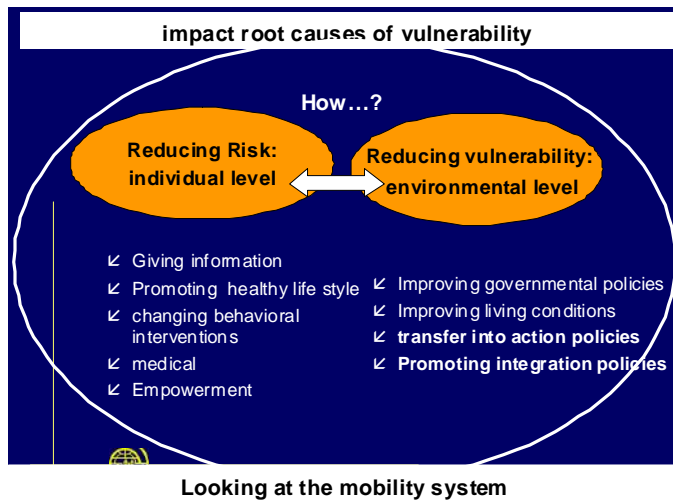


Key-problems and difficulties of health prevention among mobile groups

Migrants and mobile populations are often stigmatised because they are most likely perceived as abusers of the social welfare system, as criminals, and as a bridge for infection. For this reason, a problem that requires careful evaluation concerns the most appropriate interventions. How to reach migrants with effective strategies, while avoiding that targeted interventions and programmes lead to an increase in *stigma and discrimination*? Stigma creates a barrier for effective response. Health programmes based on a universal right to know rather than on the notion of risk groups should be favoured, making a fine differentiation among migrant groups rather than considering migrants as a generalised “other” (Haour-Knipe, 1993). Additionally if we widen the panorama to the mobility system (including countries of origin, transit and destination) we should also consider for instance at which stage of migration we should be more active in applying specific interventions. According to the experiences of IOM, gained especially in Africa, different mobile populations are vulnerable for instance to HIV/AIDS at different stages of mobility. Some migrants are most vulnerable at their destination; for example, men who work far from home and who live in men-only camps. For others, the greatest risk occurs in transit, when females may have to trade sex in order to survive or complete their journeys (IOM/UNAIDS, 2002).

Furthermore it is important to understand that not all migrants are equally vulnerable and not all migrants are facing the same health problems.

Mobilising communities of migrants and mobile people



Experience shows that migrant communities, like any other community, will contain individuals and associations willing to make significant contributions to assure access to care among their own. Given the necessary tools and resources, community members can provide peer education - and support for behaviour change and health needs - that will be more effective than support coming from “outsiders”. In collaboration with partners from host countries, migrant communities can also mobilise to influence the policies that affect them.



Migrants should not be considered only as beneficiaries and target groups within projects, but experiences suggested promoting their role as protagonist and active participants in project development and implementation. IOM is encouraging participatory approach then is one of the most effective and sustainable methods as a way to strengthen and promote the social capital of migrants.

The Social capital of migrants:

- Participatory approach
- Mobilizing migrants communities

At the light of the aforementioned concepts, IOM has implemented world-wide thousands of projects and programme, we presented here some example from different geographic area, however it is encouraged to visit the IOM website² for a wider panorama of IOM Health related projects.

Migration and Health Department - IOM

As the leading International Organisation for Migration, IOM acts with its partners in the international community in meeting the growing operation challenges of migration management, with an advance understanding of migration and public health issues, encouragement of social and economic development through migration and by upholding the human dignity and well-being of migrants and minorities.

IOM's structure is highly decentralised and service-oriented. There are currently 18 Missions with Regional functions (MRFs) serving as resource centres and 7 Special Liaison Missions (SLMs).

- **Field locations** increased from 119 in 1998 to more than 430 at present.
- **Active projects** increased from 686 in 1998 to more than 2,030 at present.
- **Operational staff** increased from approximately 1,100 in 1998 to approximately 6,690 at present, almost entirely in the field.

The Migration Health Department (MHD) addresses the needs of individual migrants as well as the public health needs of hosting communities through policies and practices corresponding to the emerging challenges facing mobile populations today. Consequently, the activities of the Department benefit a wide range of migrant populations, hosting communities as well as states and partner agencies.

