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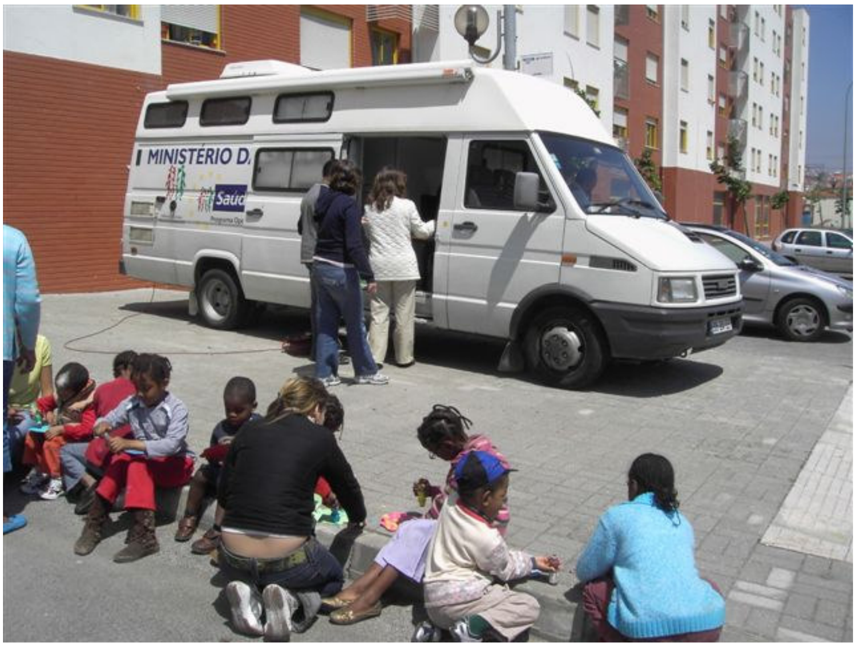
Better health for all in an inclusive society



GOOD PRACTICES ON HEALTH AND MIGRATION IN THE EU

Final Draft

Conference
**"Health and Migration in the EU:
Better health for all in an inclusive society"**

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The content of the present work is the responsibility of the editors and of the authors of the good practices presented and not necessarily reflects the position of the Portuguese authorities.

Good Practices on Health & Migration in the EU

Introduction

Aims

The aim of this report is to discuss issues of health and migration with reference to some of the interventions that EU member states have found to be effective in the field. Thus, the ultimate goal is to improve migrant health and health care in member states, primarily by sharing and exchanging different experiences but also by identifying the pitfalls of health systems when accounting for migrant health.

In general many overarching drawbacks have been identified in health systems that seem to be common in most of the countries, from communication obstacles triggered by languages barriers but also cultural and socio-economic issues that lead to increasing vulnerability of the migrant population. Thus there are many questions arising from those limitations.

It must be said that the field of health and migration is a rather new and complex ground. Health and migration issues have been either approached by different policy fields, or have been ignored. Thus, there is a lack of a comprehensive approach that leads to an integrated way to face the new situations, and hence, it is about time to get into action. Even if good practices are neither the solution nor the approach to take for future action, they are concrete ways of interventions that have been adopted as a response to new situations, mainly, but not only, where and when the state has been absent.

Health & Migration

International migration has jumped to the centre of international and national political agendas in the last decade. For the EU member states, international migration is a common reality, even if the characteristics of the flows differ in origin, quantity, intensity, qualifications, status, among other factors. In the EU, migration is related to both, demographic and economic challenges with two-folded scopes: protecting human rights and fostering economic growth. However, growth ought to be sustainable and promote equity and should not be reached at the expenses of some for the benefit of others. If this is to be fully accomplished, migrant health becomes a central issue as it has been proven that where population growth has taken place, it has been due to migration. Moreover, following European values and principles, all human beings should fully enjoy as good a state of health as possible.

Having said this, it is important to recognise that the planning and adoption of policies to deal with the mobility of people and their health are a priority. The arrival of newcomers with different cultures and practices implies a two-way street in terms of integration and adaptation: host societies adapt to these changes at the same time that newcomers adapt to a new environment and become familiar with the practices and cultures of the receiving societies.

Transition to the new life in a new country is a difficult period because it embodies several adjustments. Upon arrival migrants need to solve some issues such as finding housing and work, becoming familiar with means of transportation, learning a new language, understanding how public services work including how to gain access to health information and services; many migrants while adjusting still have to deal with unresolved issues or family matters at the county of origin. Furthermore, living in a new country usually implies a change from the known environment at home (climate, exposure to different risks to their health, changes in life style, new eating habits, etc.) that adds stress to an already stressful situation.

All of these changes are important, however those that relate to changes in migrants' health status, the determinants of their health and on how to attain access to services are our main preoccupations. Previous research has identified a 'healthy migrant effect' (also known as the 'migrant health paradox'), which indicates that when immigrants arrive to the country of destination, their health status is usually better than that of nationals (Chen and Wilkins 1996). So one could wonder what happens after arrival. On the other hand, other studies have emphasised that the intersection of health and migration is very specific because populations differ greatly (Carballo et al. 1998), especially when considering that migrants in general are populations that usually face situations of vulnerability. Consequently, the health status of some migrants deteriorates in the country of destination due to several factors (namely the determinants of health). As widely known, health depends on a combination of inter-linked factors that are usually divided into specific groups: constitutional factors, individual lifestyles, social and community networks, living and working conditions, and general socioeconomic, cultural and environmental conditions. One obvious corollary is that some health determinants are more relevant and specific for migrants than for the general population. However, on the other hand, migrant are also part of the host society.

From the public policy standpoint, it is important to improve the health and well-being of all people living in a given society, including both, EU citizens and migrants from any country residing in the EU. As part of the host society, migrants are affected by local policies or the lack of them. In this report, we will refer to as 'migrants' those people living in the EU who are from non-EU countries and their descendents. Other concepts commonly used are immigrants and ethnic minorities.

Defining Good Practices

In the last few decades, it has been suggested that in addition to describing and identifying social problems, it is fundamental to identify good/best practices, that is, activities, projects or ways of action that can be considered successful in dealing with such problems or phenomena, thus making a positive contribution to the issue at hand. We believe that the framework of good/best practices could be a useful tool, not only as a way of learning and disseminating knowledge but also because it "supplies practical ways of partnerships between communities, governments and the private sector" (UNESCO 2006). There are many advantages and positive aspects about good practices.

In this sense, several international organizations find helpful to identify GOOD/BEST PRACTICES as a way to help others to deal with similar issues by the dissemination of what has been called horizontal knowledge. However, in terms of methodology, it is important to define two aspects. On the one hand the concept of good/best practices adopted in order to agree upon certain aspects and features which are necessary to establish a common base and criteria for selection and evaluation. On the other hand, as the selected knowledge is horizontal and does not occur in a vacuum of values, it has epistemological consequences, thus it is important not only to describe techniques and tools for performing given activity, but also to make explicit the world-view or norms of validity and values implicit in those practices. Good or Best Practices are useful because they

> “provide a much-needed link between research and policy-making by inspiring decision-makers with successful initiatives and model projects that can make an innovative and sustainable contribution to actually solving problems in society” (Paul de Guchteneire and Saori Terada, UNESCO 2006).

The importance of good/best Practices has been pinpointed many times in research and in policy making, however there is not much written about theoretical frameworks or even common elements that a good/best practice should have, especially in the field of health and migration. In many cases reports mention good/best practices in their titles and contents, but without providing a definition or understanding of what a good/best practice really is or means. Thus, authors of good/best practices assume a meaning for this concept without making it explicit, as if the adjective good or best is self-defined.

Even if there are different models (implicit or explicit) for good/best practices, some can be applied to any situation and others are very specific to certain terrains such as poverty, housing, and the environment, among others. As a general framework, we adopt the UNESCO model developed for best practices in immigration planning because identifying the same target population is fundamental. Additionally, the model responds to our principles. Following UNESCO, the four main characteristics are:

1. Best Practices are innovative. A Best Practice has developed new and creative solutions to common problems that are consequence of immigration, poverty and social exclusion.
2. Best Practices make a difference. A Best Practice demonstrates a positive and tangible impact on the living conditions, quality of life or environment of the individuals, groups or communities concerned.
3. Best Practices have a sustainable effect. A Best Practice contributes to sustained eradication of poverty or social exclusion, especially by the involvement of participants.
4. Best Practices have the potential for replication. A Best Practice serves as a model for generating policies and initiatives elsewhere.

