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Responding to diversity: An exploratory study of migrant health policies in Europe

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ABSTRACT

There has been growing international attention to migrant health, reflecting recognition of the need for health systems to adapt to increasingly diverse populations. However, reports from health policy experts in 25 European countries suggest that by 2009 only eleven countries had established national policies to improve migrant health that go beyond migrants' statutory or legal entitlement to care. The objective of this paper is to compare and contrast the content of these policies and analyse their strengths and limitations. The analysis suggests that most of the national policies target either migrants or more established ethnic minorities. Countries should address the diverse needs of both groups and could learn from "intercultural" health care policies in Ireland and, in the past, the Netherlands. Policies in several countries prioritise specific diseases or conditions, but these differ and it is not clear whether they accurately reflect real differences in need among countries. Policy initiatives typically involve training health workers, providing interpreter services and/or 'cultural mediators', adapting organizational culture, improving data collection and providing information to migrants on health problems and services. A few countries stand out for their quest to increase migrants' health literacy and their participation in the development and implementation of policy. Progressive migrant health policies are not always sustainable as they can be undermined or even reversed when political contexts change. The analysis of migrant health policies in Europe is still in its infancy and there is an urgent need to monitor the implementation and evaluate the effectiveness of these diverse policies.

1. Introduction

Migrants comprise a substantial – and growing – proportion of European populations: in 2009, 4.0% of the EU's (European Union's) total population were citizens of countries outside the EU [1]. Europe needs migrants to fill labour shortages arising from falling birth rates and ageing populations, especially among those who care for the growing numbers of older people [2]. Many migrants are young and healthy and make little use of the health systems of the countries they move to, but some have complex needs that existing services address inadequately. Indeed, evidence from across the EU demonstrates considerable, but varied, inequalities between migrants and non-migrants in health and access to health services [3–10]. While the right to health is enshrined in many international and European legal instruments [11], for many migrants this has little practical meaning. This is partly because of national legislation restricting access by certain groups of migrants such as asylum seekers or undocumented migrants. However, obstacles extend beyond constraints on the legal entitlement to care [12]. For example, migrants, who are more

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likely to be poor, may be deterred from seeking care where user fees are demanded [13]. They may also lack knowledge of the national language, be unfamiliar with the health system, face administrative obstacles, and be subject to direct and indirect discrimination [14,15].

Recognising that health systems need to take measures to adapt to the specific needs of migrants, there has been growing international attention to migrant health policy. In 2007 the Portuguese government, then holding the rotating EU Presidency, made migrant health a priority, resulting in a statement by the EU Council of Ministers, while further support came from the Council of Europe in the 2007 Bratislava Declaration on Health, Human Rights and Migration and the 2008 World Health Assembly resolution on the Health of Migrants [16]. However, many European countries have been slow to respond to these international calls for action and there remain considerable differences between countries in the extent to which their health systems have adopted 'migrant-friendly' policies.

Several studies have sought to describe and analyse differences in the adoption of national health policies on migrant populations across Europe. Some have raised concern about national differences in the legal entitlement of asylum seekers and undocumented migrants to access health services. In 2004, ten of the then 25 EU member states provided only emergency care to asylum seekers [17], despite the Council of the European Union outlining, in 2003, minimum standards for the reception of asylum-seekers including "emergency care and essential treatment of illness". Undocumented migrants face even greater restrictions. In 2010, only five of now 27 EU member states (France, Italy, Netherlands, Portugal and Spain) gave undocumented migrants access to virtually the same range of services as nationals of that country [18].

One factor that may have affected access to health care by migrants in the past was the system of financing. It has been suggested that tax based systems, with their emphasis on universal coverage, find it easier to incorporate migrant health policies than do systems based on social health insurance, where entitlement is mainly linked to contributions [19]. However, most countries with social health insurance have now created statutory mechanisms to provide cover based on residence in the country regardless of the ability to pay contributions, meaning that universal coverage, which includes immigrants with permanent residence status, has, in theory, been achieved in most of the EU [20].