IOM pursues migration health activities in over 40 countries worldwide. Activities are carried out in partnership with internal departments, international agencies, universities, governments and key partners. With offices and operations on every continent, IOM helps governments and civil society through:

- Rapid humanitarian responses to sudden migration flows
- Migration medical and public health programmes, including migration health and public health related campaigns on AIDS, TB, HIV, mental health etc.
- Post-emergency return and reintegration programmes
- Assistance to migrants on their way to new homes and lives
- Facilitation of labour migration
- Assisted voluntary return for irregular migrants

(continues)

² <http://www.iom.int>



- Recruitment of highly qualified nationals for return to their countries of origin
- Aid to migrants in distress - training and capacity
- Humanitarian and Social Programme - assistance to Roma and minorities
- Training of officials and building of measures to counter trafficking in persons
- Mass information and education on migration
- Research related to migration management and other services for migrants.

Strategic Objectives 2007/2010

- Strengthen and support institution of migration health in governments, donors, and civil societies
- Improve partnerships with academic institutions for building evidence
- Strengthen and support further integration of migration within IOM
- Identify and diversify efforts for revenue generation to implement migration initiatives

2. Europe and Neighbourhood countries

2.1. "PRISMA - Foreigners Project: Mobilizing migrants' communities in receiving countries - Italy" funded by the Italian Ministry of Health

Background situation

As for HIV&AIDS, the Italian policy is both to guarantee the access to an efficient health care for people living with HIV/AIDS (PLWH), and to reduce and contain the diffusion of the infection among the population. Within this framework, the migrant population, which accounts for a 6.8% of the total population in Italy, needs to be taken into consideration. Italian instruments and strategies for HIV & AIDS prevention and surveillance of sexual behaviours have been elaborated for and applied on the local population. Yet, an integrated approach, including determinants that respect traditions and cultures of all individuals, is essential. In this panorama and in the view to improve tools on HIV & AIDS prevention, IOM and the Italian Ministry of Health - promoted a 2-year project aimed at supporting an evidence-based strategy of HIV prevention in Italy, fully respectful of traditions and cultures of all individuals.

The project at glance

This project, funded by the Italian Ministry of Health, intends to implement on scientific-base HIV & AIDS prevention initiatives in team with associations dealing with migrants and HIV & AIDS. The strategic approach behind PRISMA project is to mobilize migrants' communities in receiving country to support the prevention of the spread of HIV infection among migrant population in Italy.

The project's structure includes a first assessment phase aimed at identifying a detailed profile for migrants in Italy with respect to information, risk perception, sexual and HIV & AIDS-related behaviours. While a second operative phase: a training course on "HIV & AIDS and migration issues", followed by a call for action dedicated to participants of the course. Both activities aimed at improving the HIV&AIDS knowledge and encouraging migrants associations to



promote prevention activities among migrants in Italy. Moreover, technical assistance and capacity building were provided by IOM to beneficiaries of the project, mainly: migrants' associations and those dealing with AIDS.

Effective approaches. The strategy of the project is based on mobilizing migrants' communities by empowering migrants associations as key figures to promote HIV prevention initiatives among migrants in Italy.

Results

In the first phase, a socio-behavioural research (Knowledge Attitude and Practice - KABP) targeting 1400 migrants, as well as a qualitative investigation (aimed at assessing HIV Information, Education, Communication - IEC - material produced in Italy and in countries of origin) involving 140 migrants were carried out focusing on three selected nationalities living in Italy (Albania, Morocco and Peru). Furthermore, HIV projects implemented in Italy targeting migrants were collected in order to have an up-to-date panorama in this field and a database was created as a new tool to improve coordination among people/experts dealing with HIV and mobility.

In the second phase of the project, 13 leaders of migrants' associations and 4 members of the Italian civil society dealing with AIDS were trained on issues related to HIV and migration. As a result, the Girasole proposal, promoted by a network of 14 associations, was funded and implemented. The proposal concerned a Campaign aimed at promoting HIV raising awareness activities targeting migrants in seven Italian cities from the North, Centre, and South of Italy. As main results of the campaign, more than 10.000 multilingual HIV/AIDS leaflets produced by the Italian Ministry of Health, together with condoms provided by Lila association were distributed among migrants. Posters and leaflets were produced by promoting associations to sponsor the events and at local level, collaboration and partnerships were established between migrants' associations and local authorities. As consequence, leadership, organizational and technical skills of migrants' leaders were strengthened and their expertise on HIV improved thanks also to the knowledge-sharing established with the Italian civil society dealing with AIDS.

Recommendations

PRISMA project highlighted as in European receiving countries such as Italy, mobilizing migrants associations/communities represent a concrete and effective tool to support national strategy on HIV & AIDS.

Moreover more support to migrants' associations/communities in receiving countries, is needed, in order to strengthen their capacity to deal with health issues and promote their collaboration with the local stakeholders.



