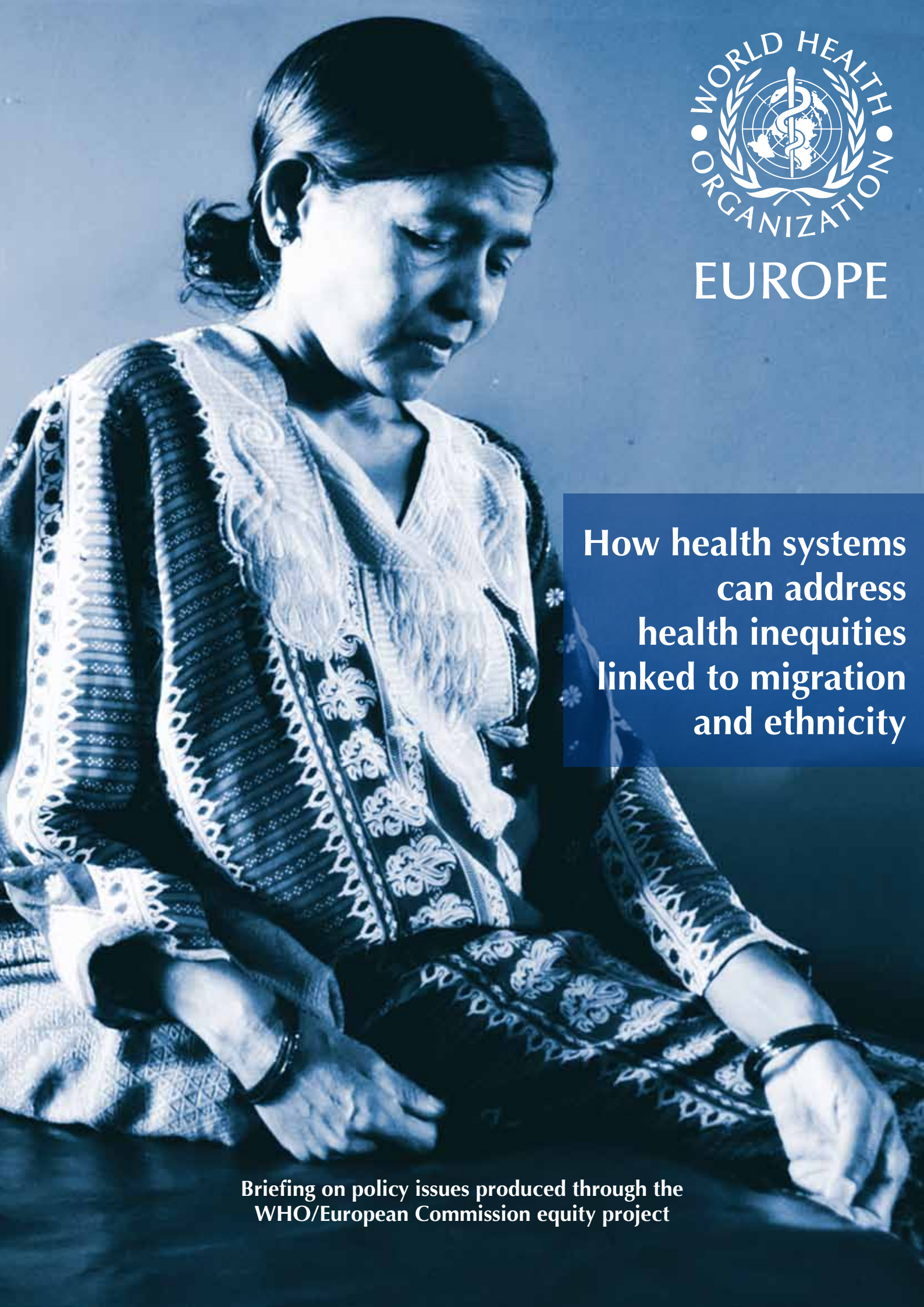

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How health systems can address health inequities linked to migration and ethnicity

Briefing on policy issues produced through the WHO/European Commission equity project

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Contents

Acronyms

AMAC	Assisting Migrants and Communities
CE	Council of Europe
CESCR	United Nations Committee on Economic, Social and Cultural Rights
CLAS	culturally and linguistically appropriate services
CSDH	WHO Commission on Social Determinants of Health
EC	European Commission
ECDC	European Centre for Disease Prevention and Control
ECOSOC	United Nations Economic and Social Council
EEA	European Economic Area
EIU	Economist Intelligence Unit
EU	European Union
EU-MIDIS	European Union Minorities and Discrimination Survey
FRA	Fundamental Rights Agency
FSG	Fundación Secretariado Gitano [Roma Secretariat Foundation (Spain)]
IOM	International Organization for Migration
MEHO	Migration and Ethnic Health Observatory
MIGHEALTHNET	Information network on good practice in health care for migrants and minorities in Europe
MIPEX	Migrant Integration Policy Index
NGO	nongovernmental organization
OMH	Office of Minority Health
ONS	Office for National Statistics
OSHA	European Agency for Safety and Health at Work
PAHO	Pan American Health Organization
PTSD	post-traumatic stress disorder
SCMH	Sainsbury Centre for Mental Health
SEKN	Social Exclusion Knowledge Network
SES	socioeconomic status
TB	tuberculosis
UN DESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme

Executive summary

Migrants and ethnic minorities are often dealt with separately by researchers and policy-makers. This briefing considers them both separately and together, given that in some countries there is partial overlap between these groups and they can face similar problems of social exclusion. At the same time, however, it must be borne in mind that the composition of both groups is very diverse.

There are about 75 million migrants in the WHO European Region, amounting to 8.4% of the total population and 39% of all migrants worldwide. Figures for ethnic minorities are not available, because there is little consensus about definitions and available data are scarce. The largest of these groups are probably Roma, with an estimated population of 12–15 million.

There is substantial evidence of inequities in both the **state of health** of these groups and the **accessibility and quality of health services** available to them. However, differences from the majority population vary according to the specific group being studied, the health problems or services involved, and the country concerned. Some groups may in certain respects enjoy health advantages, but it is mainly disadvantages that have been documented.

With rare exceptions, migrants and ethnic minorities tend to occupy a less-favourable social position and research indicates that this is strongly linked to their health problems. Statistically speaking, many health discrepancies are reduced or disappear when socioeconomic status is controlled for. Some, however, do not; even when they do, it may be more plausible to regard socioeconomic status as an intervening variable rather than as the root cause of ill health. Social disadvantage is reinforced by the manifold processes of **social exclusion** to which migrants and ethnic minorities may be exposed. Discrimination at individual and institutional levels, as well as the limited social rights accorded to many migrants, must be regarded as the fundamental cause of many health problems.

The policy framework adopted in this briefing is founded on principles that have been developed by the United Nations system (including WHO), the European Union and the Council of Europe in conjunction with the International Organization for Migration. It is a rights-based framework which seeks to relate health problems to their social determinants and to develop strategies for tackling inequities through the entire health system:

> … a health system is the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health. 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 (WHO Regional Office for Europe, 2008).

To tackle health inequities, it is necessary for health systems not only to improve the services available to migrants and ethnic minorities, but also to address the social determinants of health across many sectors. A wide range of policies and practices needs to be critically examined in the light of their consequences for the health and well-being of migrants and ethnic minorities.

Inadequate entitlement to use health services can make access difficult for many migrants and ethnic minority members. In addition, the entitlements they have may not be respected, particularly in the case of Roma. Emerging evidence demonstrates that entitlements of irregular migrants and asylum seekers show great variations between countries.

Existing health services have been developed with the needs of the majority population in mind and they may need to be adapted to provide high-quality, accessible and appropriate health services to migrants and ethnic minorities. These changes must extend to all services (health promotion and education, preventive care and screening, curative and palliative care).

A considerable amount of experience has been accumulated on the changes that are needed. This has been synthesized in a number of major recent reports, which this briefing will draw on in summarizing the "state of the art" in this area (see: Fernandes & Periera Miguel, 2008, 2009; Ministry of Health and Consumer Affairs & FSG, 2005; FSG, 2009; Peiro & Benedict, 2009; WHO, 2010a; Ministry of Health and Social Policy of Spain, 2010). However, implementation of this knowledge is at best patchy. Inequities in service delivery should be systematically investigated, "good practices" should be developed to tackle them, and the success of reforms should be critically evaluated.

Efforts to improve health systems should be undertaken in collaboration with migrants and ethnic minorities. Such efforts must involve all levels of government and have relevant agencies and actors acting in concert. Special attention should be paid to capacity building in the field of professional training and education, as well as the need to build adequate data-gathering and research capacity.

Key messages

General recommendations

- Migrants and ethnic minorities are groups that in some countries overlap to a certain extent and should therefore not be considered in isolation from each other by researchers and policy-makers.

- Policies should address both inequities in the **state of health** of these groups and in the **accessibility and quality of health services** available to them.

State of health

- Few straightforward generalizations can be made about the state of health of migrants and ethnic minorities. The effects found vary widely between different groups, countries and health conditions and as a function of gender, age and several other variables. Interventions therefore need to be appropriately targeted.

- In many countries, there is an acute shortage of information on the social situation of migrants and ethnic minority groups and their state of health. It is impossible to tackle inequities without such information. However, all due attention must be paid to the risk of misuse of data and the political sensitivity of monitoring these groups.

- Inequities in a group's state of health can only be remedied to a limited extent by improving health care: the underlying determinants must be addressed through (in the words of the Tallinn Charter) "disease prevention, health promotion and efforts to influence other sectors to address health concerns in their policies".

- In keeping with the principle of "equity and health in all policies", policies concerning discrimination, education, employment, social protection, housing, immigration, citizenship and the criminal justice system should be reviewed in light of their effect on the health and well-being of migrants and ethnic minorities. The health system can provide know-how and tools for equity-oriented health impact assessment.

- Even when socioeconomic differences appear to statistically explain health problems among migrants and ethnic minorities, policies which ignore issues of migration and ethnicity will not be able to address these inequities effectively, as the socioeconomic position of these groups is affected by complex, extensive processes of social exclusion. These processes should be regarded as the fundamental cause of many health disadvantages.

- Many health interventions focus on the problems and needs facing migrant and ethnic populations rather than on the assets they possess for creating, sustaining and safeguarding health. There are opportunities to move away from a strict deficit approach to health and incorporate programmatic elements to strengthen health-promoting assets in communities, such as social networks, intergenerational cohesion and health-supporting traditions.

Health services

- Inequities in health service delivery should be systematically investigated, "good practices" should be developed to tackle them, and the effectiveness of these interventions should be critically evaluated.

- Special efforts should be made to improve health services for groups with a particularly serious burden of ill health and for vulnerable groups such as children, older people, victims of trafficking or torture, asylum seekers and migrants in detention. Services should also take account of gender differences. However, the right of a group to equitable health services does not depend on the severity of their problems.

- When discussing access, different components of this concept must be distinguished. "Entitlement" refers to the payment of health costs through the statutory system of coverage (whether tax-based or insurance-based), while "accessibility" refers to the ease with which people who need services are able to reach them.

- Entitlements for all migrants and ethnic minorities should be as complete as possible, having regard to the political obstacles to unlimited access that exist in some countries. However, entitlements on paper are not enough: it is also essential that both users and service providers should know what the entitlements are. Information campaigns to inform migrants and ethnic minorities about the services they can claim may be necessary to ensure this.

- The rules governing entitlement to care and the procedures for securing it should not be unnecessarily complex. They should not present barriers to those with limited language skills and understanding of the health system.

- Out-of-pocket payments (including those of an informal nature) to cover part of the cost of consultations, tests or medicines should be reduced to a minimum as they exacerbate health inequities.

- Nongovernmental organizations often carry out valuable work with migrants and ethnic minorities. However, quality control and sustainability may be difficult to guarantee outside the mainstream health system, and if care outside the system becomes structural, the social exclusion of the groups being cared for may be further institutionalized.

- The accessibility of health services for migrants and ethnic minorities should be monitored by:

  - analysing levels of utilization
  - noting tendencies to seek treatment at later and more acute stages
  - consulting the groups about the barriers they experience.

- Preventive care, health promotion and health education programmes for migrants and ethnic minorities must employ an outreaching approach and must be appropriately targeted. Health promotion and education should provide information about when and how to use health services as well as how to avoid illness and promote health. This information should show awareness of divergent health beliefs, "explanatory models" and attitudes to help-seeking that some groups may adhere to, and the daily living and working conditions that may influence health and health system usage.

- Equity in health service provision does not necessarily mean being able to use the same services as everybody else. Existing services may have to be adapted to give migrants and ethnic minorities access to high-quality, appropriate health services.

- Many of the changes required involve reducing linguistic, cultural and social obstacles to access and effective service delivery:

  - language barriers can be reduced by providing interpreter services and translated materials;
  - the employment of "cultural mediators" can increase mutual understanding and improve communication between service providers and their clients; and
  - improvement of the "cultural competence" of service providers helps to reduce cultural and social barriers.

- In addition to improving the skills of individual health workers, "cultural competence" should be furthered at organizational level by regularly reviewing all procedures and processes within the organization and by paying attention to, for instance, external communications, reception procedures, opening hours and recruitment strategies. Improvements must be structurally embedded in policy to guarantee their sustainability.

- A multisectoral approach to service provision (involving, for example, coordination between health and social services) is particularly important for migrants and ethnic minorities as the problems of these groups often have several interrelated dimensions.