Even if the model provides a useful framework and defines some characteristics that are relevant, we considered it essential to have a common blueprint that provides authors and readers with more information than the aforementioned features and whether each practice meets them. Therefore, we designed a matrix that included several aspects that guided the process of writing the good/best practice, in the first place, and reading or understanding it, in the second place. This blueprint enabled us to have at least a set of aspects in order to compare and assess the degree to which practices could be considered ‘good’ or ‘best’.

Moreover, we believed that in addition to identifying the above four characteristics, it is fundamental to identify the values that underlie the design of the good/best practice. Values would enable authors and readers to understand principles informing the practices that could be fundamental for replication, and offer information about the choices, principles, philosophy that guide the conception of a given practice.

From Best to Good Practices

When we began our project, we used the concept of ‘best practice’ but this was changed later on. The existing literature uses both concepts, ‘best’ and ‘good’, although there is not an in depth discussion about the actual utilization of one or the other. In the process of building up this report, and having discussed the issue with the authors and/or practitioners involved, we opted to use the term ‘good’ rather than ‘best’.

Several reasons made us believe that good is a more adequate adjective for what we are referring. In the first place, ‘best’ tacitly implies that there are other ways and that the selected one is better that the others. ‘Best’ also suggests the existence of a hierarchy, and we did not have a complete set of practices to rank. Secondly, ‘best’ would imply that all the criteria presented above are met by all the selected practices. However, this was not the case for most of the examples found: for most of the selected practices, at least one of the criteria was not completely met. Thirdly, ‘best’ would also imply that a given practice is a better way to do things compared to other approaches. This is not necessarily true either, as practices respond to specific needs in given situations, and it was not possible for us to compare and evaluate.

Thus, due to the multiplicity of situations that indicated that the cases or practices selected could not or should not be thought as ‘best’, we opted for the word ‘good’. Using this definition we could include practices that may be a solution to some issues or problems but that do not necessarily meet the four criteria listed above. As the practices are a product of their environment, reality and circumstances, they are relative, and could be more or less creative, more or less sustainable or more or less replicable. On the other hand, in most cases, good practices make a difference for the populations involved, at least compared with what was available before the practice was in place. A more exhaustive commentary and analysis on the process and on the good practices will be presented in latter sections of this report.

Methodology

This report results from a long process that started when Portugal submitted a project to the European Commission for the organisation of some key events during its Presidency of the EU Council. The project included the organisation of a conference on Health and Migration (Lisbon, 27-28 September 2007) which would generate preparatory work, namely, the commission of two reports. The first of the reports focuses on demographic, and epidemiological issues as well as policies regarding health and migration. The second one, this present volume, is a study of Good Practices on Health and Migration in the EU.

The general methodology of works to prepare the conference and the reports comprised some working meetings which were hosted by the DG SANCO in Luxembourg in January and May. The meetings were attended, in addition to the representatives from the Portuguese Health Group and the Commission, by the consultants and the European national focal points. These European national focal points constituted an informal network, and were appointed by each national Health Ministry. The idea was to share with Member States (MS) the process of organizing the conference and show the advances of the reports, thus adopting a bottom-up approach.

For the present report on Good Practices, the main input came from the national focal points. In the first meeting held in January, we asked them for help in identifying practices in the field of Health and Migration in their own countries. Thus the report was deliberately organised in a way that would allow for the direct contribution of MS.

As already mentioned, there were two general meetings with national focal points in Luxembourg. In the first one, the editors presented important information to the focal points: models on health services provision and a base matrix to identify good practices. Also, in the first meeting, national focal points were divided into two working groups to discuss issues that could be relevant, i.e. to use some examples of good practices from their own experience, to discuss the involvement of MS, the articulation with governmental and non-governmental agencies, among others. That first discussion proved to be very challenging but also productive, and deadlines were set for the reception of samples. Following that meeting, the matrix including some basic information was sent to each national focal point. Member States then had some time to identify practices and to ask individual organizations and authors to complete and send the identified practices.

After MS and some international organizations sent the sample of matrix of good practices filled out, a first selection of samples was made and a meeting with authors was scheduled. This meeting took place in Brussels and was very helpful as it turned out to be creative, dynamic and crucial for getting to an agreement not only in the final version of the matrix, but to gain consensus on the shift from 'best' to 'good' practices, as mentioned above. A second deadline was set for sending the new version of the practices to fit the new matrix.

During the second meeting with national focal points and DG SANCO in Luxembourg, the editors summarised and explain what had been done and the criteria behind the selection of Good Practices. Also, the editors highlighted some possible directions of the conclusions, especially some regarding policies and the weak role of the state in the promotion of migration health.

Good Practices Matrix

The editors selected two possible matrixes that could be the base or guide for organizing and describing the Good Practices. One was the UNESCO Model and the other one was the State Department of Health and Human Services of the United States (Table 1).

Table 1 – Best Practices Models

UNESCO Model	**US Department of Health and Humana Services Model**
Composition of the practice Approach Purpose/objective Main Partner Other partners (community, NGO, etc.) Stakeholders Cost Time-frame Geographical scope Administrative data about the organization Contacts (organization and people) Culture sensitivity/specificity Strengths Weakness Lessons learned Brief Description of how it works	Introduction Goals & objectives Model Results Conclusions Future References (optional) For further information contact:

Based on the two matrixes presented above, the editors proposed the following matrix which combines elements of both and others that were believed to be relevant for the field of migration health. The main objective of the matrix was to identify fields that were important both for authors and readers in summarising relevant information on the good practices.

Matrix for Best Practices

- Introduction
- Goals and Objectives
- Field or Health Determinant
- Scope
- Provider
- Model
- Resources
- Management
- Indicators
- Results
- Conclusions
- Future
- References (optional)
- Contact

As a consequence of the fruitful discussions that the editors had with the majority of the authors in Brussels, some changes were introduced to this initial matrix. These changes supported the shift from ‘best’ to ‘good’ practices and also gave alternative ways to provide information for some of the fields that were problematic or more complex in some cases, such as giving the opportunity to offer testimonies and pictures as a different way to illustrate results and success. In this sense, the new fields incorporated were ‘lessons learned’ and an ‘annex’ section that would provide information to the editors for a better comprehension of the practice, mainly to be used when writing the conclusions, but that would not be published. It follows the matrix adopted for Good Practices.

Matrix for Good Practices (Model adopted)

Introduction: background information about the specific public health problem, its significance and impact, population(s) affected, and trends

Goals and Objectives: state what you seek to achieve as a result of your efforts to solve the public health problem

Model: describe the approach being taken or framework of procedures being used to address the public health problem

Field or determinant: indicate the field(s) or determinant(s) involved in the practice (i.e. prevention, promotion, maternal health, etc.)

Scope: explain the scope of the model, that is, level of centralization, decentralization, etc. that is appropriate (i.e. national, regional, local, etc.)

Provider: indicate whether the provider is a public, private or non-governmental institution, or if it is a partnership of several

Resources: describe the main financial aspects of the practice (i.e. sources of funding, etc.)

Management: indicate how decisions are made, and how they are implemented. Are interested stakeholders taken into account somehow?

Indicators: indicate if there is a way to measure or control the effect of the practice (if possible, state the before and after).

Results: Discuss the basis for determining the success of your model in terms of measurable outcomes. Use no more than one graphic, preferably in JPEG or GIF format, and not more than 400x400 pixels in size.

Conclusions: briefly summarize the meaning of your results and potential implications for public health practice and policy.

Future: outline steps that you may take to extend or further improve the model.

References (optional): provide no more than five citations.

Lessons learned: provide advice from experience, identify weaknesses and strengths thinking in replication/application.

Testimony / Picture: attach a testimony of a migrant who has taken advantage of the good practice. If you wish, you may also attach a picture.

For additional information, please contact: provide the author’s name, title, mailing address, e-mail address, and telephone number

Annex: not to be included in the publication but to be sent with the Good Practice. This section aims at providing fundamental information to editors, as authors will write details that include advantages/disadvantages, problems, etc, encountered through experience and that will be key for editors to write conclusions and make recommendations.