2.2. "Assisting Migrants and Communities: Analysis of Social Determinants of Health and Health Inequalities" co-funded by the EC Health Programme

Background situation

The AMAC project was conceived to provide follow-up to high-level events on migration health by the Portuguese EU Presidency, the Council of Europe and the World Health Organization (WHO) in 2007 and 2008. The project aims to further the migration health policy agenda and contribute to address health concerns of migrants and communities affected by migration as well as foster multi-stakeholder dialogue on migrants' health and health inequalities expanding it beyond health professionals to include stakeholders in linked fields such as social affairs and the interior.

The project at glance

Three multi-disciplinary workshops were organized gathering each 30-40 specialist participants to discuss two to three background papers on key migrant health topics prepared within the framework of the project. IOM has collaborated for the elaboration of the papers with a number of leading universities and research centres in Europe as well as WHO, the Andalusian School of Public Health (Granada, Spain) and the Meyer University Children's Hospital (Florence, Italy). The project also counts with the support of various EU health and social affairs ministries.

Effective approaches. The AMAC project has successfully created a forum for discussion and exchange among experts and academics on health and migration, governments at national and regional level, European institutions, international organizations, professional organizations in the health sector, and diaspora and civil society organizations. This widened involvement supports a multi-pronged approach beyond the traditional interlocutors on migration health in the health sector, and specifically aims to bridge the gap between the practice in hospitals, the policy design at the relevant ministerial departments and the research of universities and public health centres.

Results

Background papers have been elaborated especially for the project in a number of topics: research on migration and health in Europe, capacity building for a European public health work force, mental health, legal and policy framework and the right to health of migrants and undocumented migrants, bioethics surrounding health checks, maternal and child care, adolescent health and care for the elderly.

The background papers, together with the workshop conclusions, will be presented at a final EU-level consultation gathering key stakeholders in the fields of health, social affairs and interior with a view to developing action points for integrating the recommendations into related national and EU policy strategies. A final publication including the background papers and the final consultation conclusions will be elaborated as a final outcome of the project and disseminated widely.



Main recommendations

1. Increased collaborative research in Europe and greater institutional coordination both within funding agencies and governments and between them.
2. A Migration Health Observatory to be set up to ensure the mapping, coordination and accessibility of migration health research and existing programmes and projects. Other measures for monitoring and coordination to be considered at EU level: migrant health policies barometer, open method of coordination mechanism.
3. Migrant populations to be considered in all strategies aiming at the reduction of health inequalities; however, migrants to be given specific attention for the particular challenges they face.
4. Legal access to health care to be guaranteed to all populations residing in the EU, including those groups such as undocumented migrants and victims of trafficking.
5. Efforts to be made to respond to factors challenging accessibility of services, i.e. cultural and linguistic variables, non-trust, economic cost etc.; capacity building efforts to be stepped up including training on communication and migration health for health professionals as part of an overall policy and institutional change strategy.

2.3. "Swiss - Georgian Cooperation in the field of Migration and Substance Abuse" funded by the Swiss Federal Office for Migration (FOM)

Background situation

In 2005, during the planning phase of the return and reintegration project for Georgian Asylum Seekers in Switzerland, it was recognized that a large proportion of Georgian Asylum seekers in Switzerland had a history of substance abuse. Given this fact, IOM integrated a specific component for this group in order to adequately prepare their return travel, and the rehabilitation and reintegration once they have returned.

The project at glance

The main objective was to guarantee to migrants, who started methadone substitution treatment in Switzerland, to continue their treatment upon return to Georgia. To this end, IOM Tbilisi created an extended network with medical institutions and state services to provide medical assistance for migrants with a history of substance abuse. At the beginning of the project (2006) this was difficult and often not possible because of the very limited places of methadone substitution treatment available in the country. By now, methadone substitution places are available in all the regions in Georgia and the returnees can be directly integrated.

Furthermore, the Swiss Federal Office for Migration (FOM) finances Hepatitis C treatments and IOM Tbilisi makes the referral to free of charge HIV treatments. From 2006 - 2008 more than 100 migrants returned in the framework of this project. About 1/3 received medical assistance (principally for treatment related to substance abuse). As a result of this project the Swiss Federal Office for Migration (FOM) decided to support a structural aid project in this field in Georgia. In October 2007 the "Social Rehabilitation and Reintegration project for former drug



users and people in methadone therapy; capacity building in the field of drug addiction” started (lasting for 2 years). The project was implemented through support from the Swiss Agency for Development and cooperation (SDC). In the framework of this project social workers who conduct ambulant social counselling were trained by a Swiss NGO called Contact Netz who has extensive and long lasting experience in this specific field. The aim is to integrate the target group in society by providing them a job or training. The social work is done by a local NGO (Tanadgoma).