Studies have also examined social, cultural and historical factors. One has argued that welfare systems based on a "communitarian" or "difference-based" approach to diversity (such as the United Kingdom and the Netherlands) are more inclined to incorporate migrant-friendly health policies than systems based on a "republican" or "difference-blind" logic (such as Austria, France and Germany), which assume that all citizens should be treated equally and, in some cases, may prevent the collection of data based on citizenship or ethnicity because of the perceived potential to use it to discriminate [19]. Similar categorisations distinguish between two principal approaches to diversity, one based on the provision of mainstream services for all, the other based on the provision of separate services for migrants [14]. Similarly, one can distinguish between "active" approaches (adapting health services) versus "passive" ones (expecting migrants to adapt) [21].

As the issue of statutory entitlement to health services for migrants (i.e. primary and secondary legislation establishing health coverage of immigrants) has been well documented, this study focuses instead on the content of national migrant health policies which seek to improve migrant health through targeted interventions. While statutory entitlements allow migrants to use health services, a second level of policies enacted by the health system is needed to operationalise entitlement and ensure the responsiveness of health services to their needs. The objective of the paper is to compare and contrast the content of this second level of migrant health policies, going beyond statutory entitlement, across Europe. To date there have been few comparative publications on this topic and the literature that does exist either covers a small number of countries and/or does not develop a systematic conceptual framework for comparison of the content of the policies [6,19,22–26]. This study addresses these two limitations by covering 25 countries (although only eleven were found to have developed relevant policies and were included in the final analysis) and comparing policies within an existing conceptual framework [25]. While it is difficult to evaluate the different approaches due to a lack of information about implementation and outcomes (see limitations discussed in Section 2), as well as the potential impact of factors external to the content of the health policy (the broader social, cultural, political and economic context), some general conclusions are drawn about the possible strengths and limitations of the different approaches identified.

2. Materials and methods

The information on national policy presented in this article is drawn from two sources. The first is a survey conducted in 2008 among an existing network of health policy experts from 19 European countries: Austria, Belgium, Bulgaria, Czech Republic, Denmark, England, Estonia, Finland, France, Germany, Ireland, Italy, Lithuania, the Netherlands, Romania, Slovenia, Spain, Sweden and Turkey[1]. The survey consisted of a questionnaire sent to each of the 19 experts in the network. The experts completed the questionnaire and returned it electronically. The survey collected information on: collection and reporting of data on migrant health; government policies and programmes; and non-governmental policies and programmes. Under the section on government policies and programmes, the respondents were asked to report on the main elements of policies, programmes and/or legislation relating to health of or access to health care by migrants and/or ethnic minorities. They were asked to clearly define the groups targeted (e.g. asylum seeker, failed asylum seeker, refugee, labour

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[1] The network is part of the "Health Status and Living Conditions" project funded by the European Commission, DG Employment and Social Affairs, and implemented by the European Observatory on the Social Situation.

Table 1
National government migrant health policies in Europe analysed in the study and year of introduction.

Country	National government migrant health policy	Year
Italy	The National Health Care Plan 1998–2000 established a special programme for the health of migrants. This was further developed in the 2001–2003, 2004–2005 and 2006–2008 plans.	1998
The Netherlands	In 2000 the then Minister of Health announced a number of government-financed measures to improve health services for migrants and ethnic minorities. However, these policies were reversed or abandoned by the government which came to power in 2002, as part of a broader approach to integration which placed the onus for adaptation on the shoulders of the migrant rather than the host society.	2000
Switzerland	The "Migration and Public Health Strategy 2002–2006" envisaged decentralised initiatives and awareness-raising measures in all health institutions on the topics of migration and health. A new strategy was formulated for 2008–2013 which aims to continue and consolidate the measures from the first phase [28].	2002
Sweden	Government agencies dealing with health and social affairs, education, employment, integration, and immigration services agreed on a common migrant health policy document, the "National agreement on health and the first years in Sweden" [29].	2004
Austria	Report on "Intercultural Competence in the Health Sector", published by the Bundesministerium für Gesundheit und Frauen [30].	2005
England	Race Equality Scheme 2005–2008 and the subsequent Single Equality Schemes (2007–2010 and 2009–2012), published by the Department of Health.	2005
France	New immigrants have to sign an "integration contract". Part of it is the "visite médicale" which is compulsory for all foreigners residing in France for over three months.	2006
Germany	National Integration Plan, published by the German Federal Government [31]. The focus was not primarily on health, but the plan asked federal state governments to set up projects for an "intercultural opening" of the health system.[4]	2007
Ireland	National Intercultural Health Strategy 2007–2012, published by the Health Service Executive.	2007
Portugal	During Portugal's Presidency of the EU in 2007, the issue of migrant health was a policy priority. The country's "Plan for the Integration of Immigrants 2007–2009" includes several health objectives [32].	2007
Spain	The national Strategic Plan on Citizenship and Integration 2007–2010 includes several health-related goals. In addition, by 2008, 15 of the country's 17 autonomous communities (the exceptions being Asturias and Galicia) had developed regional immigration plans which also included health objectives. Some regional health plans also include migrant health objectives [23].	2007