- Participation of migrant and ethnic minority groups in the design and delivery of services is essential to reduce the social and cultural distance between services and their users.

Implementation

- Implementation of the measures discussed in this briefing requires a substantial programme of capacity building focused on three areas – **research, education, and training** – and on the **consolidation of expertise**. Fragmentation of effort should be combated by encouraging cooperation between disciplines, professions and Member States. The European Union has a vital role to play in furthering such cooperation through its programmes on research, health services, social protection and migration.

- Implementing these policy measures also calls for a multisectoral and multistakeholder strategy involving national, regional, provincial and municipal authorities, as well as civil society and local communities, businesses, professional, educational and scientific bodies, media, global fora and international agencies. Although national governments should play a leading role, the participation of all these actors is essential to achieving change.

- Ill-informed public opinion can undermine the acceptability of measures to promote health equity for migrants and ethnic minorities. Measures should therefore be explained and justified in public discussions and the media.

- Migration- and ethnicity-related factors should be acknowledged as powerful social determinants of health. Attention to these factors should be treated as an intrinsic component of national and international strategies to reduce health inequities. Health impact assessments should include an evaluation of the impact of measures on migration- and ethnicity-linked health inequities.

1. Introduction

Scope of this briefing on policy issues

This briefing explores how health systems in the WHO European Region[1] can address health inequities linked to migration and ethnicity. "Migrants" are defined here as those who have left their country of birth to reside elsewhere, and "ethnic minorities" as groups regarded by themselves or others as distinct from the majority population in terms of their origin, ancestry, culture, language, religion or collective identity. Although some migrants may have the same ethnicity as the majority population and some ethnic minority groups may be indigenous, in some countries many (but not all) ethnic minorities are made up of migrants and their descendents, so the two categories often overlap.

Both being a migrant and belonging to an ethnic minority are frequently associated with impaired health and poorer access to health services. Furthermore, both groups are more exposed to social disadvantage and exclusion, though it is important to emphasize that this is an average tendency which does not apply to all individuals.

In some countries, health research and policy-making focuses predominately on ethnicity while largely ignoring migrant status. In others, the very notion of "ethnicity" is regarded with suspicion and strong objections may exist to the collection of data on ethnic minorities: in this situation, attention is likely to focus on migrants. Migrants may be classified according to their country of origin, but this variable is not an adequate proxy for ethnicity: a single country may harbour many ethnic groups, while a single ethnic group may be scattered across many countries. If attention is paid only to migrants, their descendents will be overlooked, whereas health problems in later generations may be even greater than those in the first. To do justice to the interests of all groups, therefore, it is necessary to consider both migration and ethnicity.

In the past, the main focus of research and policy-making on migrant health has been on the threat which "import diseases" carried by migrants may pose to the majority population. Today, however – although the risks of contagious diseases still have to be taken very seriously – this work is informed by a "public health" perspective that considers the interests of migrants themselves and not simply those of the majority population. In this perspective, noncommunicable and chronic diseases are no-less important than those that are contagious (Bhopal, 2009).

The study of ethnicity and health has traditionally been prompted by concern about inequities, such as those between African Americans, Native Americans and whites in the United States, and that is also the focus of this briefing. It examines not only the health of ethnic minorities that have resulted from recent immigration, but also that of minorities that may have been present in a country for generations (sometimes as long as the majority population), focusing in particular on the Roma population.[2] Some Roma do in fact have a recent migration background, but this briefing concentrates on their ethnic identity.

There are two reasons for paying special attention to this group. First, Roma constitute the largest ethnic minority in the WHO European Region, with an estimated population of 10 million in the European Union (EU) and several million more in countries outside the EU. Second, research has shown that the burden of ill health among Roma is particularly severe and that most conditions are related to their disadvantaged social position. At the same time, access to appropriate health services is often inadequate (UNDP, 2002; Ministry of Health and Consumer Affairs & FSG, 2005).

Policy framework underlying this briefing

The framework within which we will treat these issues is drawn from the following sources.

First, the briefing adopts the approach to health systems elaborated in the Tallinn Charter, endorsed by all Member States of the European Region in 2008 (WHO Regional Office for Europe, 2008). In keeping with this approach, the focus here is not on health care (or even health services) alone, but on the health system in its entirety: "Health

[1] The WHO European Region comprises 53 Member States: Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, the Netherlands, Norway, Poland, Portugal, the Republic of Moldova, Romania, the Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, the United Kingdom and Uzbekistan.

[2] In this briefing, and in accordance with the Council of Europe's glossary on Roma (CE, 2006a), the encompassing term "Roma" refers to various communities that self-identify as Roma and others (such as Ashkali) that resemble Roma in certain aspects but insist on their ethnic difference.

systems are more than health care and include disease prevention, health promotion and efforts to influence other sectors to address health concerns in their policies" (WHO Regional Office for Europe, 2008:2).

The briefing also discusses health systems in terms of the four functions set out in the Tallinn Charter: delivering health services, financing the system, creation of resources, and stewardship. Efforts to improve health are viewed not as a burden, but as an investment: "Beyond its intrinsic value, improved health contributes to social well-being through its impact on economic development, competitiveness and productivity" (WHO Regional Office for Europe, 2008:1).

Second, the briefing will draw on the work of the WHO Commission on Social Determinants of Health (CSDH) (CSDH, 2008), which regards processes of social exclusion as the major cause of health inequities among migrants and ethnic minorities. The Social Exclusion Knowledge Network (SEKN) of the CSDH offers the following definition:

> Exclusion consists of dynamic, multi-dimensional processes driven by unequal power relationships interacting across four main dimensions – economic, political, social and cultural – and at different levels including individual, household, group, community, country and global levels. It results in a continuum of inclusion/exclusion characterised by unequal access to resources, capabilities and rights which leads to health inequalities (SEKN, 2008:2).

In the words of the European Commission (EC):

> Social exclusion is a process whereby certain individuals are pushed to the edge of society and prevented from participating fully by virtue of their poverty, or lack of basic competencies and lifelong learning opportunities, or as a result of discrimination. This distances them from job, income and education and training opportunities as well as social and community networks and activities. They have little access to power and decision-making bodies and thus often feel powerless and unable to take control over the decisions that affect their day to day lives (EC, 2004:10).

Whether discrimination is conscious or unconscious, individual or institutional, it has intertwined consequences across a range of sectors and these consequences have a negative impact on health. To this one may add that precisely because migrants and ethnic minorities experience widespread social exclusion, their interests tend not to be adequately represented in national policies. This is why it is often necessary for international agencies (intergovernmental, governmental and nongovernmental) to take initiatives to protect the well-being and health of these groups.

Other WHO initiatives upon which this briefing will draw are resolutions on health of migrants (World Health Assembly, 2008) and reducing health inequities through action on the social determinants of health (World Health Assembly, 2009), the social determinants of health web site (WHO, 2010b) and the work done to follow-up resolution EU/RC52/R7 (WHO Regional Office for Europe, 2010b).

Third, this briefing is informed by the framework of international covenants and conventions which endorse the universal human right to health without discrimination based on nationality or legal status (see: Pace & Shapiro, 2009; ECOSOC, 2010). Some of these are listed in Box 1.

Fourth, this briefing draws on relevant work being carried out by the EU and the Council of Europe (CE). This includes, but is not limited to: the EC communication on solidarity in health: reducing health inequities in the EU (EC, 2009); the Council of the European Union's conclusions on Roma (Council of the European Union, 2009) and equity in health in all policies (Council of the European Union, 2010); the work of CE to promote the health of migrants and the Roma population; the many research projects financed by EU agencies (see: Ingleby, 2009); and the activities of the Portuguese and Spanish EU presidencies concerned, respectively, with migrant health and health inequities (Fernandes & Pereira Miguel, 2008, 2009; Ministry of Health and Social Policy of Spain, 2010).

Fifth, the briefing draws on the work of the International Organization for Migration (IOM), which has been active for many years in the field of migrant health worldwide. Particularly relevant to this briefing are the findings of the Assisting Migrants and Communities (AMAC) project (Peiro & Benedict, 2009).

Finally, the briefing is informed by the efforts of the steadily growing community of researchers and health workers who have concerned themselves with migration and ethnicity over the past 30 years and more. A landmark event in the development of expertise on this topic was the 1983 conference organized in The Hague by the

Government of the Netherlands and the WHO Regional Office for Europe (Colledge, Van Geuns & Svensson, 1986). Since then, knowledge about migrant and minority health has increased considerably, with remarkable growth in the last 10 years (Ingleby, 2009). However, concrete steps towards implementing this knowledge and expertise in health policy have lagged behind, and it is hoped that this briefing will contribute to more sustained and far-reaching policy changes in the future.

Box 1. A selection of relevant international legal instruments

United Nations

- Universal Declaration of Human Rights (1948)
- International Convention on the Elimination of All Forms of Racial Discrimination (1969)
- International Covenant on Economic, Social and Cultural Rights (1966)
- Convention on the Elimination of All Forms of Discrimination Against Women (1979)
- Convention on the Rights of the Child (1989)
- Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990)
- The right to the highest attainable standard of health. General Comment No. 14, Committee on Economic, Social and Cultural Rights (2000)

Council of Europe

- European Convention on Human Rights (1950)
- European Social Charter (1961, revised 1996)

European Union

- Directive combating discrimination (2000) (the "racial equality directive")
- Charter of Fundamental Rights of the European Union (2000)

Major topics covered

This briefing focuses on two main topics: the state of health of migrants and ethnic minorities; and the access these groups have to appropriate, high-quality health services.

State of health

This topic concerns the health inequalities that research has identified, the factors that are believed to underlie them, and the policy measures needed to tackle inequities. It should be stressed that it is easier to identify "inequalities" than "inequities". The Pan American Health Organization (PAHO) (PAHO, 2004:9) explains the difference as follows:

> According to Whitehead (1991) and Schneider (2002), inequality is not synonymous with inequity. Inequity is an unfair and avoidable inequality, and therein lies its importance for decision-makers. Classifying an inequality as inequity implies knowing its causes and being able to substantiate a judgment as to the unfairness of those causes.

Regarding the causes of health inequalities, Stronks et al. (1999) proposed dividing these into specific (proximal) determinants such as lifestyle, physical environment, social environment (including discrimination and social networks), psychosocial stress and use of health services. Underlying these are general factors such as genetic and cultural characteristics, short-term migration history, ethnic identity and position in the host country (high/low status, social inclusion/exclusion).

Clearly, not all unequal health outcomes can be regarded as inequities. Genetic vulnerability to certain illnesses may in some cases be avoidable (through, for instance, genetic counselling or prophylactic measures), but it is unlikely – except in the case of genetic mutations caused by exposure to industrial pollutants – to be a product of injustice. However, the distinction between inequalities and inequities is sometimes blurred. Unhealthy diet and smoking, for example, may to some extent be cultural traditions, yet they may also be consequences of social disadvantage (the term "culture of poverty" was introduced by Lewis (1959)). Often, an unhealthy diet reflects the unavailability of healthy food. Many of the inequalities that have been identified can be regarded, at least in part, as "unfair and avoidable".

A fundamental point which policy-makers must bear in mind regarding the state of health of migrants and ethnic minorities is that few straightforward generalizations can be made. The effects found vary widely between different groups, countries and health conditions and as a function of sex, age and many other variables. The

health problems of first-generation migrants, for example, may differ from those of their descendents. Moreover, there are also examples of health advantages enjoyed by particular groups. Indeed, Bhopal (2009:142) asserts: "Where minorities exhibit the lowest rates of disease or risk factors they should provide the goal for other groups to emulate". However, the fact that no simple generalizations are available in no way weakens the point that the burden of ill health among certain migrant and ethnic minority groups is often unacceptably large.

Health services

The second major topic concerns the access migrants and ethnic minorities enjoy to appropriate and effective health services. Here, findings are more consistently negative but still show considerable variation between different groups and countries. Some health services also perform better than others.

When discussing access, separate attention must be paid to the different components of the concept. Whether a particular group is entitled to use health services depends on legislation and/or insurance regulations, but whether these services effectively reach a group – their accessibility – depends on the degree to which service providers have taken account of the group's special needs. In terms of health system functions distinguished in the Tallinn Charter (WHO Regional Office for Europe, 2008), "accessibility" relates to service provision, while "entitlement" relates to financing and stewardship. These are distinct issues, and it is possible to find countries in which effort is devoted to improving the quality of health services for regular migrants and their descendants, while groups such as undocumented migrants or asylum seekers are not allowed to use some of these services. This underlines the need for coordination between different components of the health system.[3]

Regarding the relationship between the topics "state of health" and "health services", three points need to be stressed.

1. Special efforts need to be made to improve health services for groups with a particularly serious burden of ill health. However, the right of a group to equitable health services does not depend on the severity of their problems. Even if the group's health profile is the same as that of the majority population, or even better, it is still entitled to enjoy an equal standard of service provision.

2. Equity in health service provision does not always mean being able to use the same services as everybody else. Because the existing health system has been developed to suit the needs of the majority population, it is not likely to be optimally adapted to the needs of other groups. Providing the "same" services for migrants and ethnic minorities may therefore amount to providing inferior ones. As we shall see below, existing services may have to be adapted to cater properly for these groups.