Effective approaches

The innovative approach of social ambulant counselling was introduced in Georgia in order to support people who want to stay away from drugs in the future.

Results

In 14 month it was achieved the following: 737 counselling session, 50 persons referred to employment, 22 persons referred to training, 17 small business projects financed and 48 outreach meetings (prevention) conducted. In addition to the training for social workers, seminars were organized for medical practitioners and policy makers in cooperation with Swiss experts. In order to gain more know-how in the field of migration and substance abuse in connection with Georgia, the FOM mandated IOM Bern to conduct an applied research (from March 9 to March 10). The research focuses on the migratory process and substance abuse as well as on the services offered to returnees from Switzerland in this regard.

Main conclusion

Returnees from Switzerland with health problems related to substance abuse now receive the adequate treatment upon their return and can then concentrate on their professional and social reintegration.

In the framework of the project “Social Rehabilitation and Reintegration project for former drug users and people in methadone therapy; capacity building in the field of drug addiction” 50 ex-users or people in a methadone substitution program in Georgia were able to find a job with the assistance of the social workers and the Job counselling and referral centre (JCRC). About 40 more received training or were supported to start a small business project.

The research currently conducted by IOM Bern will provide more know-how on the situation of Georgian migrants in Switzerland, more specifically on the substance abuse problems. Furthermore it will show how effective the offered assistance is to the returnees. The results are expected for the beginning of 2010.

**Recommendation**

IOM experience stressed the need to guarantee medical assistance and promote integration to returnees also with experience on drugs abuse. Appropriate tools and approaches will facilitate successful programme in this field.

2.4. "HIV/AIDS national capacity building and awareness raising activities in South Eastern Europe: Macedonia and Kosovo experience with NGOs and journalists" funded by the Italian Ministry of Foreign AffairsBackground situation

Mass communications has an impact on social norms, attitudes and behaviours in every community. In addition to their influence on community norms, the press and other mass media may make the acceptance of HIV-relevant interventions easier or harder and address issues of social stigma of HIV. Concerted efforts of journalists, aimed at formulating appropriate programme and intervention on HIV/AIDS, can represent a further step in reducing the spread of the disease and the social stigma.

The project at glance

The project intended contributing to reducing the spread of HIV/AIDS in South Eastern Europe among mobile groups, targeting in particular Macedonia and Kosovo. It was intended to increase local capacity involving and training media professionals in order to provide a deontologically correct information spread, and develop a coherent and sensitive communication. New alliances, both local and transnational, were experimented in order to strengthen networking among relevant actors dealing with HIV/AIDS. To this perspective, as innovative approach, a participatory 4-module training course focused on HIV prevention involving both NGOs and mass media professional was implemented and the development of a strategy agreed by both to broadcast HIV/AIDS issues was prepared and promoted. One-week study tour in Italy involving NGOs members from Macedonia and Kosovo participating at the training course, was organized to share experiences and know-how with Italian NGOs well experienced on advocacy and empowerment. In order to better explore the context and migrants need, three social researches were implemented: "HIV/AIDS communication among mass media in Macedonia", "Knowledge Attitude and Practise - KAP-survey in Macedonia" and "HIV/AIDS and mobility in Kosovo: the KAP survey"; Two national conferences (in Kosovo and in Macedonia) as well as one international conference in Skopje were carried out in the framework of this project to facilitate networking.

Effective approaches

As innovative approach this project experimented a new collaboration between NGOs and mass media.



Results

About 40 Media experts and NGOs trained in communication and broadcasting strategies on HIV/AIDS issues; One strategy to broadcast HIV/AIDS issues as agreed by both NGOs and mass media developed; 23 NGOs members (from Macedonia and Kosovo) trained on empowerment and advocacy; One study tour organized in Italy for 23 NGOs members; National and International seminars organized.

A video tape including HIV/AIDS prevention spots as developed by NGO and mass media participating at the course produced, broadcasted and monitored; Manual including training curricula on HIV/AIDS prevention target at NGOs and mass media published.

Main conclusion

We actively encourage and support the participation of non-governmental organizations and mass media complemented by life skill programs for NGOs and Institutions. Multisectoral National Aids Committees in Kosovo and Macedonia target at mobile groups should be strengthened and inter-ministerial preventive initiatives be encouraged and supported.

This project created the based for other interventions in SEE focused on mass media and NGOs. Additional projects were implemented in Albania involving also TV stars and singers and in BiH.