migrant, irregular migrant, illegal migrant, ethnic minority, migrant, naturalized citizen, first generation migrant etc.) and describe any specific targets and monitoring of those targets. The second source consists of country reports (prepared in 2009) from the MIGHEALTHNET web site (http://mighealth.net), which were used to update and triangulate this information for ten of the 19 countries[2] and to provide new information on six additional European countries (Greece, Hungary, Norway, Poland, Portugal and Switzerland). The MIGHEALTHNET country reports include information on: the background of migrant and ethnic minority (MEM) populations; state of health of MEM populations; health care system and the entitlement of MEM populations to health care; accessibility of health care; quality of care; and measures to achieve change. The reports were drawn up by the team of health care experts responsible for the project in each country. In all cases, only documented information was included in the results.

The results of the survey and MIGHEALTHNET country reports were analysed. From both sources, only information on the existence and content of national (and, in the case of Spain, regional) government policy was extracted. The other topics covered in the survey and country reports were not included in the analysis due to space limitations and incompleteness of information across the 25 countries. Following Buse et al., a policy was understood to be a "broad statement of goals, objectives and means that create a framework for activity" [27]. The content of the policies was analysed manually and systematically categorised, described and interpreted according to pre-defined themes identified in a conceptual framework developed by Mladovsky in an earlier paper [25]. The framework distinguishes between (i) population groups targeted, (ii) health issues addressed, (iii) the type of initiatives proposed and whether they target patients or providers, and (iv) the extent to which policies are being implemented.[3] Where clarification or supplementary information was needed in regard to the content, the authors referred to the original sources of documentation (where these were available online and in English) and/or followed up individually with the country experts. Details on concepts elaborated in the framework are provided in Section 3 below.

The study has several important limitations. Firstly, the evidence on migrant health policy drawn from the experts

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[2] Bulgaria, Czech Republic, Denmark, England, Germany, Lithuania, The Netherlands, Romania, Sweden and Turkey.

[3] Data collection on migrant health, included in the original conceptual framework, is not included here due to a lack of information on most of the 25 countries included in this study.

and MIGHEALTHNET may not all be equally exhaustive and valid. Secondly, the definition of a government health policy was not always clear in practice. Aside from laws and decrees, most policies took the form of explicit published documents, but in some cases, such as in the Netherlands, policies were formulated through ministerial statements which initiated (or ended) national programmes and plans. Since the definition of policy adopted in this study includes both comprehensive strategies and elements included incidentally in other policies [27], the latter type were also included in the analysis. Thirdly, the results are difficult to interpret. The lack of information on implementation makes it impossible to assess the extent to which the experience of migrants on the ground is affected by the presence or absence of a government policy. The results of the survey, combined with grey literature and anecdotal evidence, suggest that in many countries (for example France, Germany and England) there is a diverse range of programmes and projects being implemented by health service providers, social health insurance funds, NGOs, research centres, local governments and other stakeholders in migrant health. These stakeholders' initiatives are not fully reflected in national government policies, meaning that an absence of government policy does not necessarily imply worse health services for migrants in the country in question. However, due to space constraints and the limited sources of systematic information on these initiatives across Europe, they could not be documented in this article. Finally, covering a large number of countries necessarily entails a trade-off with the possibility to analyse any one country in great depth, meaning that some nuances in the different national/regional policy approaches may not be covered in detail.

3. Results

We found that most European countries included in our study did not address migrants' health and access to health services by means of specific policies: by 2009, only eleven of the 25 countries had established national policies that are aimed at improving migrant health and go beyond statutory or legal entitlements. These countries are Austria, England, France, Germany, Ireland, Italy, the Netherlands, Portugal, Spain, Sweden and Switzerland (though in the case of the Netherlands the policy has since been reversed) (Table 1).