3. Inequities in a group's state of health can only to a limited extent be remedied by improving health care: it is more important to tackle the underlying determinants through (in the words of the Tallinn Charter) "disease prevention, health promotion and efforts to influence other sectors to address health concerns in their policies". This is a question of stewardship. A multisectoral strategy for tackling health inequities is also embodied in the principle of "health in all policies", introduced by the Finnish Presidency of the EU (Stahl et al., 2006; Council of the European Union, 2006) and further elaborated as "equity and health in all policies" by the Spanish Presidency of the EU (Council of the European Union, 2010). Similarly, the Bangkok Charter for Health Promotion (WHO, 2005a) refers to the need for policy to be coherent across "all levels of government", consequently emphasizing that national, regional, provincial and municipal authorities all have a part to play in promoting health (see, for example: Campbell, 2010). Finally, the CSDH (2008:16) refers to health equity as an issue "for the whole of government" and stresses that nongovernmental actors are involved too: "civil society and local communities, business, global fora, and international agencies" (CSDH, 2008:1). This should be understood as including professional, educational and scientific bodies and the media.

2. Migrant and ethnic minority populations in the WHO European Region

As was mentioned above, there is sometimes overlap between the categories "migrant" and "ethnic minority". In this section, we will review briefly the nature of these populations in the WHO European Region. As social exclusion has been identified as a major determinant of ill health, we pay particular attention to this phenomenon.

[3] Lack of coordination between government agencies – for example, between the departments responsible for immigration policy and for public health – often underlies such discrepancies.

Migrants

This briefing defines migrants as "persons residing outside their country of birth". These people make up 8.4% of the population of all Member States of the WHO European Region and number 74.5 million, which is 39% of all migrants worldwide.[4] (Note that it does not consider the situation of internal migrants and that irregular migrants are not included in these statistics).

The term "migrant" conceals great diversity. First, the following types of migrant can be distinguished: labour migrants, refugees and asylum seekers, family members of existing migrants, victims of trafficking, returnees, and irregular (or "undocumented") migrants. The last category may include people without a valid entry permit, or residence permit, or work permit, some of whom owe their irregular status to bureaucratic delays and errors (CLANDESTINO, 2009; Vogel, 2009). Contrary to popular assumptions, only a small proportion of irregular migrants are "unauthorized entrants". Irregular migrants make up approximately 1% of the population of the EU (Düvell, 2009), though estimates for the Russian Federation and for Turkey are much higher (Ivakhniouk, 2004; Içduygu, 2008).

Second, countries of origin are diverse and tend to be associated with different types of migration. Most refugees and asylum seekers come from known areas of conflict, and most unskilled labour migrants come from lower- and middle-income countries. Country of origin is also linked to ease of entry. At one extreme, migration between EU Member States is subject to few restrictions; at the other, the possibilities for unskilled labour migrants from countries designated as "non-western" to enter Europe have been severely limited ever since the oil crisis of 1973. The numbers of irregular migrants have increased as immigration policies have become steadily more restrictive, because the pressures which induce people to migrate, and the advantages of irregular migration for employers seeking cheap labour, have not diminished. In some countries, regularization campaigns reduce the total numbers from time to time.

Migrants may remain in the host country ("settlers"), move on to another country ("transit migrants"), or move back and forth between the home and host countries ("circular migrants" such as seasonal workers). To summarize the major movements of migrants in the WHO European Region since the Second World War would go beyond the limitations of this briefing: the reader is referred to in the useful web sites section at the end.

On average, the socioeconomic status (SES) of migrants is lower than that of native-born people, though some groups may actually do better and there are marked individual differences. Lelkes, Platt & Ward (2009) showed that people in households where all the adults are migrants are more than twice as likely to live below the relative poverty line as others (Portugal being the only EU country studied where poverty levels were higher among the indigenous population). Migrants often perform work below their level of qualifications. Prior to 1973, many unqualified labour migrants were admitted to Europe as "guest workers" to remedy shortages of unskilled labour. For various reasons, a large proportion of these (especially from non-European countries) did not return to their home countries. Their SES remained low, and although their offspring generally fared better, many groups have remained in a disadvantaged position (Liebig & Widmaier, 2009).

On average, migrants tend to be younger than the majority population – indeed, the rapid ageing of "native" European populations is regarded by the United Nations Department of Economic and Social Affairs (UN DESA, 2009) as an important argument for encouraging immigration. Until recently, male migrants were in the majority, but today the sex ratio is approximately equal. Migrants tend to live in the more densely populated and industrialized areas of a country, an obvious exception being formed by (seasonal) agricultural labourers.

Ethnic minority populations

Ethnicity is a topic on which useful statistics are much harder to obtain. The main reason is that there are widely differing views about what ethnicity is, which ethnic groups exist and who should be regarded as a member. In addition, the collection of data on ethnic minorities is a highly controversial issue in many countries.

The nature of "ethnicity" has long been a topic of debate among social scientists. The classic ("primordial") definition assumes that people can be ascribed to an ethnic group on the basis of objective characteristics such as their origin, genetic heritage, language, culture or religion. "Instrumental" definitions, by contrast, regard ethnicity as a social construction and/or an individual choice, the boundaries of which are negotiated in a pragmatic way. Some ethnic minorities are officially recognized by the state, but this practice is not universal.

[4] These figures are derived from the United Nations Department of Economic and Social Affairs (UN DESA, 2009) and relate to 2005.

Ethnic groups can originate in different ways. Indigenous peoples may have lived in a country as long as, or even longer than, the majority (or dominant) ethnic group. Other ethnic groups have been created by changes in national borders, as happened, for example, during and after the First and Second World Wars, the dissolution of the Soviet Union and the Balkan wars.

Last, there are ethnic groups that have resulted from immigration. This category is particularly difficult to delineate, since there is no agreement about when a migrant should be regarded as a member of an ethnic minority, or for how many generations the descendents of migrants should continue to be regarded as ethnically distinct. Sometimes migrants are regarded as members of the majority community from the moment they acquire citizenship (if this option is available); others will continue to be regarded as "foreigners" for many generations. In some countries, children of migrants automatically acquire the nationality of the host country: in others, they do not. There may be discrepancies between legal definitions and popular definitions, as well as between the definitions used by the group in question and by the majority population.

In this situation, it is clear that hard-and-fast statistics on the number of ethnic groups in a country, and the number of members in each group, will be practically impossible to obtain. Nevertheless, it is possible to obtain a rough indication of the size of some ethnic minority populations in some countries. In the Netherlands, for example, most ethnic minorities have been formed by migration. The government defines all people with at least one foreign-born parent as "allochthonous" (that is, of foreign origin): at present, 20% of the population fall into this category, with roughly equal numbers of migrants and children of migrants. In the United Kingdom, where post-war immigration began earlier, the proportion of children of migrants is probably higher, while in Portugal or Ireland, where immigration only gathered pace at the end of the 20th century, it is likely to be lower.

Figures for indigenous minorities and for ethnic minorities created by border changes are somewhat easier to establish, because in many cases official statistics are available. The largest minority groups in the WHO European Region are Roma and Travellers, with an estimated 10 million in the EU alone. The Member State with the highest number of different ethnic minority groups is the Russian Federation, where, according to a CE report (CE, 2005), more than 170 separate groups are distinguished.

Concerning the position of ethnic minorities in majority society, some groups are relatively secure, while others experience a marginal and disadvantaged position. Roma and Travellers face persistent disadvantage stemming from poverty, unemployment, lack of education and poor health.

Ethnic minorities are often the target of discrimination and marginalization. Indeed, in the history of humankind, the catalogue of oppression, violence and even genocide engendered by interethnic hostilities is a long and terrible one.

Because of the vulnerability of ethnic minorities and for other country-specific reasons, the collection and publication of data concerning them may be discouraged. The dilemma for policy-makers is, however, that as long as the situation of such groups is not monitored, it is difficult to take steps to improve it. Adequate monitoring of the social conditions experienced by ethnic minority groups and their health is essential to be able to respond quickly to their problems, but all due attention must be paid to the risk of misuse of data and political sensitivities concerning the collection of ethnic data.

Migrants, ethnic minorities and social exclusion

Incomplete citizenship rights

Migrants, as long as they have not achieved naturalization, are subject to perhaps the most fundamental form of social exclusion: as foreign nationals ("aliens"), they do not enjoy the citizenship of the country in which they live. This is an inherent property of the nation state, which respects certain universal human rights but reserves many important rights and privileges for its own citizens.

There are considerable differences between countries in the degree to which they are prepared to extend citizens' rights to migrants. This also depends on the type of migrant in question (labour migrant, asylum seeker, family member, irregular migrant etc.). Several attempts have been made to compare the "migrant-friendliness" of different countries: these include the Migrant Integration Policy Index (MIPEX) (MIPEX, 2007) and the accessibility score developed by the Economist Intelligence Unit (EIU) (EIU, 2008). The latter index comprises ease of hiring, licensing requirements, ease of family reunification and official integration programmes for

migrants: it is highest in the traditional immigration countries (United States, Canada, Australia and New Zealand) and lowest in the Gulf states (UN DESA, 2009:38). Most European countries occupy a position in between these two extremes, with a tendency for countries accustomed to harbouring many migrants to accord them more rights.

The EIU accessibility score, however, takes no account of a number of rights that are highly important for migrants – for example, the right to naturalization, long-term residence, political participation, protection from discrimination and access to social protection services and benefits (including health and social care). Attempts at international level to improve the rights of migrants have met with only limited success. The United Nations Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (United Nations, 1990) has so far only been ratified by 42 sender countries and not by any European or North American receiving countries (MacDonald & Cholewinski, 2007).

Turning now to ethnic minorities, most indigenous groups in the WHO European Region (that is, those not formed by recent immigration) enjoy full citizenship of the countries in which they reside, though there are still some anomalies. The inadequacy of previous international legal instruments to protect national minorities led to the CE Framework Convention for the Protection of National Minorities, which was opened for signature in 1995. Although this Convention is no more than a "framework" and contains few legal mechanisms for enforcement, there are still some CE Member States that have not signed or ratified it. However, the distinction between de jure and de facto rights is important here. Some ethnic minorities, most notably members of the Roma community, may have equal rights in theory, but discriminatory practices may undermine these in practice. In the European Year for Combating Poverty and Social Exclusion (2010), much attention is being paid to the situation of the Roma community; most problems, however, do not so much concern a lack of legal rights as a failure to implement rights that Roma already have.

Discrimination

Although the legal rights of ethnic minorities may in general be more comprehensive than those of migrants, both groups are subjected to the more-diffuse forms of social exclusion rooted in discrimination. "Discrimination on the basis of cultural, social and/or racial identity generates powerful exclusionary processes" (SEKN, 2008: 66). Two main forms can be distinguished.

Individual discrimination

The most well-known form is "individual", "active" or "conscious" discrimination, which occurs when one person treats another unfairly because of, for instance, his or her sex, race, age, ethnicity, religion or nationality. The occurrence of this type of discrimination in the EU is monitored by bodies such as the Fundamental Rights Agency (FRA), which issues annual reports on the situation (see, for example: FRA, 2009a). At present, the FRA is carrying out a major research project on discrimination and victimization of immigrants and ethnic minorities, the European Union Minorities and Discrimination Survey (EU-MIDIS) (see: FRA, 2009b), with a special report on discrimination against Roma. According to the EU-MIDIS findings, employment and education are the main areas in which such discrimination is experienced. Migrants and ethnic minority members often do not know about anti-discrimination legislation and seldom report incidents. Despite the existence of such legislation, discrimination is often reinforced by media representations and the activities of certain politicians.

Institutional discrimination

A second type of discrimination – "institutional", "passive" or "indirect" – is not the result of deliberate acts by individuals: it is inherent in the structure of institutions which, because they were designed for one group, put other groups at a disadvantage. The concept of "indirect discrimination" was introduced by the United States Supreme Court in 1971, adopted in United Kingdom legislation from the 1990s onwards and incorporated in EC non-discrimination directives adopted in 2000.[5] When a previously homogenous society becomes multiethnic and multicultural, it is almost inevitable that the existing institutions will be less than optimal for the newcomers, so institutional discrimination occurs without anyone necessarily intending it or being aware of it. However, institutional discrimination can only be described as "indirect" or "passive" as long as its existence is not realized; if no steps are taken to remove it after its existence has been demonstrated, this discrimination becomes just as active and conscious as any other kind.

[5] Directive 2000/43/EC of 29 June 2000, implementing the principle of equal treatment between persons irrespective of racial or ethnic origin ("racial equality directive"); Directive 2000/78/EC of 27 November 2000, establishing a general framework for equal treatment in employment, occupation and vocational training ("employment equality directive").

Social exclusion and health inequities

So far, one has discussed three forms of social exclusion: denial of citizenship rights, individual discrimination and institutional discrimination. Together, any and all of these may place migrants and ethnic minorities at a disadvantage in terms of their social position, well-being and state of health. Much previous research on the health of these groups has presupposed that health inequalities are due to some characteristic of the groups themselves (for instance, their genetic[6] or cultural heritage). Far less attention has been paid to the structural features of the social environment.

The adoption of a "social determinants" perspective such as that promoted by the CSDH consequently represents a paradigm shift in approaches to migration- and ethnicity-linked health differences, in the light of which much previous work appears as a form of "blaming the victim". While not seeking to deny the existence of genetic and cultural differences, this briefing argues that processes of social exclusion need to be given far more emphasis in research and policy-making concerned with migrant and ethnic minority health. Efforts to improve the health of these groups should therefore prioritize policy changes aimed at improving the groups' position across a wide range of sectors – not only health services, but also employment, education, housing, social protection, social services, justice and law enforcement. Policy measures should cover a range of sectors, as exclusion in one sector can influence inequalities in another, producing a synergistic matrix of social conditions that drive health inequities.