Recommendation

The role of mass media in conjunction with NGOs in the field of health promotion should be sustained; their commitment can make the difference in tackle health issue amongst migrants. Additionally it will be relevant to continue experiences sharing with European countries with a view to harmonization with EU standards.

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(MIGHRER)

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**XVII. Migrant-friendly and culturally
competent health care: a task force of
the Health Promoting Hospitals network**

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1. Introduction

The dynamics of the migration phenomenon in Europe have created the condition for a more differentiated composition of migrants in terms of origin, legal status, motivations and levels of integration. Cattacin argues (2007) that today the increasing mix of the migrant population and the resulting growth in diversity has become a state of normality. That means not only different cultural ways of living but also different social right affiliations. Thus, the multi-cultural composition of the EU population requires health systems that take into account the differences in the needs, beliefs and practices concerning health and health delivery. However, experience in recent years show that migrant patients and members of minority ethnic communities and other disadvantaged groups tend to receive lower levels of health care compared to indigenous patients (Smedley et al. 2003) due to the lack of awareness of services available, the absence of provision for appropriate access to services and sometimes the negative attitude of staff in the delivery of health services. Moreover, migrants often lack the necessary information relating to access and to how health care services operate as well as relating to health issues generally in the specific local context. Therefore, health care organisations are finding themselves increasingly faced with the specific vulnerability of migrants who run greater risk of not receiving adequate service in diagnosis, care and prevention because of their minority status, their socio-economic position, communication difficulties and lack of familiarity with health systems. Key challenges are:

- How do we make health care services accessible, responsive and appropriate to all patients ?
- How do we ensure that health care services are effectively utilised ?
- How do we ensure that health care staff have the right skills and knowledge to deliver sensitive and equitable services ?

The aim of this paper is to present the main areas of concern in accessibility of health services and quality of care for these vulnerable groups encountered by European health organisations and what are the most effective interventions undertaken to overcome disparities and barriers. This presentation will make specific reference to the experiences collected through the work of the Task Force Migrant-Friendly and Culturally Competent Health care of the WHO international network of Health Promoting Hospitals.

2. Priority areas of concern in accessibility of health services and quality of care for migrants

There are many challenges facing both service users and providers. Examples include not only language barriers and cultural diversity, which hinder the equity of access to service and quality care, but also lower levels of health literacy among migrants, especially as concerns the appropriate use of health care systems. Migrants often lack information about available hospital and primary care services or about general health matters in the specific context of European societies. This is one of the reasons migrants often give for not using health services effectively and for not taking action themselves to prevent illness. The third challenge is represented by



the need to develop culturally adequate patient information and education and overcome low levels of cultural competence among health professionals with the development of specific training interventions. Disparity in access to health care and services can be diminished by creating culturally competent health care services, sensitive to diversity, which are able to transcend the linguistic and cultural barriers as demonstrated by the European project "Migrant Friendly Hospitals"².

During the project the Migrant-Friendly Hospitals planned and carried out a number of interventions, including "improving interpreting in clinical communication" (Novak-Zezula, 2005), "migrant-friendly information and training in mother and child care" (Karl-Trummer, 2005), and "staff training toward cultural competence (Krajic, 2006). The results were presented at a final conference - Hospitals in a Culturally Diverse Europe - in Amsterdam at the end of December 2004. The experience gained during the project was used to formulate policy recommendations for the successful development of migrant and minority-friendly services and organisational cultures in Europe. The Declaration also contains detailed recommendations for health care staff, health care users and representatives of community groups, health policy makers and administrators, and health scientists.

To sustain the momentum created by the EU project, a "Task Force on Migrant-Friendly and Culturally Competent Hospitals" (TF MFCCH) has been set up within the framework of the Health Promoting Hospital Network (HPH) of WHO Europe. The idea of creating a Task Force originated from the desire to continue working on these themes in a comparative international context after the conclusion of the MFH project, and to build on this experience in order to facilitate the diffusion of policies and experiences and stimulate new partnerships for future initiatives. As the main goal of the Task Force is to support member organisations in this process by the development of ways of improving the delivery of high quality, linguistically appropriate, culturally sensitive, equitable and accessible health care services it was decided to organise activities around three areas of concern:

- Language and communication barriers in clinical encounters,
- Low level of patient information and participation,
- Cultural barriers and lack of cultural competence.