While recent waves of large-scale migration to many European countries began in the 1960s and 1970s, it is striking how interest developed only after 1980, while specific migrant health policies emerged even later, with Italy being the first to introduce a comprehensive national migrant health policy in 1998. There is an obvious link with the timing of migration flows, with some countries in Southern Europe (such as Italy, Spain and Portugal) responding to high levels of migration in the last two decades, while countries in Central and Eastern Europe have not yet developed specific migrant health policies, reflecting in part their much lower levels of immigration. Some countries such as Ireland produced detailed policies, while others, such as Germany, only specified a few objectives as part of a wider integration plan. The remainder of this article analyses the content of these migrant health policies in the eleven countries according to the conceptual framework mentioned above [25].

Table 2
Population groups targeted in national government migrant health policies in Europe.

Country	Population groups targeted
Austria	Migrants
England	Migrant health policy is largely subsumed under policies concerned with "race" and "black and minority ethnic" (BME) groups and since 2007 under policies concerned with inequalities in general.
France	Newly arrived migrants
Germany	Migrants
Ireland	In addition to migrants, the strategy covers travellers, other ethnic minorities, and children of migrants born in Ireland.
Italy	Migrants
The Netherlands	The Dutch term "allochtoon" covers migrants and their children. The policies introduced in 2000 targeted "allochtonen" under the broad conceptual umbrella of "cultural difference" in a strategy of "intercultural" health care.
Portugal	Migrants
Spain	Migrants
Sweden	Targets migrants during their first 2–5 years in Sweden.
Switzerland	Migrants

3.1. Population groups targeted

The migration literature suggests that the definition of "migrants" is challenging and varied, including many subcategories such as students, economic migrants, asylum seekers, and irregular migrants [25]. There is no established international definition of how much time must pass before a foreign national ceases to be regarded as a migrant, and when a migrant is considered to belong to a socially, culturally or ethnically distinct group (e.g. "black British") [25].

The results of the study suggest that most national policies simply use the word "migrant" (in the native language) to define the target population, but the nuances of exactly who is included and excluded are not specified. England's and Ireland's policies employ the term "ethnic minority" or "minority ethnic group" which refer to more established migrant communities, but again, a precise definition is not given. In general, the national policies focus either on migrants or on ethnic minorities, not both (Table 2). Ireland, with its focus on "intercultural health care", has perhaps the most balanced approach. Its National Intercultural Health Strategy for 2007–2012 covers travellers, other ethnic minorities and children of migrants born in Ireland, in addition to migrants (including asylum-seekers, refugees and undocumented migrants). The strategy focuses on anti-discrimination and "interculturalism" in the provision of

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[4] Further developments in the area of migrant health in Germany are described at a dedicated website of the federal government (http://www.infodienst.bzga.de/?uid=467564467e8b8e9268c4495f8a69763d&id=migration).

health services to users from diverse cultures and ethnicities.

In the Netherlands, too, the government used to address health inequalities facing both migrants and established ethnic minorities under the broad conceptual umbrella of “cultural difference” and using the concept “allochtoon”, which includes both categories. In 1997, the Dutch Scientific Foundation established a working party on “culture and health” to stimulate research and care innovations in this area and in 2000 the Council for Public Health and Health Care published two reports highlighting the health needs of migrants and ethnic minorities and their problems in accessing services [28,29]. In response to these developments, the Minister of Health established a project group in 2001 which developed a strategy for “interculturalising” health care. However, this group resigned in 2003 when the subsequent Minister of Health made clear that he saw no role for the government in this area.

3.2. *Health issues addressed*

To meet the goal of equal access for equal need, there might be a need to design programmes which target not only specific population groups, but also certain high-burden health problems. This may include treatment and prevention programmes. At the same time, focusing exclusively on interventions which target specific conditions may distract from addressing common ailments and “upstream” determinants of health inequalities, such as socioeconomic status, housing and education [25].