Moreover, while welcoming the fact that migrants and ethnic minorities are widely recognized by international bodies as "vulnerable groups", this briefing emphasizes that their vulnerability is generally of a different kind from the individual physical or psychological vulnerability that characterizes most other groups in this category (such as disabled people, drug addicts, homeless people, the very young and the very old). Indeed, it could be argued that migrants and ethnic minorities have to be physically and psychologically stronger than average to cope with the social exclusion and other stresses and deprivations to which they are routinely exposed.

3. The state of health of migrants and ethnic minorities

Health inequalities among migrants and ethnic minorities

Although the number of studies on this topic in the European area has increased considerably in recent decades, the available research shows serious limitations. In the first place, many issues have only been studied in certain countries, or not at all. Second, research is hampered by the lack of available data (see: Ingleby, 2009). Data on health and illness are seldom categorized according to the ethnicity or migration status of the people concerned. The first phase of a major EU project aiming to review the quality of information in this field, the Migration and Ethnic Health Observatory (MEHO), completed in the summer of 2010 (see: MEHO, 2007).

Adequate monitoring of the health of migrants and ethnic minorities is essential for health systems to be able to respond quickly to the needs of these groups. In order to collect these data, it will often be necessary to go beyond standard procedures and adopt an "outreaching" approach. Researchers must adapt their methods to include, for example, people who cannot read or write in the majority language, or at all. At the same time, data collection must pay serious attention to issues of privacy, potential misuse of data and the political sensitivity of "ethnic monitoring". International cooperation should be stimulated to raise the standard of research and facilitate international comparisons. A first priority is to reach a basic level of agreement about which categories to use and how to define them.

Raw data on the health of any group can be misleading if the data are not considered in relation to certain basic characteristics of the group – particularly age, sex and SES.

Age differences are important because many health conditions are age-related and particular groups may deviate from the population average. Diseases of old age, for example, only started to increase in the post-war European immigrant population towards the end of the 20th century. Because migrant populations are usually younger than native populations, they may for this reason alone enjoy a health advantage: some of the "healthy migrant effect" that has been noted by many researchers (see: Fennelly, 2005; Kennedy, McDonald & Biddle, 2006) may be due to a failure to control for age.

[6] According to Afshari & Bhopal (2010:1): "There are limited genetic differences between racial groups, undermining the traditional use of race as an indicator of biological difference between populations". The authors conclude: "The concept of race, which has a fraught past, may soon be a relic of history, with the exception of studies on racism and the history of race science".

The importance of **sex differences** is that many health conditions are gender-linked; moreover, the social situation of male and female migrants may differ considerably. Certain risk factors affect women in particular (for example, sexual violence and abuse, trafficking and the risks surrounding pregnancy and childbirth), while men may be more exposed to accidents, physical stress and other health hazards in the workplace. In some ethnic groups, smoking may be a health risk for men but not women, simply because the practice is largely confined to men.

It is particularly important to record the **SES** of migrant and ethnic minority groups because, as we have noted, these groups often occupy disadvantaged social positions and there is a strong relationship between SES and ill health. Although early studies neglected this factor, it is becoming increasingly common to control for SES when studying migration and ethnicity. While some of the observed differences disappear when this is done, others do not. However, measuring the SES of these groups is far from being a straightforward procedure. Karlsen & Nazroo (2002:2) remark that "conventional measures of socioeconomic position may actually serve to conceal the socioeconomic disadvantage experienced by ethnic minority groups, rather than expose it".

A common mistake in this area is to assume that if health differences in migrant or ethnic minority groups disappear when SES is controlled for, the "real" determinants of health are socioeconomic ones and policies need not take account of group membership. In statistical terms, SES is assumed to be a confounder.

However, a different interpretation is possible and is in fact more likely – that SES is not a confounder but a mediator, part of the causal chain between migration status or ethnicity and health. This will be the case if membership of these groups to some extent determines a person's SES. As shown, mechanisms of social exclusion have precisely that effect. In addition, there may be a direct relationship between discrimination and poor health (Pascoe & Smart Richman, 2009). In any case, measures to reduce health inequalities may need to be specially adapted to reach migrant and ethnic minority groups effectively. The conclusion must be that policies to reduce health inequalities which do not take migrant status and ethnicity into account can only have limited success in countries where these groups are numerically significant and are not treated equitably.

Main differences found

General measures of health

Figures on mortality rates and life expectancy for migrant and ethnic minority populations are often unreliable, because the denominator (the size of the underlying population) is not always accurately known. Members of Roma communities, for example, are often reluctant to disclose their ethnic identity to public authorities, and the collection of this information may even be prohibited by law. The MEHO study (see: MEHO, 2007) has found that data on mortality rates for ethnic minorities are only available in a handful of countries, and the available information is largely restricted to total mortality, cancer mortality and cardiovascular mortality.

Such evidence as there is generally indicates lower life expectancies for migrant and ethnic minority groups (Green & Lynch, 2006), though there are some exceptions (Razum et al., 1998). Some studies show a reduction in life expectancy among Roma communities of 10–15 years (Sepkowitz, 2006). These communities also show increased rates of infant mortality.

Measures of self-reported health are often used to estimate the general level of health among migrants and ethnic minorities, and researchers consistently report lower levels for these groups. Much of this difference, but not all of it, tends to disappear when SES is controlled for (see, for example: Nazroo, 1998; Devillé et al., 2006; Al-Windi, 2008). In Belgium, Lorant, Van Oyen & Thomas (2008) showed that when migrants' living conditions were also controlled for, differences were actually reversed. However, a problem with all such studies is that it is not clear what exactly respondents mean when they rate their health as "good" or "bad", and to what extent response biases may undermine the validity of the group differences found.

Regarding specific diseases, one begins with a general observation: that the illnesses from which migrants and ethnic minorities suffer are to a large extent the same as those found in the majority population. There are some examples of unusual or "exotic" conditions (in particular among recently arrived immigrants, as well as among migrants and their children who visit the country of origin), and health services must pay due attention to these. Examples are malaria, Chagas' disease (American trypanosomiasis), Tay-Sachs disease, sickle cell disease, the effects of female genital mutilation and many lesser-known tropical diseases. However, learning to deal with such unusual conditions is seldom the main challenge when it comes to providing adequate services for migrants and ethnic minorities.

Noncommunicable diseases

Overviews of this topic are given by Carballo (2009a) and Gushulak, Pace & Weekers (2010).

Cardiovascular diseases

These diseases are currently the most common cause of death in Europe. Where migrant and ethnicity groups show deviations from average prevalence rates, their rates are usually higher – yet they are lower among some groups for certain disorders. Zaninotto, Mindell & Hirani (2007) analysed data from several ethnic groups and found that prevalence rates and risk factors (such as hypertension, obesity, diabetes, low income, smoking, drinking and lack of physical activity) showed widely varying patterns in different groups.

Cancer

This is the second most common cause of death in Europe. Here, too, the findings concerning migrants and ethnic minorities are complex, varying between groups and between types of cancer. Even though the incidence of cancer may not be raised, the disease tends to be detected at a later stage among these groups, so that timely treatment is less often possible. More effective targeting of health education and screening programmes is required.

Diabetes

Diabetes (especially type 2 diabetes) is a growing problem worldwide and has been described by WHO as an "epidemic". Studies in United Kingdom (England), the Netherlands and Norway have shown that people of migrant origin – with the exception of some groups – may be especially vulnerable to type 2 diabetes (DH, 2005; Baan 2009; Norwegian Directorate of Health, 2009).

Life events as well as lifestyle factors such as poor diet, lack of physical activity and smoking have all been implicated in the causation of diabetes, which is also associated with central obesity. Among migrants, the transition to western dietary habits may result in obesity. Preventive interventions can have an impact, but few health promotion programmes specifically adapted to migrant groups have been designed.

Maternal health, perinatal and infant mortality and morbidity

Migrant and ethnic minority groups may be particularly vulnerable to problems in this area (Machado et al., 2009), though – once again – some groups show fewer problems. For example, babies of mothers who themselves had immigrated to the England and Wales (United Kingdom) from the Caribbean and Pakistan had infant mortality rates of 9.4 and 9.0 deaths per 1000 live births, respectively, during the period 2004–2006. This was compared to an infant mortality rate of 4.8 deaths per 1000 live births for the whole population during the 2004–2006 period (Earwicker, 2010). In the Netherlands, both maternal mortality and infant mortality were higher among non-western migrants (Waelput, Stussgen & Eskes, 2008). Research on Roma communities has shown alarmingly high levels of maternal and child mortality and morbidity.

The roots of these problems are complex and include living conditions, lifestyle and health beliefs, and access to good-quality health services. A major problem demanding action is that health promotion and antenatal screening programmes often fail to reach migrant parents, and little effort is made to target them more effectively.

Occupational health and safety

Higher rates of industrial accidents, injuries and work-related diseases have been reported among migrant workers in, for example, CE (2000) and on the web sites of the European Working Conditions Observatory (EWCO, 2003) and the information network on good practice in health care for migrants and minorities in Europe (MIGHEALTHNET, 2007). Occupational accident rates are about twice as high for migrant workers as for native workers in Europe (OSHA, 2007). Kolarcik et al. (2009) report a higher frequency of accidents and injuries among a sample of Roma adolescents in Slovakia.

Several factors contribute to these problems. In the first place, members of socially excluded groups perform a disproportionate number of difficult, dangerous and dirty jobs which the majority are unwilling to take on. Second, these jobs are often inadequately supervised and regulated; employers may be operating on the fringes of legality and evading inspections, while employees worried about losing their jobs may collude with them. Third, there may be communication problems with migrant employees who cannot read safety warnings or may misunderstand instructions given to them. More stringent health and safety regulations, tighter controls, increased sanctions against employers found violating them and more attention to communication problems in the workplace are clearly necessary.

Mental illnesses: general considerations
Serious methodological issues complicate research on mental illness among migrants. These relate to the fact that concepts, beliefs and practices in this area vary greatly between countries and historical periods. Such variations are, of course, found across the whole spectrum of health problems, but they appear to be particularly wide in the case of mental disorders.

Schizophrenia and related psychotic disorders
Although the overall prevalence of these disorders is low (under 1%), some of the most remarkable findings on migrant mental health are seen here. Extensive research in the United Kingdom, the Netherlands, Sweden and Denmark has shown that the incidence of these disorders is higher among migrants, especially those from non-western countries (Ingleby, 2008). Rates may even be higher in the second generation than in the first. Moreover, migrants with these disorders tend to be more ill when they enter treatment.

Genetic explanations for the raised incidence do not seem plausible and most investigators seek causes among social factors ("social adversity", including living conditions and discrimination). However, given the low overall prevalence, individual differences are obviously also involved. Improved services for migrant and ethnic minority patients are required, as well as preventive measures.

Depression and anxiety disorders
These problems are far more common than psychoses. Many studies show a raised prevalence in certain migrant and ethnic minority groups, particularly among older people (Carta et al., 2005). However, whether these disorders are more frequent in labour migrants in general has been disputed by Lindert et al. (2009), who found an overall prevalence of 20% for depression and 21% for anxiety disorders – similar to figures for the general population.

Regarding causal mechanisms, it is known that poverty and lower SES are associated with depression. At present it is not known to what extent these factors explain the differences found among migrants and ethnic minorities. Some studies (such as Karlsen et al., 2005) have also suggested that perceived discrimination or racism can increase rates of common mental disorders. Social support and adequate social networks are also regarded as important protective factors for mental health (Levitt, Lane & Levitt, 2005), and strengthening such networks can help to combat isolation, loneliness and vulnerability (see: Hernández-Plaza et al., 2004, 2010).

Post-traumatic stress disorder (PTSD) and refugee mental health problems
Since the introduction of the diagnosis PTSD in 1980, it has been common to assume that refugees and asylum seekers show a high prevalence. Indeed, a meta-analysis by Fazel, Wheeler & Danesh (2005) showed a prevalence of 9% among refugees, which is around ten times higher than in the general population. However, this figure is not sufficiently high to justify the almost exclusive preoccupation with PTSD that has characterized refugee research and health policy. Lindert et al. (2009) concluded on the basis of a meta-analysis that rates of depression were twice as high among refugees as among labour migrants (44% versus 20%). The same was true for anxiety disorders (40% versus 21%). Clearly, mental health problems among refugees are by no means confined to PTSD.

Underlying the higher rates of PTSD among refugees are violent acts experienced or witnessed in the past. However, many of the other mental health problems that refugees experience, such as anxiety, depression, substance abuse and relational problems, may be due to the stress generated by reception conditions and asylum procedures, by social and material deprivation, and by discrimination. Asylum seekers often face acute problems of integration after obtaining a residence permit, since some will have spent years unable to work, obtain new qualifications or develop a social network. Clearly, mental health services for refugees and asylum seekers must pay special attention to all mental health problems, not just PTSD.