3. Language and communication barriers in clinical encounters

Quality of care depends largely on good patient-provider communication. Language discordance between patients and health care staff, (that is patients on the one hand, who may not be able to speak and/or understand the local language, and staff on the other, who may not be able to communicate in the patients' mother tongue), this obviously leads to communication problems and misunderstandings (Andrulis, 2002). Patients who do not share the language of the healthcare staff caring for them are at risk of receiving lower quality care because of language barriers. This is particularly true when communication is part of diagnosis and treatment. Here,

² <http://www.mfh-eu.net>



it is of utmost importance that relevant clinical information is elicited from and conveyed to the patient in a correct and appropriate manner. Effective communication of medically relevant information is a prerequisite for both clinical decision-making and client-provider trust, and hence for the patients' successful treatment and co-operation in reproducing his/her own health. Both experience and analyses show that language barriers have not only a negative impact on access to and use of services, but also on the quality of care, on patient satisfaction and on health outcomes.

Bischoff (2006) in his review of the literature, shows how in the majority of cases a higher number of tests and admissions are requested for patients who do not speak the language and these patients run a greater risk of receiving inappropriate treatment. If no adequate language support is available health staff have difficulties in establishing patients identity, conducting clinical interviews, obtaining medical information and informed consent, and giving instructions at the moment of discharge. In the same way language discordance can lead to lack of trust towards health staff on the part of patients, to poor understanding of diagnosis and treatment and to inappropriate linkage with health and social services in the community. Furthermore, migrant patients tend to fail to attend follow up visits and to turn back up at emergency outpatients. Importantly, language is also a barrier to the use of prevention services. A great deal of research has shown that migrant women have fewer mammograms, screening and pap tests. In general, it has been found that the linguistic gap leads to lack of familiarity with (and at times total ignorance of) patient needs and medical explanations, creating greater difficulties to obtaining effective compliance and, as Cattacin (2003) points out, worsens the informative asymmetry, unbalancing patient-doctor relations.

During the phase of admission and diagnosis if no adequate language support is available there are difficulties in establishing patients native language and identity, patients have difficulty describing symptoms, clinical interviews can be misleading, only minimal medical information can be obtained, and it's more difficult for patients to clearly understand diagnosis and health conditions and consequently to obtain informed consent for diagnostic procedures. During treatment language discordance can lead to lack of trust on the part of patients towards physicians, patients may feel that the provider does not care; patients may have poor understanding of current treatment or follow up care, and it is difficult to obtain informed consent for therapeutic measures. In the same way the absence of language support at the moment of discharge could lead to having discharge instructions given in writing but in the local language, inappropriate linkage with health and social services in the community for the management of chronic illness or health behaviours.



4. Effective interventions to reduce language barriers

Investment in professional interpreting and intercultural mediation services for migrant/ethnic minority patients is a crucial precondition for communication with patients who do not speak the local language. Jacobs and colleagues (2001) were the first to show the effectiveness of professional interpreter services in improving the delivery of health care to a population of foreign-language patients. In a retrospective cohort study they found that patients who used the interpreter services had a significantly higher number of consultations, prescriptions and screening exams than the control group who did not have interpreters. Various modes of interpreting services are available and prove to be effective. Professional medical interpreters are presented as being the most effective strategy. Language competence alone is not considered sufficient to facilitate effective clinical communication across language barriers. Hence the recommendation is to work with professional interpreters who have acquired both the necessary communication skills and knowledge as well as the vocabulary needed to work in the medical sector as part of their training. The two options on how the services of professional interpreters could be obtained depend on the characteristics of the health service and its language needs. In-house interpreting system and interpreters could be hired as regular staff where the need for a particular language is high or when a single staff interpreter could be qualified to work with several foreign language patient groups. Co-operation with external interpreting services implies that interpreters are hired as hourly, on-call employees or as independent contractors. This is most useful where demand for a particular language is intermittent or infrequent, or when a health care organisation has fewer common language groups in its service area. One particular strategy is the establishment of community-based interpreting as a shared resource for various health care organisations.

Intercultural mediation, advocacy, and patient counselling should be provided for patients. The difference between interpreting and intercultural mediation lies in the role of the intercultural mediator acting on the one hand as an advocate supporting the patient or patient groups and on the other assisting health organisations in the process of making the services offered more respondent to users needs. Intercultural mediators serve as liaisons between patients and providers to mediate interactions, enhance mutual understanding and reduce conflicts. The required professional skills (although there is no recognised professional profile) are to be able to recognise the different migrant needs and resources; to mediate patient provider encounters in a linguistically and culturally competent manner and, finally, to orientate communication in a way that satisfies the patient as well as the provider.