Analysis

Criteria for selecting a 'Good Practice'

Since the beginning some criteria was made explicit by the editors for the selection of the good practices cases. The issues and aspects that the editors would consider were varied, and included from geographical regions within Europe to scope (national, local, international), from target population among migrants to types of interventions in migrant health. These criteria were taken into account for the selection. However, for the analysis of these good practices, in addition to these criteria, other aspects can be added as well (conditions that the good practice pretends to solve, type of organization that carries out the good practice, type of funding and management, etc.).

As editors did not select the good practices cases in MS, this aspect of the selection process was not under their control. In the meetings, national focal points were asked to identify good practice in the area of health and migration, but they were given freedom on which ones to choose or select. Thus this face of the selection process needs to be recognised as biased and limited. Nevertheless, it was never the purpose of the report to do a complete survey or have a representative sample of all the good practice experiences in place in all EU member states. Thus this is a limitation of the report and of the analysis that can be carried out with this set of good practices. On the positive side, these good practices are examples of the variety of possible good practices in spite of all limitations.

Analysing the Good Practices

With the collaboration of national focal points, a total of 55 good practices were collected by the editors based on the existence of at least three of the four characteristics set by the UNESCO model to define a good practice (de Guchteneire and Terada, 2006). In this report we present the selected 35 good practices. This selection became necessary because not all requirements set by the editors in the matrix presented above were fulfilled.

As the good practices included in this report do not reflect an exhaustive inventory of all good practices in the EU countries the main question regarding their analysis lies more on what can be learned from them than on the thorough evaluation of accomplishments and shortcomings.

Good practices are in essence innovations. Which lessons can we learn from reviewing these innovations? Firstly, *diversity*. Good practices point out several fields and ways through which health care systems can be improved. Secondly, *commitment*. Good practices bring out the assurance that human resources, both at an individual and collective level, can be activated to undertake action in favour of a better system. Thirdly, *competency*. Good practices show that a substantial bulk of knowledge and skills for implementing change exists. We proceed with a closer look into each of these aspects.

1. Diversity

The most striking aspect regarding good practices lies on the diversity that characterizes them. Good practices accrue a highly diversified set of interventions designed to respond to the needs of many different target populations at multiple levels. This leaves no doubt as to the vast range of possibilities through which health care systems can be improved. On the other hand, it points out the urgent need for health care systems to promote structural change. Good practices often flourish where statutory responses fall short and problems abound. In this sense, they are not only able to point the way to introduce change but they also identify critical areas in need for intervention.

The good practices presented in this report vary widely in terms of target populations, aims, scope and organization and on geographic distribution.

a. Target Populations

Good practices focus on several target populations. These include refugees and asylum seekers, undocumented and irregular migrants, disadvantaged populations, women and children and adolescents.

Good practices are more or less equally distributed over these groups often focusing on several of them at the time with the exception of undocumented and irregular migrants. Where practices exist for this population they tend to target for it exclusively. This suggests that undocumented and irregular migrants in particular experience greater vulnerability both in terms of health status and access to care when compared to other migrant groups. Good practices developed for this population stress the need for promoting health literacy and empower migrants in these circumstances, including information dissemination on their rights.

b. Aims

The aims of good practices in place are virtually set in all fields associated with health and health care: research, information dissemination, training, illness prevention, health promotion, health access and quality of service delivery. This shows the important challenge posed by ‘multicultural’ societies to health care systems. The ongoing processes of globalisation, worldwide migration and EU expansion are leading to an increase of ethno-cultural differences in the EU countries and there is a need to re-think health care delivery towards more culturally-competent and flexible services. Good practices offer unprecedented expertise and knowledge on how to deliver care to migrant populations and in identifying the fields in which this need appears more urgently.

Access to care appears to be one of the major concerns at present, judging from the number of good practices that sets it as one of their main goals. While undocumented and irregular migrants seem to be most affected by the lack of access to care, this problem is not exclusive to them. Good practices alert us to the fact that even migrants with full entitlement to health care have difficulties navigating health care systems. These difficulties derive from the lack of information about where to get treatment, complex administrative procedures, discrimination and cultural and linguistic barriers. These problems might be counteracted by creating more user friendly-services, providing culturally-sensitive training to the staff, promoting health literacy and user involvement and developing new policies able to accommodate the changing needs of an ever-more diverse population in the EU.

c. Scope and organization

The scope of good practices is connected to two different aspects: administrative organization and the type of care. On the one hand, good practices differ in the formal way national administrative systems are set in each country, thus good practices are national, regional or local, and inclusively, if they transcend the national boundaries as we found, they are transnational or international. On the other hand, good practices either exist within public institutions or are offered by Non-Governmental Organization (NGOs). Good practices provided by NGOs tend to have a more limited scope, operating at a more local level while governmental good practices reach up more easily to national levels. In the case of the latter these might be more or less centralised, depending on state policy.

It is important to mention the active role and involvement of NGOs on migrant health which is often on the forefront in attending migrants' needs. While this might prove highly beneficial as a result of a greater accent on bottom-up approaches which attempt to involve all stakeholders and to promote horizontal relationships, this must not conceal the fact that more often than not, NGOs operate as substitutes where public care falls short and where there is a vacuum of state intervention. The responsibility of EU MS towards migrant health must be reinforced within the international agenda, bearing in mind the danger of an increasingly weaker public health care system with possible consequences for population health protection and health gains.

d. Geographic distribution

There is a significant variability between different geographic regions[1] in the EU concerning the good practices in place (or the lack of them) as a result of social, political and historical aspects associated with migration flows.

North-west countries, where migration has been present since the 1950s, tend to have a well-established set of good practices. These concern the use of cultural mediators, translation of health-related information and a considerable investment on research through the creating knowledge and expertise centres on migrant health. On the other end, are countries such as Lithuania, Estonia and Latvia where good practices are absent perhaps as a consequence of the novelty of the migration phenomena.

Some of the countries which have recently joined the EU have been confronted with an urgent need to tackle problems associated with human trafficking (e.g. high risk for HIV/AIDS transmission). These countries have focused on the dissemination of information in the main languages of their migrant populations.

Southern countries, and in particular Spain and Italy, appear to experience a boom of good practices. Migration to these countries is a relatively new phenomena following a long history of emigration. The right to health and access to care for all, including irregular and undocumented migrants, have been two of the chief concerns in these countries.

Despite the scope and organization of Good Practices and their geographic distribution, it is worth mentioning that most good practices are experiences from metropolitan and urban areas, reinforcing the idea that migration tend to be an urban phenomenon.

2. Commitment

The vast array of good practices currently in place in the EU would not exist if it was not for the enormous dedication of individuals and groups who invest a great deal of energy and enthusiasm in the search for solutions. One might argue that health care staff are only doing their job but those in the field will know that when the appropriate resources are scarce, this demands a considerable amount of perseverance and creativeness. This suggests a great deal of willingness among health service personnel to adapt to the demands of changing social conditions. New policies will not have to be forced on a reluctant workforce, provided their aim and rationale is made perfectly clear and that they involve all personnel, from the receptionist to the surgeon in chief.

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[1] We have adopted the following classification for EU geographical regions: North-West, East, Central, and Southern Europe.

3. Competency

Good practices tend to arise out of identified problems which remain unanswered. In this sense, they work as a kind of pilot projects, generating possible solutions which can be implemented and tested on the ground. The novelty and variety of these solutions turns them into a resourceful ‘pool of knowledge’ from where policy-makers and state officials can draw evidence-based data to design informed policies. Furthermore, it demonstrates the availability of widespread expertise, a valuable asset when putting in practice new policies.

Two other aspects are worth of attention in this section: the dissemination of knowledge and user involvement on good practices.

Dissemination

Most will agree that is extremely important that innovation in migrant health should be cumulative. Yet, side by side with the lack of a systematic evaluation of good practices’ achievements there seems to be an overall scarcity of user-friendly channels able to facilitate the dissemination of the knowledge gathered.

What often occurs is that promising interventions fizzle out when funding ends and whole initiatives elapse, only to be rediscovered some years later by another party who again will have to re-think the do’s and don’ts of this kind of intervention. In other words, it is essential to learn from past mistakes and capitalize on existing knowledge instead of continually ‘reinventing the wheel’.