Migrant health policies in the eleven countries diverge considerably in the types of health issues addressed. While some countries address a range of health issues, others have a very specific focus (Table 3). Broadly speaking, in England, Spain and the Netherlands there has been a strong focus on improving mental health care. In the Netherlands, in addition to the action plan for intercultural mental health, an “intercultural mental health centre of expertise” called MIKADO was set up in 2000 with financing guaranteed until 2007 [4]. By contrast, in Italy there is no specific mention of mental health of migrants in the national health plans. Instead, the focus is on sexual and reproductive health care and communicable disease. Similarly, in Germany, specific health-related issues in the National Integration Plan are mostly to be found in the chapter on strategies for improving the situation of women and girls and fostering gender equity [30]. In Spain, regional plans focus on different health issues, reflecting the decentralised nature of the health system.

In Switzerland, the “Migration and Public Health Strategy 2002–2006” grew out of a national HIV/AIDS prevention strategy which had been developed in the 1990s. HIV/AIDS remained a priority in the 2002–2006 strategy, but the topics covered were broadened (Table 3) [31].

In France, new migrants must undergo a medical examination that includes a general clinical examination, radiographic examination of the lungs, and verification of vaccination status. Some people may also be screened for diabetes and offered screening for other diseases. The following conditions may preclude the issuance of a certificate of good health: certain diseases covered by the WHO International Health Regulations (diseases which have a serious public health impact); active pulmonary tuberculosis if the person refuses treatment; and mental disorders requiring treatment, endangering others or likely to endanger public order if the examinee refuses treatment.

Table 3
Main diseases or conditions targeted by national government migrant health policies in Europe.

Country	Diseases or conditions targeted
Austria	Mental health, gynaecology, obstetrics and paediatrics.
England	The main focus has been on mental health, for example in the document “Delivering racial equality in mental health care” published in 2005. However there is also a focus on a wider range of conditions including chronic illness and risk behaviours, such as drug use and smoking; long term care; infectious diseases; maternal, infant and child health.
France	Communicable diseases, plus a general medical exam.
Germany	Health issues affecting women and girls are specifically highlighted in the National Integration Plan.
Ireland	The National Intercultural Health Strategy covers a wide range of health issues, including women’s health, mental health, care needs of children, families and older people, disability, sexual health, alcohol, addiction and screening.
Italy	Sexual and reproductive health.
The Netherlands	Main focus on mental health. For example, in 2000 a four-year action plan for intercultural mental health was approved.
Portugal	Information not available.
Spain	Each region has its own specific focus. In general, sexual and reproductive health, mental health, paediatric services and communicable diseases are the main focus.
Sweden	Information not available.
Switzerland	Sexual and reproductive health (with a historical focus on HIV/AIDS), occupational safety and workplace health, substance abuse, and mental health.

3.3. *Targeting patients or providers*

Initiatives to overcome the barriers faced by migrants when accessing health services are divided in this article into those targeting patients (demand-side) and providers (supply-side) [25]. Across the eleven countries, the national government policies propose a mix of programmes and projects at all levels of the health system to tackle both supply-side and demand-side issues. However, the policies typically aim to provide broad strategic direction and do not set out to define systematically and in detail the range of government initiatives which are envisaged in each country. In any case, the range of activities would be too large to describe systematically in this article. Therefore, the overview of projects and programmes provided here cannot be regarded as a systematic comparative analysis of what governments (and indeed non-governmental actors) are doing, or plan to do, on the ground.

Turning first to the supply-side, several countries aim to improve training. For example, the English Department of Health has set specific goals for the Delivering Race Equality initiative in terms of mental health services, committing primary care trusts (local health authorities) to provide racial equality training to people working in the health sector and to appoint leaders to take forward the racial equality agenda, as well as community development workers. The Austrian policy includes a programme to train physicians and nurses as a means of improving the intercultural competence of general practitioners and hospital staff. The Portuguese "Plan for the Integration of Immigrants 2007–2009" introduced, inter alia, training, education and communication programmes to inform health professionals about the legal rights of migrants. Ireland's policy proposes training for culturally competent, anti-racist and non-discriminatory services.

The provision of interpreter services is also a common goal and is included in the policies of many countries, including Austria, England, Ireland, the Netherlands, Portugal, Spain and Switzerland. In some countries such as Sweden, migrants are guaranteed a legal right to interpreters (although this right may not necessarily be implemented in practice).