Main areas of concern	Effective interventions
<ul style="list-style-type: none"> - Migrant patients do not receive complete information about their care. - Clinical staff is not able to understand patients' needs - Frequent communication problems and misunderstandings - Ineffective communication when non professionals are used as interpreters (e.g. family members) 	<ul style="list-style-type: none"> - Development of coordinated interpreting services (organisational level) - Use of professional interpreters and intercultural mediators (cultural brokers) - Use of telephone interpreting (regional level) - Use of culturally adequate written information (effective translations) - Development of policies on interpreting services (procedures and regulations) - Increase intercultural communication skills of health care staff (staff training) - Clinical staff need to become empowered on how to work competently with interpreters to overcome language barriers and obtain better outcomes (staff training)

5. Low level of patient information and participation

Both migrant patients and health care staff often emphasize the need to improve information and familiarity with access pathways, with how services work and with discharge procedures (in particular women's services, paediatric services and emergency outpatients). The improper use of services, lack of continuity of care after discharge (follow up visits, home treatment), the excessive in-take in hospital at certain times and during the weekend are all highlighted. Information, education and empowerment emerge as the fundamental elements in the care process and hospital assistance, both for identification of needs and for definition of solutions.

Patient and migrant community involvement is emphasized as being essential in order to identify both the obstacles and the potential and relevant resources needed to serve a multi-ethnic community. Encouraging the participation of patients and communities means ensuring they play an active role in identifying needs and in developing, implementing and evaluating prevention and health promotion programmes and service quality improvements. Whereas intervention on the issue of communication is necessary to overcome linguistic barriers and cultural competence is crucial to meet the needs of a migrant population, with empowerment another important step forward can be taken in the direction of greater health literacy for migrant patients, the aim being to make migrant patients more autonomous and to enable them to obtain, process and understand health information, navigate the healthcare system, actively participating in therapeutic decisions and health care processes, thus effectively managing their own health and healthy life styles.



6. Effective interventions to improve patient information and participation

Despite the fact that many already enjoy the benefits of the advancement of Information and communication technology all over the world, there are knowledge gaps and inequalities in access to information that impede access, to health services and inhibit participation. Therefore it is important to empower migrant patients by ensuring that they have access to the information that they need and that they are able to understand information. Empowering patients means also empowering their carers and families to have an active role in the care process. However, an over reliance on written information can become a barrier to patients' understanding of disease prevention, health promotion programmes and proposed treatment. Translation of leaflets and education materials would not help migrant patients who have limited literacy skills. Therefore health care organisations should have health literacy programmes to support patients to navigate and negotiate with the health system.

Involving communities is crucial in priority setting, planning, delivery and coordination of care. Kruseman's (2003) study reports on an intervention which aimed to reduce cooking-oil consumption by a group of refugees. The main goal of the dietary counselling programme was to decrease dietary fat consumption by refugees from former Yugoslavia living in Geneva, Switzerland. Cooking-oil was highly valued in participants' representation of health. In a series of participatory and motivational workshops, participants identified and practiced ways of reducing fat consumption. Knowledge and skills were measured after the workshops. The average reduction in oil used per recipe was 58%. The application of oil-reducing techniques increased nine-fold. Furthermore it is important to be aware of local knowledge in the process of engaging communities, that is those factors that affect demographic, social and spatial characteristics as well as the social and political infrastructure of communities. Therefore, the gathering of social data and local knowledge such as work patterns, social interactions and networks, internal and external power relationships of the target communities are fundamental. Finally, health care organisations need not only to build relationships with migrants communities, but also to develop alliances with local authorities, community services, schools, voluntary organisations etc., to work towards the common goal of empowerment. Improving community participation in prevention and health promotion programmes (e.g. screening) could benefit from the use of Community Health Educators (CHE) to provide outreach and enhance the social and cultural acceptability of the care provided within minority ethnic communities.



Main areas of concern	Effective interventions
<ul style="list-style-type: none"> - Not understanding explanations on treatments and ensuring fully informed consent - Not being able to ask questions and discuss implications - Difficulties in taking an active role in the care process - Not being able to effectively utilise health services and to self-manage health - Difficulties in receiving and understanding useful health education, health promotion and disease prevention programmes 	<ul style="list-style-type: none"> - Provide adequate information and education courses (health education) - Increase patients' ability to access and understand health information and navigate the system (health literacy) - Increase patient participation in the decision-making process regarding treatment (empowerment Vs compliance) - Involve communities in the planning and implementation of health promotion and prevention programmes (Community engagement) - Employing Community Health Educators to provide outreach to underserved groups (CHE)