<u>Communicable diseases</u>
As noted, the original focus of much work on migrant health was on diseases with which migrants might infect the majority population. This concern was revived when global epidemics of tuberculosis (TB), hepatitis A and B and HIV/AIDS occurred towards the end of the 20th century, although in fact the risk of transmission from migrants to the host society seems to be very small. Useful overviews on contagious diseases affecting migrants are provided by Carballo (2009b), European Centre for Disease Prevention and Control (ECDC, 2009) and WHO Regional Office for Europe (2010b).

Tuberculosis
In 2008, 22.4% of new cases of TB in EU and European Economic Area countries concerned migrants, most of them coming from Asia or Africa (ECDC/WHO Regional Office for Europe, 2010:3). TB is not simply the result of

infection, but is also more likely to develop under conditions of poverty, poor housing and malnutrition; there is also considerable co-morbidity with HIV/AIDS. Early treatment is important, but is hampered by the fact that many migrants do not have easy access to good primary care. Screening programmes have been adopted by some countries for asylum seekers and other migrants coming from countries where rates are high, but the advantages of screening are debatable. Concerning TB among Roma populations, Schaaf (2010) describes the link between social exclusion and increased vulnerability to the disease, delayed diagnosis, poor access to treatment and lower treatment adherence. Treatment default is particularly dangerous because of the possibility of the creation of drug resistance.

A combination of risk factors leads to high vulnerability to TB in some migrant populations, such as labour migrants to the Russian Federation from Tajikistan (Gilpin et al., in press) and the Republic of Moldova (WHO Regional Office for Europe, 2010c), or to Kazakhstan from Uzbekistan (Huffman, 2009). All these countries have a high incidence of TB and the poor living conditions of these migrants while abroad increase their liability to contract the disease. Many are irregular migrants and have little or no access to affordable and effective health care in the destination country, while the treatment available in their home country is also often inadequate or expensive. Lack of knowledge about the disease and the treatments available for it completes this potentially lethal cocktail of risk factors.

Hepatitis A and B
Both forms of hepatitis can be transmitted through blood and body fluids, while hepatitis A can also be transmitted by faecal contamination. Unprotected sexual contact is a significant pathway of infection. Prevalence is much lower in Europe than in developing countries.

These diseases are associated with poor sanitation, overcrowding and poverty. Tourists as well as migrants can become infected with hepatitis, especially when sexual contacts occur. Migrant sex workers coming from countries of high prevalence are particularly at risk of catching and spreading the disease.

Health promotion for migrants and ethnic minorities, focusing on early detection of the symptoms and prevention of contagion through sexual hygiene, is an important priority. However, all such programmes encounter problems of low uptake and language barriers. Cultural practices and taboos may also increase resistance.

HIV/AIDS
Much of what has been said about hepatitis also applies to HIV/AIDS. Around 40% of heterosexually acquired cases in European Free Trade Association countries in 2008 were diagnosed in people originating from countries with generalized epidemics (ECDC/WHO Regional Office for Europe, 2009). Associating migrants with HIV/AIDS may result in negative attitudes, adding to their social exclusion and exacerbating the situation still further (WHO Regional Office for Europe, 2010b:15). Petrosillo & Bröring (2006) also report a high prevalence of HIV/AIDS among Roma communities in Hungary and Bulgaria.

This disease can be spread by sexual contact (both heterosexual and between men), by injecting drug use and by mother-to-baby transmission. Limited access to HIV prevention, counselling, testing and treatment services is a problem deserving urgent attention from health services. The European network AIDS&Mobility (2000) has carried out pioneering work in developing outreaching programmes that, among other things, increase awareness of HIV/AIDS and other sexually transmitted diseases among migrants.

Determinants of health and policy measures required to tackle them

Combating the social exclusion of migrants and ethnic minorities

To the extent that the health problems of these groups result from (or are exacerbated by) their disadvantaged social position, measures which combat social exclusion are likely to have the most fundamental effect on health. Equity-oriented health impact assessments should be used to review the impact of policies across sectors on social determinants of health.

In relation to migrants, some countries have already tried to tackle the social determinants of their health through "multicultural" policies inspired by the example of countries such as Canada. In Europe, however, such policies have often been surrounded by controversy.

Attempts to tackle the social exclusion of ethnic minorities have received renewed impetus from the focus during the "decade of Roma inclusion" (2005–2015) on the urgent problems of Roma communities in Europe. Since

the Amsterdam Treaty of 1999, the European Community has had specific powers to take action to combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation. The European strategy for social protection and social inclusion "strives to increase the labour market participation of immigrants and ethnic minorities to the same level as the majority population, and to promote their participation in social, cultural and political life" (EC, 2010). The Treaty of Lisbon, which came into force in 2009, reaffirmed the importance of combating social exclusion and discrimination. The UN Committee on the Elimination of Racial Discrimination (2010) has expressed concerns over the stand of some countries towards Roma. The CE's commissioner for human rights, Thomas Hammarberg, has written:

> There is a shameful lack of implementation concerning the human rights of Roma. The issue has been put on the agenda of all major international organizations and national governments in Europe, for example through national action plans, but without much impact (Hammarberg, 2010).

Among the relevant policy measures to foster social inclusion are the following.

1. Measures to combat discrimination against migrants and ethnic minorities include education of the public and effectively enforced legislation. Institutional discrimination should be combated by imposing statutory requirements on organizations to deal with all groups equitably.

2. Educational policies can pay special attention to the needs of migrant and ethnic children by, for example, facilitating their integration into mainstream schools and ensuring that selection policies make allowances for the extra time required for acculturation and language learning. Segregation, tracking and ability grouping can have particularly negative impacts on migrant and ethnic minority children (EC, 2008). The education of such children in special schools is an extreme form of segregation.

3. Employment policies can be directed at the removal of barriers and systematic disadvantages for migrants and ethnic minorities in the labour market.

4. Social protection policies can ensure migrants and ethnic minorities do not fall into poverty, destitution and homelessness (Luckanachai & Rieger, 2010).

5. Housing and environmental policies (such as reduction of environmental health hazards, improved transport and other amenities) designed to improve the living conditions of migrants and ethnic minorities (Stanciole & Huber, 2009).

6. Health policies can ensure equitable access to appropriate services (including prevention and health promotion) for all groups. This topic is dealt with in detail in the next section of this briefing.

Two further policy measures apply to migrants in particular.

7. Policies on naturalization, political participation, family reunification etc. can reduce the gap between the rights of aliens and those of citizens. Ratification and implementation of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (United Nations, 1990) would make a major contribution to migrant health.

8. Integration programmes for new migrants can offer help with language-learning, orientation to the host country and access to education, health and social care services. Particular attention should be paid to the situation of refugees, who may spend years waiting for their asylum claim to be processed. Limitations during this period on their opportunities to work, receive education (if over 18) and make contacts in the host country can seriously hamper their integration in the case that they are granted permission to remain (UNHCR, 2007; Laban et al., 2008).

Health and safety at work

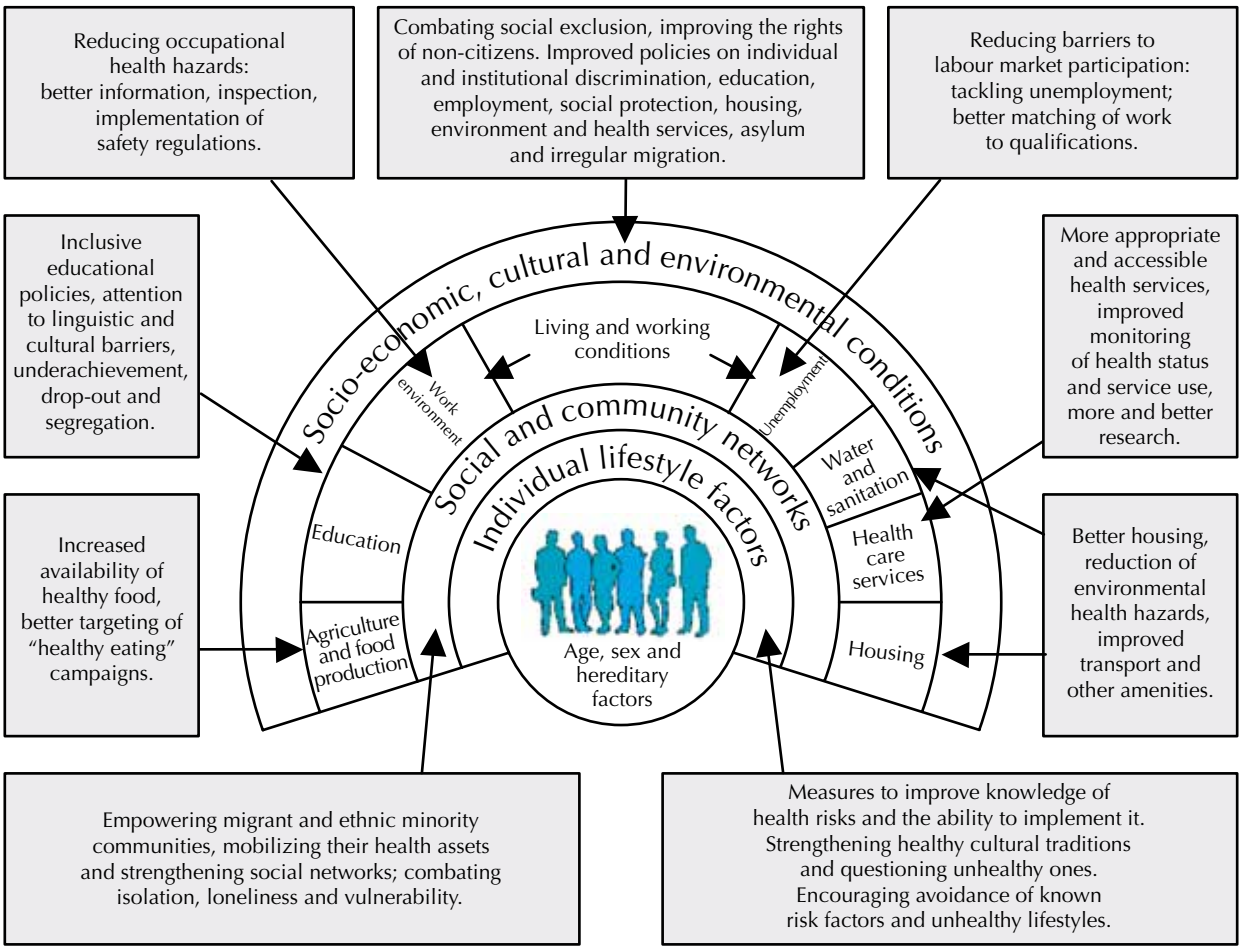
As discussed above, the typical working conditions of migrants increase the risk of industrial accidents and health hazards. Stricter regulations and inspection, as well as information campaigns to encourage a more proactive approach to health protection by both employers and employees, are required. Material and activities intended for migrants and ethnic minorities should be linguistically and culturally appropriate.

Health hazards for asylum seekers and irregular migrants

The conditions under which asylum seekers are held pending a decision on their claim, and the extreme slowness of the procedures in many cases, may be a direct cause of ill health (Nygren-Krug, 2003; Silove, Austin & Steel, 2007; Ryan, Kelly & Kelly, 2009; IOM, 2010). The EU's minimum standards on the reception of applicants for asylum in Member States (Council of the European Union, 2003) are not always effectively implemented and do not provide an adequate safeguard against these health risks. Where (failed) asylum seekers and irregular migrants are kept in detention, the risks are intensified. Many failed asylum seekers who cannot be returned to their country of origin are reduced to a state of homelessness and destitution. On all these issues, a balance needs to be struck between the aims of immigration policy and considerations of public health (Silove, Steel & Watters, 2000; O'Nions, 2006).

The themes we have discussed in this section are summarized in Fig. 1.

Fig. 1. Policy measures required to tackle the social determinants of health for migrants and ethnic minorities



Source: The diagram is inspired by a presentation from Dr Nani Nair, TB Regional Advisor, on 15–16 September 2005 at the WHO Regional Office for South East Asia consultation on the social determinants of health, subsequently adapted by Theadora Koller to address determinants of the health of socially excluded migrant populations, and further adapted for the purposes of this policy briefing. The well-known "rainbow" is from Dahlgren & Whitehead (1991).

4. Promoting access to appropriate and effective health services

Introduction to the topic

The previous section focused on inequalities in health among migrants and ethnic minorities and their determinants, as well as the policy changes required to tackle them. Since the major determinants of health are not located within the health sector itself, the stewardship function of health services was placed at the forefront – in particular, the need to promote multisectoral policies to protect the health of these groups.

However, health services do, of course, have an impact on levels of health and illness, and there is evidence that migrants and members of ethnic minorities are often poorly served by existing services. These groups may be prevented from obtaining help by the rules governing entitlement or by other barriers to access. The services offered may not be well-adapted to their particular needs by, for example, making too little allowance for linguistic, social and cultural differences. To some extent, the concepts of "accessibility" and "quality" overlap, because services perceived as irrelevant, inadequate or unfriendly will be less likely to reach the target group.

In the last quarter of the 20th century, increasing attention was paid in Europe to service delivery for migrants and ethnic minorities, often under the label of "culturally sensitive" or "culturally competent" care. Since the turn of the century, however, it has become clear that the issues are much broader than was initially realized.

Whole-organization approach

In the past, efforts typically focused on enhancing the "cultural competence" of the individual caregiver, but experience has shown that this has little benefit if nothing is done to change the rest of the organization. For example, publicity material and information folders, procedures at reception desks, opening hours and staff recruitment and training policies must all be reviewed in the light of the diversity of service users. Moreover, improvements must be systematic and sustainable: adequate resources must be allocated to them and changes must be embedded in policy at all levels, from national to institutional and professional.