A few countries focus on the organizational level. The Portuguese Plan identified broad organizational goals, where the promotion of inter-sectoral partnerships to improve the quality of services and facilitate change in organizational culture is part of the national policy. In Ireland, the intercultural strategy envisages a "whole organization approach" to support interculturalism and collaboration with the NGO sector in the design and delivery of services. Interestingly, it also seeks participation by ethnic minority communities in the rollout of the primary care strategy. Similarly, in England the Department of Health Equality Schemes make provisions for participation of BME (black and minority ethnic) citizens in the commissioning, provision and scrutiny of health services. In Switzerland, the "Migration and public health strategy" aims to remove barriers to access through "Migrant-Friendly Hospitals" and coordination of different types of services (the "Integration and Health" Service in East Switzerland).

Finally, some policies specify interventions to improve data collection on migrants' use of health services. For example, health policy in Italy includes efforts to improve the health information system covering migrants registered with the National Health Service, as well as registration of foreigners with a residence permit. In 2007 the Minister of Health established the "Commission for the Health of Migrants". The commission aims, among other things, to monitor the quality and equity of health services provided to both regular and irregular migrants. Ireland's national policy aims to improve data and research, including the implementation of ethnic identification variables in routine data and the development of a database on minority ethnic health. The objectives of the Catalan Immigration Master Plan for Health include the development of better data collection systems on migrant health and health service utilization. The National Health Service in England has long required collection of data on ethnicity in activity data, but the quality of recording is variable [32].

Other types of intervention target the demand-side, aiming to modify the care-seeking behaviour of migrants. Most countries' policies aim for provision of translated information on the health system. For example, in France the initial medical examination includes the provision of information on the major diseases which may affect migrants depending on their country of origin and the process of migration, as well as guidance on accessing the health system. In the Netherlands, migrant health promoters coordinated by the Netherlands Institute for Health Promotion and Disease Prevention have given migrants health information in their native languages since 1988. However, central government funding for information in languages other than Dutch has now been withdrawn and these services only survive where local authorities are prepared to finance them. In Ireland the policy envisages the development of guidelines on the provision of translated material. The Swedish "National agreement on health and the first years" also aims to improve the provision of information to migrants on the right to health services. The Swiss strategy aims to provide health information materials to migrants by distributing and updating the "Health Guide Switzerland".

In some countries the policies also refer to the need to improve health education. In Italy the 2001–2003 plan stated that local health offices (*Azienda Sanitaria Locale*) should promote information campaigns for migrants, while the 2006–2008 plan aimed to promote education programmes in cooperation with volunteer and not-for-profit organizations. In Germany, the National Integration Plan proposed projects in nurseries and primary schools that link German language support with health-related education for children. The Federal Ministry of Health (via the Federal Centre for Health Education) and a few other country-wide initiatives also provide telephone services or leaflets in migrant languages, although the general use of interpreters by health care providers has not yet been established [33]. The Portuguese "Plan for the Integration of Immigrants 2007–2009" provides for training, education and communication programmes to improve the information available to migrants on health services and to encourage the use of the national health service. The national plan in Spain includes the provision of information on health services, the right to health care, and health education and promotion. All the regional plans in Spain also promote the improvement of information for migrants on health services. In England, the Department of Health notes that written translations of material may not be cost-effective as many of those who live in the UK who cannot read English also cannot read their own preferred language. Instead, it suggests exploring different strategies, such as the use of video- or audio cassettes [34], although these have largely been limited to basic health promotion messages.

Finally, improving communication at the interface between patients and providers is the focus of policies that entail the use of health promoters, mediating between providers and migrants. The Dutch, Irish and Swiss national policies envisage cultural mediators, as well as the national and most of the regional plans in Spain.

3.4. Implementation

Very little information on implementation was provided in the national policy documents or published in follow-up documentation, making it difficult to compare countries' implementation strategies systematically. For example, the Austrian report on "Intercultural Competence in the Health Sector" provided no details on implementation. In England, there has been a review of "Delivering Race Equality in Mental Health Care" [35] but this is mainly an overview of activities undertaken and does not provide an in-depth analysis of problems of implementation.