A similar point can be made about European cooperation. At present, because of language barriers and lack of international cooperation, experience gained in one country may be overlooked in another. A pioneer venture at this level was the project on ‘Good practices in mental health and social care for refugees and asylum seekers’ which as well as research, included the exchange of two good practices between the Netherlands and the UK. The authors concluded that in spite of marked variation between and within countries the transfer of good practices in the EU is not only possible but extremely fruitful (see Watters *et al.*, 2003). Another effort in this direction is this report, even if does not pretend to provide a complete survey.

To enhance the transferability of good practices it is imperative that comprehensive databases on all aspects related to migrant health and networks are created. In this domain, the COST Action HOME and the project MIGHEALTHNET constitute cutting-edge initiatives. Set up with the specific purpose of countering the fragmentation of efforts in the field of migrant health and good practices caused by disciplinary, national and linguistic divisions, these projects aim at creating a network of different stakeholders who will exchange and make available knowledge in this field through the creation of wikis (interactive web sites) and national and international meetings and conferences. Similar projects are presently being evaluated by the Commission.

User Involvement

The obvious question when discussing user involvement in good practices is how bottom-up are they i.e. are they needs-driven? And if they are, to what extent are users involved? It seems fair to say that good practices at a local level devised by NGOs tend to provide services based on users’ identified needs, rather than simply reflecting the enthusiasm of a group of ‘good-doers’. At the national level of governmental good practices user engagement is not so evident. In ‘smaller’ good practices relationships tend to be more horizontal enhancing a different view of power (less concentrated and more fluid), which in turn facilitates users' voices. Nevertheless, the extent to which users are involved in the planning, implementation and evaluation of these good practices is not known.

User involvement is a particularly relevant issue when discussing health care for typically vulnerable and unassisted populations, often referred to as 'hard-to-reach groups'. These groups are not only unable to access care but care providers often experience difficulty in reaching out for them or are simply unaware of them and their problems. As we have seen, migrants appear to have less access to care services compared to native populations and where user involvement in health care exists migrants are often underrepresented (Crawford *et al*., 2003) or experience token participation (Minas, Silove and Kunst, 1993 in Sozomenou *et al*., 2000).

Within Europe, the UK appears to be one of the MS at the forefront when it comes to recognising the relevance of user engagement in health care. The British government has recently released a plan to promote "user and public involvement at all levels of the health and social care system, and to create a system which enables more people to become involved and have their voices heard" (DH, 2006).

Users hold untapped resources which can be mobilized to raise awareness for neglected health problems, disseminate information about available care, and generate new and more comprehensive care solutions (Frankisch *et al*., 2002). Participation has also been noted to increase communities' level of responsibility and consciousness regarding their own health (Blakeney and Patterson, 1972 in Sozomenou *et al*., 2000; WHO, 1985). Given the current state of affairs these are particularly important aspects to take into consideration in migrant health. In the future, we hope good practices as well as all practices, will establish a thorough commitment with the promotion of user involvement.

Limitations of the Good Practice Approach

As mentioned previously, good practices compile a relevant and diverse body of knowledge and competencies. However, most practices are set at a micro-level and are transitory. Good practices are interim solutions and they must not be seen as 'end products' or as the sole catalyst for change.

While the lack of policies might be advantageous (a heavily regulated system can diminish the scope for action within care), falling short on structural support (e.g. policies, funds, new institutions) can be even more dramatic as it is likely that for each good practice that succeeds another ten fade away.

Good practices must been seen as 'inspiring muses'. They point the right way through the fog, but it must not be expected that they steer the ship. Good practices have the ability to formulate new routes and assess difficulties and benefits but they are not improvements in themselves. The need for structural change and new policies together with systematic research and training of staff is crucial.

Limitations of the good practices themselves have been already pinpointed. However, in order to avoid misunderstanding, other conclusions can be drawn concerning what good practices should not be or represent. First of all, it should be mentioned that the cases presented here and compiled in the Annex of this report, summarised and expressed the opinion of the authors. In this sense the choice of words and approach they use are not necessarily shared by the editors. One clear example is the different words or adjectives used in the description of a specific target population such as 'irregular' or 'undocumented' migrants. As it could be noted, some practices incorporate the word 'illegal'. The adoption of each of these words is in itself a statement. We, as editors, respected the option of each author.

Another aspect that should be discussed about good practices is that even if we did have a complete overview of all the ´good practices´ that have been devised at the moment, it would only describe what is happening now and would not be a blueprint for the future. Good practices do not allow forecasting. There are three reasons for this:

First, the good practices that have been generated to date reflect the constraints of the opportunities and the availability of funding. Most of them arise at rather low levels in the system (at the level of individual service providers), or outside the system altogether (within non-governmental organizations). To get higher-level policies changed is much more difficult and requires campaigns, lobbying, political influence and much more money than most innovators or enthusiastic and philanthropic initiatives are able to gain. For example, few good practices concern changes in medical training, education, professional requirements, etc., because this would mean changing national policies and legislation. Nevertheless, there is nothing to stop people from offering short courses, seminars, among others, on a ´freelance´ basis, and which can provide inspiration for reforms at national level at a later stage. In spite of these limitations, small-scale, grass-roots initiatives have an indispensable function in pointing the way for the development of broader, structural improvements.

Second, this exemplary function of good practices should not be taken too literally. We can illustrate this by using the analogy of a leaking roof. Problems come to light when health systems designed for a (more or less) homogenous population have to deal with new and different users. Remedies are devised for these problems, but they tend to be short-term, small-scale and local: people use the means they have at their disposal. If one discovers a leaking roof, the best remedy in the short term may be to cover it with a sheet of plastic. But that does not mean that in the future, all new houses should be built with a sheet of plastic over the roof. Rather, *structural* improvements should be made, making use of the experience gained in grass-roots innovations. The form the structural improvement takes may be different from the form of the original intervention: only certain insights and innovations may be taken over.

Third, the needs which good practices address tend to be chosen in a somewhat arbitrary, selective way. Innovations are seldom a reaction to an objective assessment of needs based on comprehensive statistics, still less to the needs which are felt by users to be most acute. On the contrary, they depend on the good feelings and interests of those social innovators who are entrepreneurs of initiatives in which they have an interest, even if altruistic and humanitarian.

All these reasons lead us to believe that even the identification of good practices is an important step, to have a real impact, structural changes must be sought.

The importance of structural change: why "good practices" are not enough

The good practices illustrated in this report have mostly been devised by service providers or professionals in response to their perceptions of the need for change. Very few of them have been developed in response to policy directives from above. This is only to be expected, because the people who are in contact with the day-to-day realities of health care are usually the ones who first become aware of the shortcomings of existing service provision and are motivated to make things better. There is much more awareness of the need for change at the 'coal face' than at the level of management and government policy (though as we shall see later in the migrant policy cases, countries differ widely in this respect).

The advantage of innovations generated at this ‘grass-roots’ level is that they can count on a high level of individual commitment, inventiveness and relevance. Nobody who reads these reports can fail to be impressed by the high level of dedication to the cause of migrant health which they display, and the creativity of the solutions that have been found.

But there are disadvantages too. ‘Grass-roots’ initiatives often have an arbitrary character: they may improve service provision for one particular group, or in one particular place, but not for all groups in all places. Facilities for migrants will be provided in City A, while City B – perhaps only a short distance away – may have nothing on offer, in spite of an equally high level of need. In the Migrant Friendly Hospitals Project, this experimental or exemplary character was explicit: the project set out to achieve change in a single hospital within each of the participating countries, but did not (and could not) aim directly to improve services throughout the whole country.

In contrast, the few good practices in this report which were developed at government level, such as the Finnish initiative on interpreter services, did have universal scope – but such ‘top-down’ initiatives constitute a small minority of all innovations. The improvements in service provision which arise through ‘grass-roots’ initiatives tend to be localised, limited and – and we have seen – to a certain extent arbitrary. Although one of the criteria we have used for good practices is that they should be *replicable,* this is a fairly abstract requirement; it does not guarantee that they will, in fact, be replicated across the board.

Whereas most initiatives are not ‘top-down’, they can hardly be described as ‘bottom-up’, if by this is meant that they originate from the users. Most initiatives originate at an intermediate level, i.e. from the organisations or individuals providing services. While it is true that people in day-to-day contact with migrants may be more aware of their needs than managers and planners, this is not always the case. The greatest needs may exist among the migrants who are *not* seen by health care workers: the ones who are not entitled to care, who do not know how to find it or are unable to do so, or whose needs are not addressed by the existing services. Contacts with service providers may therefore not be the ideal context for an exploration of unmet needs. In general, far too little attention is paid to the voice of users themselves in the planning of services for migrants (cf. Watters & Ingleby, 2004).