Health system approach

As the Tallinn Charter emphasizes, "health services" comprise more than "health care". Preventive measures such as vaccination and screening, as well as health promotion and health education, are vital activities that maintain health by avoiding illness in the first place, or by ensuring that those who become ill receive treatment at an early stage when it has most chance of success.[7] In the case of groups living outside the social mainstream, these activities are all the more important, yet it is precisely these groups who are often less effectively reached by existing programmes. A health system approach also emphasizes the need for a multisectoral or "joined-up" approach to care provision: for example, coordination between health services and social services is important, because the health problems of migrants are frequently rooted in social or practical problems requiring intervention by non-medical agencies. Measures such as care management or "one-stop services" may help to link care sectors.

Community involvement

Bridging the gap between services and migrant or ethnic minority communities, however this "gap" is characterized, cannot be done without close involvement on the part of these communities. To build a bridge, it is necessary to start from both ends. However, developing close relationships between formal (statutory) services and minority communities is a challenge where the general level of social inclusion and participation of the communities is low.

What follows will first discuss the issue of entitlement to health services for migrants and ethnic minorities. This will be followed by an analysis of issues concerning accessibility and quality. In the last section, we will examine strategies for implementing the necessary improvements.

Entitlement of migrants and ethnic minorities to health services

Since a person who can pay his or her own costs will seldom be excluded from health services, "entitlement" here has the meaning of "entitlement to payment of health costs under the statutory system of coverage". Such systems of coverage vary greatly, as does the extent to which migrants (as long as they are not naturalized) are entitled to use them.

In theory, fewer problems of entitlement should arise for members of indigenous ethnic minorities and descendents of migrants, as they are usually nationals of the country in which they reside. However, entitlement in theory is not the same as entitlement in practice. As the SEKN (SEKN, 2008:69) points out:

> Lack of access to healthcare contributes to the poor health of Roma people, in large part due to lack of identity documents including birth certificates. Problems are compounded by prejudiced attitudes amongst service providers with widespread reports of health professionals refusing to provide treatment or services (OSCE HCNM, CE & EUMC, 2003).

[7] This is the aim of primary care services in general. Policies that have the effect of concentrating health care for migrants and ethnic minorities in hospital emergency departments are therefore highly counterproductive.

Systems of coverage vary between countries and are often highly complex. The extent to which migrants, in particular, can participate in these systems may be hard to define, as the degree of entitlement often depends on their migration status and the health services involved. This makes it all the more important that migrants and members of minority ethnic communities receive comprehensive and clear information about the way the health system is financed and what their entitlements are. Entitlements are of little use to people if they do not know what they are.

Regular migrants

By and large, regular migrants in the WHO European Region are entitled to all or most of the coverage enjoyed by ordinary citizens. (The adequacy of this coverage varies widely, of course, according to the size of the government's investment in health services.) There may be restrictions based on a migrant's length of stay in the country; also, in countries where employers pay all or part of social health insurance or private insurance premiums, employment status may affect coverage. There may also be exclusions and "blind spots" in the rules governing entitlement which create inequities for some regular migrants and their children.

Asylum seekers and irregular migrants

Entitlements for these groups are much more uneven. Theoretically, in accordance with the minimum standards on the reception of applicants for asylum in Member States (Council of the European Union, 2003), asylum seekers are entitled to health care in all EU countries. However, there are wide variations in the quality, accessibility and extent of the care provided (Huber et al., 2008), and the standards only apply to health services regarded as "care" (excluding, for example, health promotion and health education). Where irregular migrants are concerned, the variations are even more striking (Björngren Cuadra & Cattacin, 2010). Some EU Member States grant irregular migrants free access to all medical services irrespective of their residence or employment status and without the threat of being reported to the authorities. In others, undocumented migrants may be granted access to emergency medical care but at the risk of being reported to authorities. There may also be measures in place to restrict medical staff from offering services to undocumented migrants. The arguments for withholding free access are generally based on economic considerations and the fear that health systems will be overburdened by uncontrolled demand from irregular immigrants. Advocates of free access argue, on the other hand, that seeking health care is hardly ever a motive for irregular migration. They base their case on human rights considerations – in particular, the fundamental human right to health (CESCR, 2000) – and on principles of public health. In their view, compelling a section of the population which is at risk of serious health problems (including contagious diseases) to ignore these problems as long as possible poses unacceptable risks to the health of the whole population.

Health equity would be improved by ensuring that entitlements for all migrants and ethnic minorities are as complete as possible, having regard to the political obstacles to unlimited access that exist in some countries. However, as we have stressed, formal entitlements on paper are not enough: it is also essential that people should know what their entitlements are. Even more importantly, perhaps, service providers should also know what they are – and respect them. Particularly in the case of the Roma population, there are many reports of doctors, hospital and ambulance services simply refusing to provide care, or intimidating patients through hostility and discriminatory behaviour (Mladovsky, 2007). Although the general conclusion of the annual reports by the Fundamental Rights Agency is that direct discrimination in health care is not a major problem (see, for example: FRA, 2009a), the treatment of Roma is consistently mentioned as an exception.

The complex conditions and bureaucratic requirements that are sometimes imposed present additional barriers to the implementation of entitlements. Individuals have to find their way through a maze of rules and regulations, obliging them to produce documents they may not have and to fill in forms they may not understand.

Another barrier may be formed by the out-of-pocket payments (including those of an informal nature) that users are required to make – even within some "universal" national health systems – to cover part of the cost of consultations, tests or medicines. For migrants and ethnic minority members living on or below the poverty level, these costs may be prohibitive, especially if (as is often the case) they have multiple health problems.

For people not entitled to use the national system of health care coverage, there is a long and honourable tradition of service provision by nongovernmental organizations (NGOs) (such as charities and church organizations). As was mentioned above, such organizations may have closer contacts with the groups in question: they may therefore understand users better and enjoy more trust than formal services. In some cases, they may even receive financial support from government authorities for carrying out this work. In the long run, however, the interests of socially excluded groups are not well-served by outsourcing their care to organizations outside the regular system. Quality control and sustainability may be difficult to guarantee, and if care outside the

formal system becomes structural, the social exclusion of the groups being cared for will only be further institutionalized.

Accessibility of health services

The concept of "matching"

This section and the following one on health service quality are concerned with the issue of matching between services and their users. The Tallinn Charter (WHO Regional Office for Europe, 2008:2) commits Member States to "make health systems more responsive to people's needs, preferences and expectations". In fact, the issue of "responsiveness" or "matching" has been a theme of health system reforms for half a century. From the 1960s onwards, "top-down" or "one-size-fits-all" approaches have been challenged by patients' rights movements and proponents of "needs-led", "demand-driven" and "patient-centred" care.

Although Saha, Beach & Cooper (2009) have demonstrated the substantial overlap between the concepts of patient-centred and culturally competent care, the "needs, preferences and expectations" which health systems have responded to have generally been those of the majority population. Many measures that have been taken to "fine-tune" health services to their users have not benefited migrant and ethnic minority users, because these groups have been ignored in research and in consultation procedures. For a number of reasons, the ability of these groups to influence policy through the usual channels is limited.

"Institutional discrimination" occurs when a group is disadvantaged by the practices, procedures and unwritten rules of an organization. It may arise without any conscious intention to discriminate, simply as a result of the fact that the organization has been set up with a different population in mind. As we have noted above, when populations change, or when an effort is made to include hitherto excluded groups, it is practically inevitable that the new groups will not be optimally served by existing services and that adaptations will be required. Changes will therefore often be necessary to improve both the accessibility and the quality of services (including health promotion and education) for migrants and ethnic minorities.

The most basic form of matching is quantitative: the amount of service provision available should be adequate to meet the needs of all users, in particular groups with health problems that are not shared by the majority. To the extent that migrants and ethnic minorities are affected by disorders that require special expertise and treatment methods, special services must be made available (for example, facilities for the treatment of torture victims among asylum seekers and refugees). The main forms of adaptation required, however, are qualitative changes in the way services are delivered, and we shall now consider what kinds of changes may be necessary.

What is accessibility?

The "accessibility" of services refers to the ease with which people can make use of them when they need them. In the case of health education, health promotion and preventive care, accessibility relates to the success of these activities in reaching and influencing their intended target group.

A possible indication of problems with accessibility is underutilization of care provision. However, caution is required when interpreting figures about "care consumption": it is also necessary to know the size of the relevant population in the catchment area concerned and the extent of its needs. If the group's needs are less, then lower care consumption is to be expected; on the other hand, if its needs are greater, then more of its members should be receiving care.

Another indication that a particular group is experiencing problems of access may be that its members more often access care when problems are more advanced and symptoms are more severe. For example, it is found that psychiatric problems among certain groups only receive attention when they are at an advanced stage. Problems during pregnancy and childbirth may not receive medical attention until it is too late to successfully manage them. This illustrates once again the crucial importance of easily accessible primary care.

Once problems of accessibility have come to light, the next step is to establish the nature of the barriers involved. Many different factors influence a person's ability to make use of services when they need them. (Because problems of entitlement are different in nature from other barriers, they were discussed separately in the previous section.)

Health beliefs and help-seeking behaviour

The first potential barrier to access is that the person, or those around him or her, may not realize that he or she needs professional help. People's views about the nature of their problems, their threshold for seeking

help and the forms of help they regard as appropriate, differ widely. To begin with, we must bear in mind the spectacular growth in the west during the last 50 years in the amount spent on health and the range of situations regarded as "health problems". As a result of this growth, the concept of health has become much broader, and the threshold for treating problems much lower, than in less well-off countries. Those who migrate from these countries to the west – as well as impoverished and isolated minorities within western countries – may therefore have views on health that diverge strongly from those of (western) health professionals. According to one report (FSG, 2009:13), in some Roma communities "health only becomes a concern in the presence of very dramatic symptoms and incapacitating consequences". "Explanatory models" (notions about the nature of problems, their causes and appropriate remedies) may vary widely between (and even within) cultures (Kleinman, Eisenberg & Good, 1978).

These issues are usually formulated in terms of inadequate "health literacy"; for groups with diverging beliefs and health-seeking behaviour, health education is regarded as the solution. However, health education programmes for migrant and minority groups need to be appropriately targeted to reach these groups effectively (Netto et al., 2010). In particular, they are unlikely to be taken seriously unless they reflect the views of the groups. Simply to regard the professional view as correct and all other views as a symptom of ignorance or superstition will only reinforce the belief among these groups that mainstream health services are irrelevant to their needs.

Linguistic barriers to access

Limited proficiency in the majority language can present a formidable obstacle to access. Brochures, folders and web sites on, for instance, patient information for health problems, should be provided in whatever languages are necessary to reach potential users. Service providers should make high-quality interpretation facilities available for users who need them. This creates dilemmas for cost-conscious policy-makers, as the number of languages migrants speak may run into hundreds, while interpretation and translation are expensive. A compromise will always have to be made, but all decisions should be informed by considerations of equity and principles of public health.

There is currently a tendency in some countries to restrict language assistance by, for example, withholding it from migrants who have resided in the country for a certain length of time, or withdrawing funding from health education programmes – even for newcomers – in migrants' own languages. At this point, the intersectoral dimension of health systems becomes relevant. These restrictive policies are not based on health considerations, but on policy goals concerning migrant integration. Those with responsibility for health have to make clear to the other government agencies involved that such policies can be detrimental to public health.

Sometimes language barriers can be bridged by bilingual health workers, but professional interpretation services are needed in most cases. These can be delivered through a telephone service or face-to-face interpreting (Crossman et al., 2010). Even when these facilities are available, however, health service providers often prefer to rely on "informal" interpreters (family members, friends or other health service personnel who happen to speak the language in question). This may save time and money in the short term, but in the long term it is likely to undermine the quality of treatment and may lead to misunderstandings with potentially serious medical consequences (Flores, 2005).

Social and cultural barriers to access: the role of cultural mediators

Even a professional interpreter cannot simply be regarded as a "translation machine": it is not just words that have to be translated, but also their meaning. To do this properly may require, on the one hand, considerable medical knowledge and, on the other, an intimate knowledge of the patient's social and cultural context. For this reason, it is not always possible to separate linguistic barriers from social and cultural ones, and it is increasingly common to find the role of interpreter being extended to that of "cultural mediator". This concept has been pioneered by a small group of countries (mainly the United Kingdom, the Netherlands, Belgium, Spain, France and Italy) and is now increasingly being adopted elsewhere (Minervino & Martin, 2007), particularly in response to the challenge of improving Roma access to health services.

"Cultural mediators", "brokers" or "consultants" can be employed in several different ways. Most of them are drawn from the migrant or minority group in question, although complete "ethnic matching" is not always feasible. Some act as go-betweens in order to link services and communities, trying to improve understanding of the community by health workers and of the health system by community members. Some have a "stand-alone" function and may guide people to treatment, perhaps carrying out the initial stages of the intake process. Others work only as auxiliaries in the treatment situation, in which their role is similar to that of an interpreter, but broader.

Cultural mediators can fulfil a very important role in reducing barriers to access and bridging the gap between migrant and minority communities and the health system. However, many issues have yet to be resolved. What is the relation between the responsibilities and legal liabilities of the cultural mediator and those of the health professional? How can sustainable financing be provided? What kinds of competence are required, and how is training and accreditation to be organized?