Due to political decentralisation, uneven implementation across regions or geographic areas is likely to occur in many countries. For example, in Germany the regional governments, and not the federal government, are tasked with implementation of the goals of the National Integration Plan. Implementation is therefore likely to vary, although regular monitoring of implementation was envisaged. In Spain, policy formulation and implementation are decentralised to the regional level, resulting in heterogeneity of plans, programmes and implementation strategies. Implementation of the Swiss strategy takes place at cantonal level but in cooperation with federal agencies and organizations and is coordinated by an inter-institutional group at the federal level [31].

In addition to uneven implementation across space, there is the issue of implementation over time. The Netherlands provides an important example of the problem of sustainability. While the Netherlands used to stand out in Europe for its attention to migrant health, many of its initiatives have lost government support. The "Culture and Health" programme and the Action Plan both ended in 2004, and the government which came to power in 2002 distanced itself from interculturalisation [4]. In 2004 the then Minister of Health, Welfare and Sport announced that no additional government support would be provided for measures to address migrant health, although the Secretary of State for Health noted in 2006 that, at least with respect to older immigrants, new programmes may be needed to improve care [36]. However, since 2002 migrant health policy in the Netherlands has been almost entirely regressive, with the exception of a reform that came into force in 2009, increasing access to health services for undocumented migrants [37].

Another issue is which body is responsible for implementation. In Ireland, the implementation of the intercultural strategy was planned to take place mainly through existing health service structures, although guided by a National Advisory Body. This representative, multi-sectoral body, established in September 2008, links with national, regional and local organizations and groups and reports to the Social Inclusion Directorate and the Health Services Executive. In Portugal, the multidisciplinary group "Health & Migrants" was established to support the implementation of the "Plan for the Integration of Immigrants" under the coordination of the General Directorate of Health. The High Commissariat for Immigration and Intercultural Dialogue reports annually on the implementation of the plan, but has found it difficult to establish whether some goals have been achieved, due to a lack of statistical information [38].

In sum, a lack of information on the implementation of migrant health policies is a challenge in most of the countries covered in this study, making it very difficult to assess the success of policy initiatives.

4. Discussion

Our study found a wide variety of national migrant health policies in Europe. Across the eleven countries, with the exception of Ireland (and, in the past, the Netherlands) with their focus on "intercultural health care", there seems to be a tendency to focus policies either on migrants or on established ethnic minorities. Such policy divergence across countries is not entirely surprising, given the different patterns and levels of immigration [26]. For example Italy, Portugal and Spain have experienced large-scale immigration only relatively recently, so a focus on newly arrived migrants is understandable. However, new migrants face different health challenges to older migrants and the descendants of migrants [39], so that policies targeting the latter might soon be necessary in these countries (this point is also highlighted in a recent publication comparing policies in England, Italy and Spain [23]). The focus on reproductive health and the service needs of children indicate that some countries are reaching the first stage of a comprehensive policy (Table 3). In contrast, France already has many descendants of migrants whose needs cannot be sufficiently addressed by current policies targeting only new arrivals. England also has a long history of immigration, but there, the focus on "race" and BME groups may result in the specific health needs of newly arrived migrants being overlooked [23,40]. A sign that the limitations of this approach have been recognised is the launch in 2010 of a "migrant health guide" by the Health Protection Agency of the United Kingdom [41].

The second issue addressed in this study is whether specific diseases affecting migrants are prioritised. Ideally, differences in targeting across countries and contexts should reflect different health needs of migrants and deficiencies in existing health service structures. This does not always seem to be the case. It is for example conceivable that migrants in Italy have as much need for targeted mental health care services as those in England and the Netherlands, which would present an opportunity for knowledge transfer from one country to another. Unfortunately, however, there are insufficient data and research to understand such issues properly. More generally, given lower immunization rates among some migrant groups [42,43], it seems that preventive services do not receive sufficient attention. The increasing importance of older migrants and the resulting need to develop culturally appropriate long-term care is another area that seems to have been ignored in most countries.