Another disadvantage of most of the innovations we have surveyed is their temporary character. Although *sustainability* is one of our criteria for a good practice, this too is a somewhat abstract requirement: it only means that there are good prospects for sustaining the intervention – not that concrete guarantees of continuity exist. This is logical, because the agencies that finance such projects are seldom able to write a blank cheque to enable the work to be continued indefinitely.

Apart from a few unexpected success stories, most good practices turn out to be much less sustainable in practice than the project organisers had hoped or claimed. The turnover of promising interventions is therefore high. Large numbers of initiatives in the field of migrant health have been made by individuals or small groups, relying on their own enthusiasm and a minimum of official support. Because these initiatives are not structurally embedded, the personnel involved often work under intense pressure and are liable to burnout or disillusionment: when they go, there may be nobody to take their place.

Most of the good practices in this area are financed on a temporary project basis: when the funds run out, the project “fades out like a nightlight”, in the words of Van Dijk et al. (2000). Grant-giving agencies may feel it is time to give other applicants a chance, while management may have become accustomed to depend on the external financing and be reluctant to take on new burdens. In this area we can also observe the statistical phenomenon of ‘regression to the mean’. Bold new projects arise because of an exceptional, more or less coincidental, combination of inspired innovators and sympathetic financers. When the time comes to renew the funds, however, the financers may have been replaced by less sympathetic ones: other priorities may have replaced migrant health on the agenda and the political climate may have changed.

All of these considerations imply that it is crucial that innovations aimed at improving migrant health should be *structurally embedded* in the policies of service providers, health authorities and governments, if they are to have adequate coverage and a sustained impact. As can be seen in the Annex to this report, individual creativity and personal dedication have led to some truly impressive innovative projects – but these initiatives have to be backed up by support from the highest levels of management and government if the effort is not to be wasted.

Unfortunately, the need to improve migrant health care has come to the fore during a period in which health services are under enormous pressure to cut their costs and ´streamline´ their ways of working - which all too often means providing only a basic, standardised level of service that takes little account of special needs. The question of contact time is a case in point. Workers in this field are unanimous in their call for more time and effort to be devoted to consultations with migrant patients, in order to overcome communication problems and cultural differences and to obtain insight into the migrant's special situation. However, such an appeal is likely to fall on deaf ears in a period when managers are busy trying to reduce the contact time available to *all* users and to standardise working methods with the help of universal diagnostic instruments and protocols. To make matters worse, the political climate may be unfavourable – or even strongly hostile – to any suggestion that special resources should be made available to migrants. Rational calculations showing that such measures can, in the long run, actually save money, have little impact when decisions are swayed by hostile emotions concerning migrants.

Our conclusion is therefore that in order to back up the impressive array of good practices which have been generated, there must be firm 'top-down' support for improving migrant health, embedded in policy-making at all levels. Such 'migrant-friendly' policies do not have to specify *in detail* the form which innovations take: usually it is better for the detailed initiatives to be generated by service providers and users, who are in touch with conditions 'on the ground'. However, even this is not always the case. It may be that a particular need only becomes visible to health planners with a sophisticated apparatus of epidemiological data-gathering at their disposal. Such data may play an important role in highlighting the need for attention to cardio-vascular disorders, cancer, perinatal mortality and morbidity, psychoses and infectious diseases among migrants (to name but a few conditions).

Policies concerning migrant health

When we examine the state of policies concerning the health of migrants and ethnic minorities in Europe at the present time, we see that improving this topic has only recently started to appear on the agenda. The following brief overview is only intended as a very rough sketch: it does not intend to be complete or any way definitive. Despite some pioneering efforts, there is an acute need for a wide-ranging, in-depth survey of existing policies in this field. To start with, however, certain important conceptual distinctions can be made.

1. What do we mean by 'policy'?

A large number of organisations have an impact on migrant health. Those explicitly concerned with health include agencies at European, national, regional, and local levels, as well as insurance companies, professional bodies, individual service providers and NGOs. All of these agencies may have policies which impact directly or indirectly on migrant health. Moreover, even agencies that are not explicitly concerned with health can have a crucial impact: legislation and practices concerning (for example) immigration, discrimination, equality of opportunities, industrial safety, housing and welfare, among others, can all influence strongly the health of migrants.

This means that it is extremely difficult to generalise about migrant health policy in a particular country. For example, there may be strong regional differences: typically, more attention is paid to migrant health in areas with a high concentration of migrants. Even within the same region, one individual hospital or primary care agency may have an outstanding policy on migrant care, while others – perhaps even encouraged by the existence of the ‘good’ service provider – do nothing at all.

Another complication is the fact that policy directives on paper often bear little relation to the reality on the ground. Governments may legislate to give migrants unconditional access to health care – but the receptionist at the entrance to the hospital may not know about these rules or feel like implementing them. Sometimes the reverse is true: individual doctors and nurses may turn a blind eye to the rules when it comes to helping patients who, formally speaking, have no right to help. Service providers may have a legal obligation to fulfil various legislative obligations concerning equality and diversity, while in practice nobody monitors what they do or takes action when they fail to meet their obligations. Here too, the reverse situation can be found: ‘progressive’ hospitals and clinics may go far beyond their statutory requirements in providing good quality care to migrants and minorities.

2. What are the main areas in which policy can be made?

As mentioned above, policy on migrant health has a number of possible dimensions, of which the following are perhaps the most significant.

a. Control of infectious disease

Until only a few decades ago, this topic was regarded as virtually synonymous with ‘migrant health’. In this perspective, migrants are viewed primarily as a threat to the rest of the population, while screening, prevention and treatment of infectious disease are the most important instruments of policy.

More recently, of course, other perspectives on migrant health have come to the fore, in the light of which this approach by itself seems – both politically and in medical terms – one-sided or even primitive. It would be good news if the approach were as irrelevant as its critics sometimes suggest, but unfortunately the global epidemics of HIV/AIDS, tuberculosis and hepatitis which began to arise in the 1980’s and 1990’s have given it renewed importance. However, some of the identified Good Practices fall within this category: Greece, Slovenia, the Slovak Republic and Malta.

The 'policy referential'[2] underlying the control of infectious disease concerns the protection of the population as a whole. This may seem like a self-evidently desirable goal, but it becomes a controversial one when juxtaposed alongside three other goals. One concerns the protection of the human rights of those who may be prevented from migrating; a second concerns limits on entitlement to health care for non-nationals (particularly undocumented migrants); and a third concerns the universal human right to health and health care. The ensuing conflicts of values ensure that this area of policy will provide an arena for intense political debate for many years to come.

b. Tackling the environmental determinants of ill-health among migrants.

The policy referential in this case concerns the maintenance of public health in general and the right to health of the migrant population in particular.

Some of the determinants of ill-health among migrants can be related to the **disadvantaged socio-economic position** which many of them occupy in the host country. To this extent, policies directed at migrant health should be incorporated in general policies designed to combat the negative health effects of socio-economic inequality. Unfortunately, both at the level of scientific theory and practical initiatives, there is often little connection between these two approaches. In practice, we found very few practices with this approach. One is the Portuguese project on community intervention in a housing project that is based on a global intervention perspective, not designed only for migrants but for vulnerable populations, including migrants.

Another determinant of ill-health which has recently received much scientific attention (notably in the UK and Sweden, following the publication of research carried out in the USA) is **discrimination.** In most countries efforts to combat discrimination are based on human rights considerations: however, to the extent that discrimination is actually capable of undermining mental and physical health, it should be considered as a public health problem too. For example the Good Practice presented by the IOM investigated discrimination towards migrants and religious and ethnic minorities in health care services, and the Swedish case on international health advisor that includes in their multi-level goals, to combat inequalities.

Not all the determinants of ill-health among migrants have to do with environmental disadvantages. Some have to do with life-style, access to health care and beliefs about health. (It is important to note, incidentally, that not all 'cultural' influences on health are negative: low alcohol consumption among Muslims exempts this group from many health problems that burden other groups). The area of **health promotion** has particular importance in migrant health policy because of the need to ensure that migrants are optimally informed about health problems and the best ways of preventing and treating them. For example in the case of the Healthy Cities network, organised under the WHO-Europe, some projects develop health promotion activities aimed at influencing some of the migrants' risk behaviours. Also the German Good Practice which encourages healthy eating among adolescents of migrant descent, and again the Swedish experience of international health advisor that includes a section on raising awareness on healthy life styles, among other issues.