Finding one's way and holding one's own within the health system

Like knowledge about health, these issues are regarded as components of health literacy: however, they involve not only knowledge, but also skills. Health education must teach newcomers to the health system how it works and how to make best use of it.

Migrants may come from countries with very different health systems. They may not be aware, for example, of the "gatekeeper" function that the primary care physician has in many European countries. Their assumptions about the behaviour they can expect from the health professional, as well as that which is expected from them, may not correspond to the contextual reality. Indeed, learning to use the health system is an important component of acculturation. Integration programmes for immigrants are a suitable context for initiatives to stimulate health literacy: this requires intersectoral cooperation among the different agencies involved. One should also never lose sight of the fact that many members of the majority population have similar problems, particularly older people who find it difficult to keep up with the rapid changes that characterize modern health systems.

Regarding the skills needed to negotiate the system, it is an unfortunate paradox that users who are more socially excluded are likely to have a greater need for care, but at the same time to be less capable of getting hold of it. They may have less ability to locate the information they need and to effectively communicate their problems and needs to health service personnel over the telephone, at the reception desk or in the consulting room. Staff may lack the skills or the motivation to help them to articulate their needs. Such groups are often labelled "hard to reach", but it is sometimes questionable whether adequate effort has been made to reach them. For example, Meeuwesen et al. (2006) found that general practitioners spent less, rather than more, time on consultations with non-western migrants. Education of health service workers and outreaching activities are therefore essential to improving the accessibility of services for migrant and ethnic minority users.

Stigma and (social) anxieties

Some users may be reluctant to make use of services because of anxieties about reactions within their own community. Mental health, for example, is often surrounded by stigma in migrant communities: this is understandable given the fact that in many countries of origin, mental health services are restricted to closed institutions for seriously ill psychotic patients. The idea of disclosing intimate details of one's personal or family life to a stranger, as in psychotherapy, may evoke resistance among those not familiar with the practice. Reproduction, sexuality, pregnancy and childbirth are sensitive topics which people find difficult to discuss with a stranger. There may also be worries about sensitive information reaching persons for whom it is not intended: many migrant users will not know that the confidentiality of medical encounters is protected by law. Finally, certain illnesses may be surrounded by anxieties which health professionals are unaware of. All these barriers to access can also be found, to a certain extent, among the majority population.

Practical barriers to access

There may be particular practical barriers to seeking medical treatment for people with limited financial means. It may be difficult to take time off work to attend consultations during the service provider's opening hours. Long waiting lists are another potential barrier to access. The location of service providers may be inconvenient, and transport can be expensive and time-consuming. The closure of many small local providers and their incorporation within larger institutions is a continuing trend that exacerbates this problem.

Perceptions of the health system

Finally, one returns to the theme of the basic relationship between health services and migrant and ethnic minority communities. The most basic prerequisite of access is **trust**. Users must be confident that they will be treated with respect and receive appropriate and relevant treatment. They are bound to be influenced by the stories that other members of their community have to tell about their experiences with service providers: these stories are often negative among many groups (especially Roma).

Apart from out-and-out discrimination, there are many less obvious forms of insensitivity that can give minority users the feeling that they do not really "belong" in the regular health system. Recruitment policies that ensure

staff are representative of the diversity of the population may go some way to reducing this feeling, but respect for migrants and ethnic minorities and special attention to their needs should be embedded in the policies of all health service providers.

Nevertheless, encouraging trust will be an uphill task where there is a history of conflict and misunderstanding between a group and the majority population. In such cases, extra effort is needed to develop the close working relationship between health services and communities that was promoted in the Declaration of Alma-Ata (WHO, 1978):

> The people have the right and duty to participate individually and collectively in the planning and implementation of their health care. ... Primary health care ... requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate.

NGOs, especially those that cultivate a grassroots, bottom-up method of working, may enjoy the trust of socially excluded groups to a much greater extent than mainstream services. In this way, urgent health problems can be tackled, but – as seen above – the underlying problem of exclusion remains. Issues concerning health service provision for migrant or ethnic minority communities are inextricably tied up with the general relationship between these communities and the host society. This underlines the importance of a multisectoral approach: inclusive policies in the health sector both require and reinforce inclusive policies in other sectors.

Quality of services for migrants and ethnic minorities

What is meant by "quality"?

There are several different approaches to assessing the quality of health services. Bearing in mind that services consist of health care (preventive, curative and palliative), health education and health promotion elements, the criteria of assessment will depend on the function in question. Palliative care, for example, will not be judged on its ability to cure people. There are basically three different ways in which quality can be conceptualized.

Measurement of outcomes

This approach assesses in quantitative terms how successful an activity is in achieving its intended aim. For treatments, the "gold standard" here is the randomized, double-blind clinical trial with placebo, although it is often impossible to reach this level of assessment for practical, financial and ethical reasons.

Subjective measures

These measures look at the degree of satisfaction of patients and, in some cases, caregivers. "Satisfaction" here usually relates not only to the outcome of the intervention, but also to the experience of undergoing it and feelings about how well or badly it is going. Both quantitative and qualitative measures may be employed.

Procedural evaluation

This type of evaluation examines whether an intervention was carried out as intended. It can be regarded as a preliminary stage to the first two types of assessment. If, for example, few people attend for vaccination or screening, or many patients drop out of treatment before it is completed, or patients do not cooperate in their treatment (lack of "therapy compliance" or "adherence"), then the procedural evaluation will be negative, implying that outcomes and satisfaction will also be inadequate.

Three issues need to be addressed by assessments of quality. In the first place, one needs to evaluate existing methods to find out if they are just as effective, satisfying and as well carried out for migrants and ethnic minorities as for the majority population. Then, if the answer is "no", the logical next step is to analyse the reasons for the discrepancy and to develop "good practices" to improve quality for these groups. Finally, these revised methods must be evaluated to see if they are as successful as their proponents hope.

Claims that migrant and ethnic minority populations are not well-served by existing services often arise spontaneously rather than as the outcome of systematic research projects. In fact, there is a serious shortage of research comparing interventions with majority and minority patients. For a long time it has even been standard practice to exclude minority groups from clinical trials and psychological research to reduce sources of variance regarded as "extraneous". The result is that for most treatments, it is simply not known whether they are equally effective for all groups. This in itself constitutes a serious inequity: it means that "evidence-based" practice has been widely implemented in health

systems for majority populations, but not for minority ones. In the United States, the National Institutes of Health published successively stricter guidelines between 1990 and 2001 mandating the inclusion of minority groups in research, but no comparable measures appear to have been adopted in European countries. Considerations of equity require that urgent measures should be taken to ensure the inclusiveness of health service research in all countries. In spite of these "blind spots", there is an extensive literature showing that migrants and ethnic minority groups are often poorly served by existing services. As yet there is nothing in Europe to compare with the monumental report of the Institute of Medicine in the United States (Smedley, Stith & Nelson, 2003), which, over 764 pages, catalogued a wide range of evidence about shortcomings in health services for minorities and discussed "good practices" and training methods to remedy these deficiencies. Nevertheless, there have been several major reports in the United Kingdom on the quality of health services for black and minority ethnic groups (see, for example: SCMH, 2002; Aspinall & Jacobson, 2004), and studies have appeared in many other European countries (see: MIGHEALTHNET, 2007).

Specific problems of matching that have been identified

Having identified shortcomings in service delivery for migrants and/or ethnic minorities, the next step is to diagnose the underlying causes and to propose revised methods ("good practices"). This section describes some of the factors that have been regarded as responsible for shortcomings in service provision, and the following section examines some of the remedies that have been proposed. As will be seen, there is considerable overlap between the factors that reduce accessibility and quality.

Language barriers

Language barriers, where they exist, are perhaps the most serious obstacles to high-quality service provision. A level of language proficiency sufficient to enable a person to "get by" in everyday situations may not be sufficient to meet the demands of a clinical encounter. This topic has been discussed in the previous section.

Divergent health beliefs

The previous section also discussed divergences between users and health professionals in beliefs about when and where to seek help. Differences in the "explanatory models" of caregiver and patient can also cause difficulties when help is being given. Particular problems arise when the patient regards the proposed treatment as unwarranted or irrelevant.

Ever since the introduction of the concept of explanatory models by Kleinman, Eisenberg & Good (1978), controversy has continued about the importance of such conflicts of perspective. Some researchers regard it as vital that clients and caregivers should see eye-to-eye about the way to tackle health problems: health education is regarded as essential to ensure "therapy compliance" and avoid drop-out. Others argue, however, that people's explanatory models are manifold and flexible: they point to the existence of "medical pluralism" – the tendency of people in both rich and poor countries to seek remedies from different medical systems simultaneously, without regard for the logical contradictions involved. On this view, the important factors are not cognitive, but affective. A caregiver who can inspire trust and confidence will be taken seriously regardless of the explanatory model he or she uses, while one who does not give the impression of respecting and wanting to understand the client will command little authority (Williams & Healy, 2001).

Cultural barriers

The concept of "culture" played a key role in attempts to tackle the problems of service delivery for migrants and ethnic minorities in the last quarter of the 20th century, though today it is acknowledged that many other issues also have to be considered. Most questions relating to "responsiveness" or "matching" have been labelled as matters of "cultural competence", but this concept has undergone many transformations since it was first proposed in the 1980s.

The term previously used was "cultural sensitivity", interpreted as knowledge about the characteristics of faraway cultures (not only beliefs and customs concerning health, but also rules of interaction, values and norms). This knowledge was often packaged in manuals describing how the health worker should deal with people from culture "A", "B" or "C".

However, this approach quickly fell into discredit. The main reason is perhaps that the number of cultures services have to deal with has become simply too large for the manuals to keep up with. More fundamentally, however, the very existence of these cultures as self-contained entities has been called into question by anthropologists inspired by Geertz (1973). Geertz and his followers insisted that cultures are heterogeneous, many-layered and subject to

continual change. Migrants, in particular, draw on many cultural sources: pigeon-holing them as representatives of this or that culture came to be regarded as stereotyping and liable to do more harm than good.

In this way, attention shifted to cultural self-knowledge. Professionals were encouraged to focus critical attention on their own world view, values and implicit presuppositions. In relation to the cultural "other", they were urged to cultivate an attitude of humility and openness. Learning to relate to unfamiliar systems of meaning requires receptiveness and communication skills that are sometimes at odds with traditional medical ways of communicating. Managers, in particular, have to accept that there are no short cuts to proving good care to a diverse population: time and resources have to be invested in getting to know the patients and building trust.

Another shift was the development of the "whole-organization approach" described earlier. In 2000, the United States Department of Health (OMH, 2000) removed the emphasis from individual caregivers by redefining "cultural competence" as "culturally and linguistically appropriate services" (CLAS).

The most recent shift is the realization that "culture" must be interpreted very broadly to include all aspects of a person's "life–world" – not just the "cultural baggage" that they or their ancestors may have brought with them, but also their present situation, socioeconomic circumstances, social and physical environment and daily life – in short, their whole context (CE, 2006b). For asylum seekers and irregular migrants, their legal situation is a crucial part of this context.

"Good practices" developed to remedy problems of matching

An overview of "good practices" in the EU is provided by Padilla et al. (2009). This collection of 35 interventions covers all aspects of service provision, including treatment, health promotion and prevention. Stegeman & Costongs (2004) describe 52 "good practices" aimed at tackling health equalities, many of which are aimed at migrants and ethnic minorities. A number of strategies can be identified in proposals that have been made for improving services.

Training of staff

Training and education of health service staff are regarded as the main prerequisite for developing "cultural competence". These activities should not only be directed at caregivers, but also at administrators, researchers, receptionists, managers and policy-makers. Though views about the content of such training differ, there seems to be almost unanimous agreement on one issue: far too little of this kind of education is presently available, whether it be basic training or refresher courses and supplementary education (Sánchez et al., 2009).

Diversification of the workforce

This briefing already mentioned the importance attached to recruitment policies in ensuring that health service personnel will reflect the diversity of the population. This does not mean, however, that complete "ethnic matching" is either possible or desirable.

Use of "cultural mediators"

The notion of cultural mediation was also discussed in the previous section. Cultural mediators, chosen for their familiarity with the culture and "life–world" of the service user, participate in health interventions to bridge the social and cultural gap between service providers and users.

Adaptation of protocols, procedures and treatment methods

For the most part, "cultural competence" is more a matter of the way services are delivered than the nature of the services themselves. However, new or modified treatments and methodologies can sometimes be developed to cater for the special needs of migrants and ethnic minorities. In the mental health field, for example, the "cultural interview" (Lewis-Fernández, 1996) can be used to make diagnoses more sensitive to the social context. System therapy can be adapted for migrant patients whose problems are inextricably related to the dynamics of large extended families (Yahyaoui, 2010). Another innovation in French psychiatry is "ethnopsychoanalysis", which combines anthropological and psychoanalytic methods of interpretation (Sturm, Nadig & Moro, in press). Some practitioners combine western treatment methods with non-western ones by, for example, involving religious agencies in the treatment. Many migrants and ethnic minority community members seek health care from providers outside the formal system who are able to treat them within culturally specific frameworks (traditional medicine or folk medicine). Such "alternative healers" are to be found in every multicultural society – and their clientele often includes members of the majority population. The methods they use deserve investigation to see whether lessons can be learned for improving the quality of care.