All the national policies propose a mix of initiatives targeting both patients and providers. It is difficult systematically to compare and evaluate them using the available data, partly because as already discussed national policies are unlikely to include complete information, but also because there is very little evidence about which initiatives are effective [15]. However, notwithstanding these limitations, it seems that across the eleven countries a diverse range of initiatives targeting providers is proposed, including training staff and providing interpreter services and to a lesser extent, use of cultural mediators and improving data collection. Adapting organizational culture is mentioned by some countries but it is not made clear which specific interventions are envisaged. This suggests a need for a greater focus by policymakers on the “whole organization approach” to migrant health, in which cultural competence is no longer regarded as a property of individuals but of organizations [15,44]. Key strategies highlighted as important in the literature (such as diversification of the workforce, increasing resources and infrastructure for migrant health services, adaptation of protocols, procedures and treatment methods and simplifying administrative procedures [15,23,44]) are rarely mentioned in the national policies analysed. There also seems to be scope for promoting the participation of migrants in developing and implementing health policies since this appears to be proposed only in England and Ireland. Indeed, participation is an essential component of good governance but is rarely achieved in relation to vulnerable groups such as migrants [15,44].

In terms of initiatives targeting patients, most countries seek to influence uptake of care simply by providing basic information on available services. Italy and Germany are among the few countries in which national policies propose developing programmes to improve health literacy, in both cases by forming partnerships outside the public health sector. Recent studies suggest that migrants benefit from better information on health services and entitlements, as well as from education programmes to improve health literacy [45]. This suggests many countries could increase their focus on health literacy and education initiatives, while recognising that simply to regard the professional view as correct may reinforce the belief among some migrant groups that mainstream health services are irrelevant to their needs [15]. Overall, France stands out for its narrow range of government policies; the initial health check seems inadequate in light of the broader health inequalities experienced by migrants across Europe. However, this may be partially compensated for by non-governmental activity, not documented in this article.

Finally, the scarcity of data on implementation raises the concern that the adoption of national policies may not be felt on the ground. The development and implementation of migrant health policies can be a challenging task for governments, in view of the highly contested and political nature of any public policy related to immigration in many European countries. Indeed, migrants' right to appropriate health services may become increasingly controversial, as public spending on health is under growing pressure and many European countries have experienced a resurgence of far-right parties, often exploiting the erroneous [12,46,47] but widespread belief that provision of welfare is attracting migrants to Europe. In face of these concerns, it is worth highlighting that the provision of more appropriate services for migrants may actually reduce some costs by improving treatment adherence, enhancing outcomes and reducing the likelihood of needing expensive emergency treatment [47]. Implementation is affected by a number of other factors, including the administrative arrangements in the respective country and its health system, demographic patterns of migration, election cycles, data availability, collaboration with other sectors, and budgetary restraints due to the current economic crisis.

The wide differences observed across (and sometimes even within) countries in the different dimensions of migrant health policies suggest that there are considerable opportunities for cross-country learning and policy dialogue. However, it is also important to recognise that countries have varying traditions and national contexts, so that there can be no “one size fits all” approach to migrant health policies in Europe. Distinguishing between “communitarian” and “republican” approaches to diversity [19] might help explain why a country with a relatively long history of immigration such as France focuses narrowly on newly arrived migrants and has not yet developed intercultural or ethnic minority health policies. Further research is needed to understand how migrant health policies can be developed in different national contexts.

5. Conclusion

The findings presented here may help countries to learn from each other's experiences and to design more appropriate migrant health policies. As such, it can firstly be tentatively concluded that countries focusing policies on either migrants or on more established ethnic minorities need to start focusing on both. Secondly, targeting of specific diseases or conditions may in certain cases be somewhat arbitrary and should be revised to reflect the different health needs of migrants and deficiencies in existing health service structures. Thirdly, building on initiatives targeting patients and providers that are already in place, countries need to adopt more complex but possibly more effective approaches such as the “whole organization approach”. Health literacy programmes and the participation of migrants in the development and implementation of policy should also be encouraged. Finally, there is an urgent need for better monitoring and evaluation of policy implementation.

However, the analysis of migrant health policies in Europe is still in its infancy. There is a need to further refine the analytical framework, evaluate the effectiveness of policies, document the wide range of sub-national and non-governmental programmes and projects taking place across Europe, evaluate the quality of health services provided to migrants, and better understand how migrant health policies can be developed in countries with varying political, social and cultural contexts. There is also the challenge of sustaining momentum, particularly in the current climate of economic crisis and budgetary constraints and the rise of anti-immigration sentiment.

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