Consequently, the promotion of health in all policies specifically addressing migrant health might mitigate the negative effects of health determinants for these vulnerable populations.

c. Entitlement to health care for (different categories of) migrants.

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[2] The term "policy referential" is used by Björngren Cuadra & Cattacin (2007), Cattacin et al. (2007) and other authors to refer to the value system underlying a policy. Such a value system is always embedded in a particular conceptual framework, system of assumptions or ideology.

Although the biggest obstacle to health care for migrants is often the fact that they are excluded from the free or subsidised health services available to others, it is noticeable that very few of the good practices that have been developed in the field of migrant health care concern themselves with this issue of *entitlement* to care. The reason for this is that most innovations, as we have seen, are generated at the level of individual service providers or NGO's, whereas the rules which determine entitlement are almost always laid down by governments. The most that other actors can do is to lobby for changes in the rules, or to devise ways of reducing their negative impact. Some of the Good Practices are breaking through this path are the ones presented in the Annex by *Médicins du Monde* and PICUM, namely for undocumented or irregular migrants, but also the services provided for refugees and asylum seekers in both of the practices from the UK. In addition to these practices, others intent to provide services and reach migrants in general, as the health improvement plan for migrants in Leganes, Spain, the Health Support Office of CNAI, in Portugal and the ethnic health educators/care consultants in the Netherlands.

Furthermore, experience indicates that many of the good practices in place target very specific groups, namely those perceived as more vulnerable, such as women and children, some of them focusing on even more specific health issues such as HIV/AIDs or female genital mutilation. There are several examples in this field: the Romanian, the APF from the Algarve region in Portugal, the campaign against female genital mutilation in France, the Immediate Intervention Project in the Netherlands, and the Swedish project on multidisciplinary treatment model for asylum seeking children. Another group identified by the good practices as vulnerable are adolescents, with the German example on healthy eating, and the MIKADO project on the empowerment of adolescents in the deprived areas of Eindhoven, in the Netherlands.

d. Accessibility and quality of service provision.

This theme in migrant health policy is a relatively new one. Whereas in the traditional immigration countries (Canada, the USA, Australia and New Zealand), policies in this area have been in place for decades, in many European countries the theme is non-existent. In such countries, attention for migrant health is limited to controlling infectious disease or including migrants in the health system: the notion of adapting the health system to enable it to better meet their needs is not yet on the agenda. Nevertheless, even in such countries many initiatives and good practices have been devised at 'grass-roots' level to improve migrant health. The realisation has grown that existing service provisions designed for the majority indigenous population often fail to meet the needs of other groups (Watters, 2002): the services may not be accessible, appropriate or effective. As we shall see below, NGO's often play a central role when formal health services fail to address the problems of migrant health. Examples can be found across the board, namely practices such as MIKADO in the Netherlands and the Well-Being Project in Manchester, in the UK. However, some governmental and collaboration/partnership initiatives have proved important, such as the governmental French practice with cultural mediators and the partnership between Salud y Familia in Catalonia, Spain with the government, among others.

e. Education and research

Although institutions of education and research do not themselves provide health care, their contribution to the health care system is absolutely fundamental. This is particularly true in the relatively new field of migrant health. Interventions need a secure knowledge base, and this necessitates sustained research effort on migrants' state of health and on processes and outcomes in care delivery. Training and education of health service personnel must include adequate attention to these issues.

Unfortunately, at the present time migrant health is conspicuous by its absence from most curricula in the field of medical education and other health professional training, while the amount of attention paid to migrant health by researchers varies enormously between countries. The setting-up of 'centres of excellence' and specialised institutions for research on migrant health can play an important role in promoting the formation of an adequate body of knowledge. One interesting example is the Portuguese Good Practice “GIS” which disseminates information and research findings among a network of researchers, care-givers, community organisers and advocates while also organises seminars and workshops on topics of migrant health. Other examples of this type of practices are the Migrant Friendly Hospital and the Taskforce purposely created to follow up the original project, which among their aims included training and education for the health staff, and the project on international health advisors in Sweden which also includes as a goal to train (and employ) migrants for this specific duty, taking advantages of their competences.

f. International Cooperation

This topic is an old theme of international relations which has come to the forefront lately and needs special consideration and negotiation between countries of origin, transit and destination and among different sectors/ministries within governments. Migration is a complex phenomenon and thus it requires a comprehensive understanding and approach in many different fronts that should lead to cooperation and agreements of different natures. One important aspect, but not the only one, is cooperation and international aid on health issues such as vaccination, health promotion, disease prevention and treatment between countries of destination and origin. One good example is the Italian Good Practice that promotes cooperation between Italy and Ethiopia.

Another aspect is the training of the health professionals by international teams that takes place at origin as a way to avoid or foster the brain-drain of the health workforce of countries already in a disadvantageous situation. The Gulbenkian Foundation in Lisbon has already carried out this type of training with Cape Verde and is planning similar events in the near future with other countries.

One more aspect within the international cooperation field is the recognition of qualifications/diplomas of health professionals coming from non-EU countries. Without encouraging the recruitment of health professional from other countries, this issue becomes important as many doctors or nurses or other health professionals may be already living as migrants in the EU and could be fully integrated in the health sector in a more productive and efficient way for both, the migrants themselves who would prefer to work in their fields, and for the host society that usually needs health professionals anyway. One excellent example is the Portuguese partnership presented in the Annex, between the Jesuit Refugee Services and the Gulbenkian Foundation.

3. Differences in migrant health policy

We have already called attention to the fact that European work on migrant health lags behind that in Canada, the USA, Australia and New Zealand. While each of these countries could regard themselves as virtually ‘a nation of immigrants’, some European countries have been reluctant to acknowledge the existence of migration as a structural phenomenon – even on a small scale. The tendency has been to treat migration as an incidental, temporary, or accidental phenomenon. In recent decades, of course, this standpoint has rapidly become untenable – even for countries which never had many migrants in the past.

Because there are strong regional variations in the nature and size of the migrant population in Europe, it is not surprising that the amount of attention paid to migrant health issues varies greatly. Here we suggest some broad distinctions that can be made, although considerable variations *within* regions make it impossible to make any confident generalisations.

- In the countries of **North-western Europe** (with some exceptions such as Finland and – until recently – Ireland), migrant populations tend to be well-established and to form a significant part of the population. Their origins lie in labour migration during the industrial boom of 1950-1973, ex-colonial migration, forced migration and family reunification. In these countries, migration and integration policy is a long-standing, complex and controversial political issue, also accompanied by substantial research activity.
- Most **Southern European** countries have until the 1990's tended to be predominantly countries of *emigration,* but the reverse is becoming more and more the case. Democratisation, economic expansion and long, permeable borders have all played a part in the recent influx of immigrants to Southern European countries. In these countries, policies on migration tend to be less established; the debate on the politics of immigration is relatively recent. Health and social care provisions often have less resources than in the North-West – though this does not necessarily mean that policies are less inclusive. These countries have a history of three decades of National Health Services that is being currently challenged by the new waves of migration. Consequently, the debate on migrant health is very much part of the agenda.
- In **Eastern Europe** immigration is often a new phenomenon, influenced by factors such as break-up of the Soviet Union and the successive enlargements of the EU. In certain countries it is still far outweighed by emigration. However, there often exist substantial *ethnic minorities,* comprising long-standing communities of foreign nationals as well as Roma communities. In this respect, the large-scale population displacements and boundary revisions resulting from World War II are still very much visible. In addition, asylum seekers, migrants in transition and labour migrants are becoming increasingly numerous. In these countries, policy making on migrants and minorities is in a state of flux. For many countries, accession to the EU (or the prospect of such accession) has had had a strong effect on emigration, immigration and policy making.

In order to show how complex the factors are and what potential impact may have on migration health policy, we will now single out a few countries within each region in order to highlight some aspects of their policies.