The evaluation of "good practices"

At present, only a small number of the "good practices" that have been developed have been subjected to proper evaluation (Fortier & Bishop, 2003). In the field of mental health, however, Griner & Smith (2006) located 76 relevant evaluation studies and demonstrated by means of a meta-analysis that interventions to improve "cultural competence" showed substantial positive effect sizes. There is an urgent need for more evaluations of "good practices" to establish whether or not they are worthy of the name.

Integrated versus separate service provision

In some cases, separate services are set up to provide specialized care outside the mainstream of the health system to specific groups of migrants or ethnic minorities. The advantages and disadvantages of such "categorical" service provision have been hotly debated. Segregated services (whether provided by health authorities, NGOs or private companies) may in some cases be more accessible and more effective than integrated ones, but this has to be balanced against the disadvantage that in the long term, they do nothing to reduce the segregation and social exclusion of the groups they serve.

Participation

Finally, one should emphasize once again that creating a responsive health system cannot be achieved without substantial participation by the intended beneficiaries. Good governance in health systems implies the need to involve migrants and ethnic minorities closely in the planning and implementation of health services. The ten "common basic principles of Roma inclusion" put forward by the Council of the European Union (2009) include one on "active participation of the Roma". Participation is one of the three values (alongside equity and solidarity) underlying the policy framework for attaining health for all in the European Region (WHO, 2005b). However, as the latter document acknowledges, existing mechanisms for encouraging participation often do not succeed in reaching migrants and ethnic minorities. It states: "[Policy-makers] should actively support the participation of the most underprivileged and vulnerable groups, whose members tend to lack experience and confidence in making their voices heard" (WHO, 2005b:50).

There is clearly a long way to go before the goal of adequate participation by these groups can be realized. However, a more dynamic view of participation is offered by "community-based" and "asset-based" approaches (García-Ramirez & Hatzidimitriadou, 2009; Ministry of Health and Social Policy of Spain, 2010:72). Such approaches aim to mobilize the resources migrant and ethnic minority communities possess and to empower these communities, in partnership with the existing health system, to improve their own health and well-being while strengthening the services provided and making optimal use of them.

Measures to promote equity in health services

This section will briefly summarize strategies and instruments – "levers for change" – that can be used to promote equity for migrants and ethnic minorities in health systems.

Capacity building

Capacity building (resource development) is one of the major functions of health systems identified by the Tallinn Charter (WHO Regional Office for Europe, 2008). In this context, it refers to research, education and the consolidation of expertise.

Research

A substantial investment in research is needed to develop an adequate evidence base on the health of migrants and ethnic minorities (Ingleby, 2009). This will entail improving data collection on these groups and the monitoring of their health status and health service utilization.

Education

The urgent need for more training and education on the topics of this policy briefing was discussed above. This need is not confined to health workers alone, but also applies to all those concerned with administration, management and policy-making. Here, too, resources need to be scaled up.

Consolidation of expertise

Improving the theoretical and practical "state of the art" in this field is currently hampered by fragmentation and a lack of synergy. Initiatives are developed separately in many sectors without any overarching coordination. There is a lack of communication between the many different professions, specialties and scientific disciplines involved.

To overcome this, it is necessary to combine forces and pool resources in interdisciplinary expertise centres and centres of excellence, which should be actively supported by national governments.

At European level, the lack of international coordination is a further source of fragmentation, which often leads to "reinventing the wheel" in countries that have inadequate access to knowledge about the state of the art in other countries. This problem is being addressed to some extent by joint initiatives set up by intergovernmental bodies such as WHO, EC, CE and IOM. NGOs, notably those concerned with irregular migrants and Roma communities, are also playing a considerable role. However, the degree of international cooperation needs to be scaled up (see: Rijks, 2010).

The need for involvement of all relevant actors

As noted, tackling issues of health equity requires a concerted approach by many agencies and actors. In the first place, a multisectoral approach is required, involving not only health but also employment, education, housing and immigration policy (WHO, 2010a). Second, all levels of government (intergovernmental, national, regional or provincial and municipal) must act in a coordinated way. Third, all other relevant partners must also be involved: health service providers, professional and licensing bodies, insurance systems and companies, research and educational organizations, the private sector, NGOs and community and users' organizations.

More effort should be devoted to increasing awareness of health equity among the general public. Instead of carrying on a discussion among experts over the heads of the general public, there is a need to promote understanding of the issues discussed in this policy briefing and support for the measures proposed, which will ultimately stand or fall according to their ability to command public support. Enlisting the help of media and opinion-makers is indispensible in this respect.

Migration and ethnicity as part of a comprehensive health equity agenda

Finally, it is essential that initiatives to promote health equity for migrants and ethnic minorities should be fully integrated into campaigns targeting socioeconomic inequalities in health. As we have noted, there is a tendency to regard these agendas as separate, based on different research paradigms and requiring different policy measures (see, for example: Salway et al., 2010). However, this briefing has attempted to show attention to the health of migrants and ethnic minorities must be a central component of any plan to tackle health inequities in the WHO European Region. Failure to fully join up these agendas will weaken both efforts and result in an important, and perhaps unique, opportunity being missed.

It is important to ensure that migration and ethnicity are considered in the context of wider efforts to address health inequities across the social gradient and for all population groups. A number of European countries have advanced measures for addressing health inequities across the gradient, including:

- monitoring the social determinants of health and health inequities through improvements to information systems and the creation of health equity indicators;
- establishing national (and local) strategies and action plans for the reduction of health inequities;
- training health professionals on the social determinants of health and health inequities;
- using tools such as equity-oriented health impact assessments to review the impact of policies across sectors on health equity and social determinants of health; and
- creating cross-government platforms and other institutional mechanisms for applying the principles of the "equity and health in all policies" approach.

In each of the above measures, the concerns of migrants and ethnic minorities should be considered. Likewise, equity-oriented health impact assessments should be conducted on policy areas affecting the social inclusion of migrants and ethnic minorities.

5. Priorities for further research

Data gathering

Demographic information about migrant and ethnic minority populations is essential to plan policies and carry out epidemiological studies. Besides variables such as age and sex, such data must also give insight into the social and material conditions in which these groups live (such as their education, employment and location).

However, two basic issues must be resolved before such data can be collected. First, a working consensus must be achieved on definitions of the variables to be investigated and the criteria to be used. The second issue concerns legal and political barriers to collecting such data. These need to be analysed with a view to finding solutions so that problems can be tackled while respecting considerations of privacy and political sensitivity. This applies particularly to data on the Roma population (see: McDonald & Negrin, 2010).

Health inequalities and social determinants of health

Epidemiological research is required on the state of health of migrants and ethnic minorities. This should cover the full spectrum, including contagious diseases, chronic and noncommunicable illnesses, mental health, prenatal and perinatal problems and work-related health problems. Research should also be carried out to identify the determinants of ill health among these groups.

Disentangling the nexus of discrimination, social exclusion and material or environmental determinants of ill health should have a high priority. In the past, work on migrant and ethnic minority health has to a large extent been carried out within different frameworks and networks from work on "social determinants of health". These two approaches need to be fully integrated to maximize the benefits of both. Attention to migration and ethnicity-linked health differences is essential in policies aimed at reducing health inequalities in general.

Health services and systems

Research on health systems and services should focus on the issues of entitlement to, and accessibility and quality of, services for migrants and ethnic minorities. A review of existing work is offered by Ingleby (2009). Three lessons that are important for future work are:

- a mix of quantitative and qualitative methods is essential to obtain valid and meaningful results;
- members of the groups being studied must play a central role in research; and
- more effort should be made to overcome the fragmentation of effort caused by national and disciplinary boundaries; international centres of excellence, as well as support from the EU and other international bodies, should play a central role in this.

Policy development and implementation

Comparative research on achieving change in policies and practices should identify how change can be facilitated and effectively implemented. A major problem in this area is that "good practices" are seldom adequately supported by structural measures, so improvements are often only local and temporary. The sustainability of initiatives is low (see: Padilla et al., 2009). Economic, political and human-rights justifications for policy should be developed and effective arguments and strategies for change explored. In particular, efforts should be made to quantify the costs of not attending to migrant- and ethnicity-linked health inequities.

Annex

Grouping of select recommendations by health system functions

Service delivery (Including health promotion and education, preventive care and screening, curative and palliative care)	• Monitor the accessibility and quality of health services for migrants and ethnic minorities. • Identify and analyse problems, devise remedies and evaluate their effectiveness. The following measures can be used to improve matching of health services to the needs of migrants and ethnic minorities. • Reduce language barriers by providing interpreter services and translated materials where necessary. • Reduce administrative and practical barriers to access which may be particularly problematic for migrants and ethnic minorities. • Adapt service delivery to cultural and social differences, including health beliefs and behaviour as well as people's living and working situations. • Allocate resources in response to the incidence and seriousness of health problems, where necessary developing new, specialized expertise and practices. • Use a targeted, outreaching approach to provide migrants and ethnic minorities with information about health and the health system. • Adopt a whole-organization approach to the elimination of institutional discrimination and the development of "cultural competence". • Increase intersectoral cooperation with other services, in particular those concerned with social care, education, immigration and integration, using one-stop services, care management and "joined-up care". • Foster the involvement of migrant and ethnic minority communities in the design, implementation, monitoring and evaluation of health services. • Strengthen primary health care provision and reduce inappropriate dependence on emergency services. • Integrate health services for migrants and ethnic minorities as completely as possible into mainstream care to facilitate quality control, guarantee sustainability and avoid institutionalizing social exclusion.
Resource generation	• Develop a well-equipped workforce through training and education (both pre-service and in-service) concerning migration, ethnicity and health. Programmes should be aimed not only at health workers, but also at researchers, managers, administrators and policy-makers. • Formalize new functions such as cultural mediators, health interpreters or community development workers, paying attention to training, professional standards, sustainable financing and positioning in the health system. • Establish systems for generating and disseminating knowledge about migrant and minority ethnic health. This must be based on adequate basic information about these groups and their social position. • Strengthen and consolidate the expertise of researchers and health workers by improving cooperation between disciplines, professions and health sectors.

Stewardship	• Develop a multisectoral approach to tackling the social determinants of migrant and ethnic minority health, based on the principle of "equity and health in all policies" (see Fig. 1 for an operationalization of this approach). • Ensure the primacy of the right to health and the public health perspective in policy issues concerning the entitlement of migrants and ethnic minorities to health services. • Build coalitions for migrant and ethnic minority health involving all relevant actors and stakeholders, and promote this issue in political fora and the media. • Foster international cooperation on health protection mechanisms concerning migrants and ethnic minorities and on the exchange of expertise and good practices. • Ensure maximum synergy between measures directed at ethnicity- and migration-linked health inequities and other strategies to reduce health inequities. • Develop interventions to strengthen social networks and empower migrant and minority communities, treating them as a source of solutions rather than just problems.
Financing	• Reduce financial barriers to health care for the less well-off by limiting out-of-pocket payments and promoting universal coverage (see also "Stewardship"). • Ensure migrant and ethnic minority users are aware of their entitlements and that these entitlements are respected by service providers. • Investigate the economic costs of health inequities and of inadequate diagnosis, inappropriate treatment, medical errors, "drop-out" and poor treatment adherence resulting from a lack of culturally and linguistically appropriate service provision. Use equity-oriented health impact assessment to help articulate the relationship between policy measures, health outcomes, costs and benefits.

Source: Adapted from presentations on migrant health by Theadora Koller, WHO Regional Office for Europe.

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Useful web sites

World Health Organization
Web sites on social determinants of health
http://www.euro.who.int/en/what-we-do/health-topics/health-determinants/socioeconomic-determinants
http://www.who.int/social_determinants/en/

WHO/IOM Global Consultation on Migrant Health, Madrid, Spain, 3–5 March 2010
(in collaboration with the Spanish Government):
http://www.who.int/hac/events/3_5march2010/en/

International Organization for Migration (IOM)
EU-level Consultation on Migration Health, "Better Health for All"
http://www.migrant-health-europe.org/

European Union (EU)
EU web site on social protection and social inclusion (can be searched using the terms "migrant" and "ethnic minority")
http://ec.europa.eu/social/main.jsp?langId=en&catId=750

Council of Europe
Roma and Travellers: http://www.coe.int/t/dg3/romatravellers/default_en.asp
Migration: http://www.coe.int/t/dg3/migration/default_en.asp

European Agency for Fundamental Human Rights (FRA)
http://fra.europa.eu/fraWebsite/home/home_en.htm

EURoma (European Network on Social Inclusion and Roma under the Structural Funds)
http://www.euromanet.eu/

European Roma Rights Centre
http://www.errc.org/index.php

European Public Health Association – Migrant Health Section
http://www.eupha.org/site/section_mh.php

Fundación Secretariado Gitano [Roma Secretariat Foundation]
http://www.gitanos.org/english/organitation.htm

Health Promoting Hospitals Task force on Migrant Friendly and Culturally Competent Health Care
http://www.ausl.re.it/HPH/FrontEnd/Home/Default.aspx?channel_id=48

Regional Roma Health Intelligence Centre
http://www.rrhic.org/our_objectives_and_goals.php

Mighealth.net – information network on good practices in health care for migrants and ethnic minorities in Europe
http://mighealth.net/index.php/Main_Page

Trends in total migrant stock: the 2008 revision
http://esa.un.org/migration/index.asp?panel=1

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