7. Cultural barriers and lack of cultural competence

A recurrent issue in migrant patients' surveys is the need to increase awareness, sensitivity and the skill to deal with different cultures on the part of health care staff. At the same time, health care staff often emphasize the need to increase their own knowledge of different cultures, of migrant health, how health is perceived and what clashes there may be between healthcare and religious beliefs. Culture and ethnicity create specific models of belief and perception of the meaning of health and illness, which influence how symptoms are recognised and interpreted and have a direct impact on how health services are accessed. The acquisition of cultural competence means, therefore, having the ability to perform efficiently as a professional and as an organisation in the context of beliefs, behaviours and needs presented by patients of different ethnic and cultural backgrounds and their communities. cultural competence requires staff to have a working knowledge of the diverse spiritual, cultural and social needs of service users enabling them to provide culturally competent service. This means, on the one hand, being able to respond appropriately and without discrimination to the needs of migrant patients and, on the other hand, contributing to ensuring the efficiency and effectiveness of health care, reducing the number of clinical errors, unnecessary diagnostic tests and the improper use of services (Betancourt, 2002).



8. Effective interventions to improve staff cultural competence

To respond adequately to these challenges health care organisations need to develop the necessary cultural competence to improve awareness, knowledge and sensitivity of health care staff by identifying and assessing specific training pathways. To this end, health staff is to be provided with the knowledge, abilities and elements of awareness needed to improve the process of assistance, through a programme of training aimed at developing a multicultural approach and dialogue. The objective is to enable staff to act sensitively and competently in a multi-cultural context, overcoming stereotypes and prejudice, and reconciling different perceptions of health and beliefs with effective care pathways. Carillo and colleagues (1999) describe a cross-cultural medical curriculum that explicitly attempts to avoid the oversimplification and stereotyping that can accompany "cultural competence" curricula. They provide "practical cross-cultural skills" that providers can use when interviewing patients that take into account the patients' unique and multi-faceted social contexts.

However it is necessary to overcome an exclusively "cultural" approach to the question of migration, in so far as it is not so much a question of positioning the issue of "culture" in the foreground, as the actual experience of migration itself and the interaction between people in the context of migration. According to this approach, "cultural competence" does not mean having recourse to some kind of "cultural recipe" nor providing consultants and therapies for so-called "foreign cultures", but rather placing the individual person at the heart of the matter, with their individual history and sphere of personal life. As Domenig (2001) points out, it is extremely important nowadays to avoid a "culturalizing" attitude, as there is a general tendency in health services to stereotype migrants and to judge situations on the basis of prejudice and generic cultural constructs. This attitude should be replaced by an empathetic approach, which can be distinguished for its openness, curiosity and interest towards migrant histories and experiences. It is the migrants themselves, in fact, who can show the way towards a better understanding of their migrant life stories and, therefore, towards more competent health care and assistance from a "trans-cultural" point of view.

Main areas of concern	Effective interventions
- Respecting the legitimacy of patients' health beliefs and recognising their role in effective health delivery	- Include cultural competency training as a standard element in continuous professional education programmes
- Eliciting patients' explanations of illness and its perceived causes	- Include cultural competence as part of regular routine training
- Explaining the doctor's understanding of illness and its perceived causes in a language accessible to patients	- Develop culturally competent clinical practice, preventive services and health promotion activities
- Negotiating an understanding within which a safe and effective mutually agreeable treatment could be implemented	- Improve intercultural communication skills - Improve ability to use interpreting services effectively
- Being aware of health disparities and discrimination affecting minority groups	- Build a body of knowledge of local communities and needs



9. Conclusions

Disparities in accessibility and health care quality may result not only from linguistic, cultural and other barriers between patients and health care providers but also between entire communities and the health care system. Therefore there is a need not only to improve communication, patients' health literacy and the cultural competence of health care staff but also to design health care organisations sensitive to social and cultural diversity.

In order to respond adequately to the different needs of a diverse population, health care organisations have to engage themselves in a process of change. A precondition for initiating this process is that the value of "migrant-friendliness/cultural competence/diversity sensitivity become a central value in the organisation. That means acknowledging equal social dignity for different migrant groups and ethnic minorities, in addition to their right that action be taken to remove the obstacles to equality and equal opportunity, as there is no equality of opportunity if difference is not recognised and valued. At the same time we should avoid the risk of viewing patients as merely members of ethnic or cultural groups rather than individuals with unique experiences and perspectives as this could lead to stereotyping patients and making inappropriate assumptions. Implementing diversity sensitivity is not about privileging the underprivileged; by strengthening quality for the most vulnerable, quality for all patients is improved in the direction of more personalised services, taking the specific individuality of each person into account. Investments in increased responsiveness to the needs of populations at risk becomes an important step towards overall quality assurance and development.

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