North-West Europe:

The United Kingdom and the Netherlands

It is instructive to compare these two countries, in which the levels and types of immigration are broadly speaking comparable. We should note at the outset that the way these issues are talked about in the UK differs from the usage in most other European countries. For example, discrimination and health differences tend to be referred to as 'racial', even when religion (e.g. Muslim, Catholic) and national origin (e.g. Irish, Polish) may be more relevant. The word 'migrant' is reserved for recent arrivals; the term 'black and minority ethnic (BME) groups' is used to refer to more established communities of migrant origin.

In both countries, considerable attention has been paid since the 1970's to the health problems of migrants and ethnic minorities. A sizeable community of health workers and researchers has concerned itself with this topic. However, whereas in the Netherlands this activity has mostly arisen at 'grass-roots' level, in the UK it also enjoys a strong measure of 'top-down' support. Policies addressing diversity in health care receive substantial government funding and are embedded in a firm legal framework. Since 2000, all public authorities have had a legally enforceable 'general duty' to eliminate unlawful racial discrimination, promote equality of opportunity and good relations between persons of different racial groups, and ensure 'racial equality' in employment, training and promotion. Within the National Health Service this has resulted in a large number of initiatives addressing problems of health care and diversity (DH, 2003 & 2005).

The reasons for this high level of government involvement in the UK are too complex to be discussed here (see Ingleby 2006). Two important factors, however, are the ‘top-down’ character of policy making in the NHS and the relatively strong political influence of BME groups.

In The Netherlands, by contrast, the health service has traditionally been a much looser and less centralised system of interlocking agencies, while migrants and ethnic minorities have not built up a level of political influence in any way comparable to that found in the UK. Despite this situation, in 2000 the Health Minister of the day announced a number of government-financed measures to improve health care for migrants and ethnic minorities. However, these policies were reversed or abandoned by the government which came to power in 2002 in the wake of the assassination of the politician Pim Fortuyn. ‘Migrant-friendly’ policies were now regarded as the problem, not the solution, while central government sought to reduce its role in health and social care even further. It is too soon to say what line will be adopted by the government which was elected in 2007.

Central Europe:

France

From the end of the 80s, NGOs such as Doctors of the World or the French Red Cross set up free medical consultations for the destitute especially foreigners without identity papers. These measures for health care and social welfare appeared in state-run hospitals such as the Baudelaire’s consultation at the Saint Antoine’s hospital.

In 1998, a law against exclusions established the measures PASS more widely in order to reach all the men and women with no resources and no information.

The creation of the Universal Medical Coverage (C.M.U) ensures that any legal resident in France who is not covered by another mandatory health care insurance scheme, has access to the health care insurance to cover all medical costs: the basic CMU that extends eligibility for social security health insurance to low income people on the basis of legal residence in France and no more on the basis of professional activity and led to the PASS’ evolution toward access to health care for all the foreigners without papers. The reimbursement of their medical expenses is completed by the creation of A.M.E.

Established in January, 1, 2000 after the coming into force of the July 27, 1999 the law creating the Universal Medical Coverage, the State Medical Care (A.M.E) provides healthcare insurance to people who do not meet the conditions to get universal healthcare insurance, that is all the foreigners whose papers are not in order.

A patient has to fulfil two conditions based on resources and residence basis to take advantage of A.M.E. He/she must have been living in France for over three months and earning less than 597,16€ per month.

The State medical Care gives access to the reimbursement of medical healthcare and especially medical consultations given by hospitals or not, medical examinations, medicines, nursing or dental care, hospital care. Beneficiaries of A.M.E are not required to advance healthcare expenses and they can choose their service providers. The Act that should define the proportion of medical expenses payable by the patient has not been promulgated yet. As a result, the medical expenses payable are reimbursed at 100% on the basis of health insurance responsibility rate.

The benefit of the State Medical Care is not automatic: a request must be presented and all the written proof of identity, residence and resources must be provided because statements on the honour are not admitted anymore. State Medical Care is granted by the French Social Security Office of the beneficiary’s residence.

State Medical Care is allocated for one year and can be renewed each year on request and concerns the beneficiary but also the relatives. At the end of June 2005, 170 000 beneficiaries of State Medical Care were counted.

Undocumented residents living in France for less than three months are the beneficiaries of free health care insurance for first care whose absence could put in danger a vital forecast or lead to a serious and durable deterioration of the health of the person or the new born child.

All the medical care delivered to undocumented residents is undertaken by the French government who reimburses the French Social Security Offices. In 2006, the supplies allocated to the State Medical Care were more than 230 millions of euros.

Southern Europe

Portugal and Greece

Migrant health was not an issue in southern European countries until the 1990s when migration flows to those countries began to intensify and health care workers were confronted with newcomers whose cultural, social and linguistic backgrounds were not only diverse but also unfamiliar.

Portugal and Greece are two interesting cases worth of comparing given the existence of some tight similarities but also some sharp differences. In both countries, most policy addressing migrants' health started to be implemented in the beginning of the 2000s. Initially, policy was concerned mainly with regulating migrants' entitlement to health care and policy-makers recognised no need for nationwide multicultural programmes like those existing elsewhere in the EU. NGOs and a few local government initiatives were exemplary in providing the only culturally-sensitive care available in these countries (Ingleby *et al.,* 2005). This situation has changed in the case of Portugal as we will show below.

Although considerable attention has been put to migrants' entitlement to health care in both Greece and Portugal some differences can be identified. Whilst in Portugal specific directives were set to grant all migrants, including irregulars and undocumented, the right to health and health care (ACIME, 2002) in Greece formal access to free-of-charge services of the national health care system for migrants is dependant on registered employment, regular status and insurance coverage, except in emergency situations (Hatziprokopiou, 2004a). Additionally, Greek policy differentiates between Ethnic Greek migrants and other migrants when it comes to health care provision for the uninsured. The former are eligible for a special welfare programme for low-income people which allow them to benefit from care services. The latter must pay for services in full and these are often much too costly for most. Even though the number of migrants with a regularised status and insurance in Greece has been growing (Hatziprokopiou, 2004b) this structural policy has a negative impact excluding many uninsured migrants from appropriate health care and differentiating between 'first' and 'second' class migrants.

Aside from the differences on health care entitlement policy problems with migrants' access to care persist at the ground-level in both Portugal and Greece. Language barriers, migrants' difficulties to attain relevant information on how to navigate the health system and insufficient training and diffusion of cultural sensitivity among professionals are problems common to both (IAPAD, 2002; De Freitas, 2003; Ormond, 2004). Portugal is also confronted with difficulties in enforcing the law and the denial of care to undocumented migrants is not infrequent (Fonseca *et al.,* 2005). Bureaucracy, overcrowding and the inadequate infrastructure of the health care system in Greece affect migrants' access to care (Hatziprokopiou, 2004a). In addition, health care officers and practitioners view migrants as a 'threat' to the existing structures (Psimmenos and Kasimati, 2003) and this is coupled with an overall resistance of the wider population to a multicultural society (Coenders, Lubbers and Scheepers, 2003). These circumstances have been pushing migrants in Portugal and Greece into hospital emergency units (De Freitas, 2003; Hatziprokopiou, 2004a) putting their health at greater risk and overflowing the available services.

Once again, it is important to re-state the role of not-for-profit organizations in delivering adequate care to migrants in these countries.

Migrant and health minorities' health problems in Portugal have recently been the focus of attention from 'top-down' structures breaking away from the 'assimilationist model by default'[3] (De Freitas, 2006) that characterised the Portuguese health care system. The 'Integration Plan for Migrants', recently approved by the government, involved a set of measures that address diversity in health care provision (ACIDI, 2007). Two of these measures concern a serious attempt to diversify care from within – the appointment of cultural mediators of migrant origin in health care centres and hospitals in areas with a high representation of migrant populations and the hiring of migrant medical doctors. Access to care by migrants has deserved special attention showing a thorough commitment from the government to resolve the most pressuring issues currently at hand. It is important to evaluate the impact of these policies on access and on the quality of care in the future.

Regarding Greece, there seems to be an urgent need for greater engagement of public authorities in promoting migrants' access to care, developing culturally-sensitive training programmes for professionals and enforcing anti-discrimination measures.

Eastern Europe and countries of recent incorporation

Poland

The phenomenon of migration is a new situation in these countries, so policies tend to be more incipient. As research has highlighted, in health policy analysis there is an inseparability of policy and political context (Collins et al., 1999; Sen, 2003), and this becomes more visible and evident for recently incorporated MS, many of which face a double transition: a post communist regime and the incorporation to the EU. In this sense, Poland can be taken as an example.

During the last years (mainly between 2002 and 2004) and due to its incorporation to the EU, Poland has developed new pieces of legislation on migrants and health care accessibility, aiming at regulating who is entitled to gain access to health care services financed with public funds. The Polish health system is organised at the national level with regional branches and is based on general health insurance known as the National Health Fund (NFZ). The NFZ is the institution responsible for assuring health services for insured persons and members of their families and assures refund of medicines within assigned financial means. Thus coverage is guarantee for insured residents and EU travellers. Uninsured people, including migrants, can only access services very limited services reserved for sudden illness, injury, intoxication, life threat or childbirth.

Research indicates that even if solidarity and equity were the baseline for health care reform in Poland in 1999, which substituted a model of central state funding by a social insurance model, the health system has witnessed increasing health inequalities (Watson 2006). As co-payments have increased, a selective reduction of access to care has become more widely spread, mainly among the poor and vulnerable population.

Even if only basic entitlements are provided to migrants in Poland, some positive steps have been taken with regards to international cooperation on health insurances. International agreements have been reached with

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[3] The lack of nationwide multicultural health care programmes was not a consequence of deliberate governmental policy but rather a result of the lack of policy on the field of migrant health. The health care system was operating as it was first 'programmed', i.e. to attend the needs of considerably more homogenous population, providing the same care to everybody. Using a metaphor from the field of informatics, the system was running 'by default'. Its assimilationist character was not intentional but accidental (De Freitas, 2006).

Albania, former Yugoslavia and the Russian Federation, although they focus on reciprocity and emergencies. On the other hand, from the Polish point of view, there is a preoccupation with the exodus of Polish health professional that migrate to other EU countries.

Because migration has increased in the last few years in Poland (as pinpointed in Report I), health issues are expected to arise in the near future and new policies will certainly have to be designed as a response. In this sense, learning from what other MS have already done is a valuable option.

This policy briefing helps to better understand and explain the type, timing, target population and organisation of the Good Practices presented in the Annex. History plays a role in many ways, not only on determining how well-established some policies may be, but also in understanding approaches and the relationship with more settled groups such as those coming from the former colonies. Thus it is not a surprise that in some countries, mainly in the North-West and Central Europe, good practices were in place much earlier than in other countries (e.g. southern and recently incorporated countries). Yet, although the former countries may already have legal frameworks that allow to intervene when situations of discrimination or bad quality treatment arise some of the same difficulties are still inherent to both. One such example are the problems with ensuring long-term funding to guarantee the sustainability of good practices.

For the countries of Southern Europe, emigration shifted into immigration, changing rapidly their realities. However, this sudden change has propelled them to create numerous and diverse arrays of good practices that provide concrete answers to their new social reality. In this sense, these countries have been really prolific.

On the other extreme, countries of Eastern Europe and those of recent incorporation to the EU are experiencing, in general, several challenges simultaneously: from the readjustment to the end of the socialist era to the transition of becoming a member of the EU, including the experience of migration (both emigration or immigration). All these factors in combination have contributed to bring about new and challenging social phenomena. One of these new realities is human trafficking which has become more common and widespread in recent years in those countries, so it should not be a surprise that some of the few practices that are in place target this very vulnerable population. Other practices identified follow the traditional approach of focusing mainly on the control of infectious diseases.

Conclusions

What are the possible conclusion to draw from all the above? Certainly many general ideas and some recommendations. First, as it emerges from the previous developments, Good Practices are excellent, practical and creative solutions designed and implemented by NGOs, individuals or the state to solve problematic issues in the field of migrant health. They have been devised to counter the shortcomings in the mainstream toolkits or policies already in place for the majority of the population and that do not respond to the needs of specific groups. Thus, it is important to recognise their value. **Good Practices in migrant health are extraordinary contributions that can guide future structural change**.

Of the many problems affecting the field of health and migration, the most critical one seems to be the limited access of migrants to care. As we have seen, many of the Good Practices aim at counteracting the problem of accessibility. If couple with the issue of quality, these limitations become more notorious and acute.

The discussion on 'quality' brings into the debate issues of discrimination and equity which translate into different temporal dimensions: what we have at present and what the next generations will be able to attain.

Lessons taken from these experiences indicate that it is fundamental to reinforce the public health perspective of migrant health regardless of politics or ideological views. While health protection and health threats are a competence of the EU as a whole, the capacity to foster and reinforce accessibility, quality and equity of all residents to care is a competence and responsibility of MS. These two levels and aspects complement one another. One way for public health to achieve its goals is to encompass within its domain, human and social rights.

Fair and adequate health care systems, need to take into consideration the needs of EU citizens and migrants alike as a condition for achieving better health for all. In this sense, it is critical that when health systems may need to be redesigned in some of their features to enable them to respond to the challenge of integration at MS level and therefore in the EU, the needs of all are considered.

It is crucial to recognise that health and health related problems pose challenges that over span the scope of intervention of health ministries alone. It is important to promote collaborations between the different ministries in order to face these challenges and to have coherent and overarching policies. A vision based on 'health in all policies' may contribute to foster a change in this direction. **Health gains, particularly in the case of migrant populations, should not exclusively be carried on the sole domain of health sectors but should be the result of a combination of policies and interventions from different sectors and ministries.** As mentioned before, health determinants and the state of health transcend the restricted definition of disease.

Most Good Practices in place point to a weak or timid role of the state in migrant health. This issue brings to the forefront a serious debate on what the role of the state should be, on the one hand, and what position the civil society should have when state response fall short, on the other hand. **Europeans need to reach an agreement about the role and responsibilities awarded to each party**. We believe that fruitful partnerships can be established between the two without this meaning a dismissal of responsibility of the state in the field of migrant health.

Good Practices also indicate that migration is a much evident phenomenon in metropolitan areas. **Most of the Good Practices are in place in metropolitan/urban areas**. This shows the importance of designing policies and interventions on migration and health which take into account specific local needs in local areas as oppose to adopting exclusively a national perspective. However, it is also important to consider other types of migration, namely seasonal migration and the needs of migrants in rural areas.

One health field where consensus is more obvious is women and children health, including maternal care, family planning and new born & infant care (immunisation, nutrition and hygiene). This is a positive aspect that becomes evident in the Good Practices since women and children are more vulnerable groups. Interventions that target these groups allow for more health gains because impact on the future generations.

Even if health professionals and the health workforce was not the main focus of the Good Practices identified, some conclusions may be sketched. **There is an increasing need to reinforce international cooperation among countries of origin and destination with regard to the management of health workforce**. Initiatives and policies are being developed to: avoid brain-drain of health professionals, to build health systems' capacity in the countries of origin, allow technology transfer to improve the quality of life at the country of origin, among others.

Thus, **an overall conclusion lies in re-stating the importance of placing migrant health in the EU policy and research agendas**. This would certainly enable the exchange of experiences and data among EU MS in the future and would assist on the design of more culturally sensitive training and services in the EU. In this context, the knowledge gathered by Good Practices in both, old and new countries of immigration within the EU, becomes an asset and a drive for action. **The final objective of those Good Practices is the same: to improve the health of migrants in the EU either by facilitating and enhancing integration or by reducing health inequalities, and overall, by improving health outcomes.**

10 Recommendations

- MS and the EU should promote the compilation and analysis of Good Practices in migration and health for designing future policies.
- MS and the EU should link issues of accessibility, quality and equity when planning health policies, also in the field of migrant health.
- MS might consider designing their health systems taking into account the needs pose by new migration flows and other vulnerable populations.
- MS and the EU should promote intersectorial policies for better health outcomes. ‘Health in all policies’ is the guiding principle.
- MS and the EU should foster an in-depth debate on the boundaries of state and civil society responsibilities and duties on providing health services to specific populations.
- MS and the EU should identify the ‘right’ geographical and administrative levels for health policies, namely the specificities for metropolitan/urban areas.
- MS should consider paying particular attention to the health of migrant women and children.
- MS and the EU should encourage cultural sensitive training of the health workforce for accommodating migrants’ needs and a better integration.
- MS should promote users’ involvement in service design, planning and evaluation. This allows for the empowerment of migrants and the development of needs-driven care and it enhances the responsiveness of services.
- MS and the EU should actively promote research in the field of migrant health as a way to assist evidence-informed policy making.

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