JOINT ACTION

HEALTH EQUITY EUROPE

Work Package 7 – Migration and Health

Deliverable 7.1

Policy Framework for Action

Report Information

Contributors:	David Ingleby, Sonia Dias, Jeanette Magnus, Charlott Nordström, Bernadette Kumar
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Glossary and acronyms

(To be seen in conjunction with other WP PFAs.)

Glossary

Downstream	Refers to proximal causes of illness. Also used for interventions at the level of health service provision, and/or local and incidental interventions (see also Upstream).
Health inequalities or inequities	These can be of two types, concerning (a) health status or (b) the provision of health services and other forms of health protection.
Health services	Health care (treatment of all kinds including palliative care) as well as preventive activities carried out by health care service providers, such as vaccinations, check-ups, health education and health literacy, registration and monitoring of (patient) data.
Health promotion	Activities empowering people to make healthy choices. These activities may or may not fall within the realm of the health sector.
Health protection	Health services are a form of health protection, but the concept also extends to population-wide public health activities such as monitoring of population health, screening programmes, research, and other preventive measures not carried out by health services. Because reduction of health risks often requires taking measures outside the health system, intersectoral action using the HiAP principle is usually needed.
Health in All Policies	Intersectoral action to tackle social determinants of health
Inequality	A difference, regardless of how it is caused.
Inequity	An unfair and avoidable difference. It is often unclear to what extent differences in health status should be regarded as inequities, but differences in service provision are almost always regarded as 'unfair and avoidable'.
Mediator (Statistics)	A factor or process that lies on the causal path between two variables.
Migrant	IOM defines a migrant as any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the

	movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is. Guidelines published in 1998 by UNDESA[1] define a migrant as someone who changes their country of residence for longer than 3 months, for whatever reason. An actual or intended stay of 3-12 months is 'short-term migration', 12 months or over is 'long-term'.
Moderator	(Statistics) A variable that can alter the strength or direction (positive or negative) of the link between two variables. Sometimes referred to as an 'effect modifier'.
Upstream	Refers to distal influences on health. Also used for health interventions going beyond health services and/or embedded in broad, structural and sustainable policies.

Acronyms

CoE	Council of Europe
CSO	Civil society organisation
EC	European Commission
EEA	European Economic Area
EU	European Union
HiAP	Health in All Policies
IOM	International Organization for Migration
IGO	International Governmental Organization
NGO	Non-governmental organisation
PFA	Policy Framework for Action
SDH	Social Determinants of Health
SEP	Socioeconomic position
TCN	Third-country national
WHO	World Health Organization

Executive Summary

This Policy Framework for Action (PFA) explores opportunities in the context of Joint Action on Health Equity Europe JAHEE Work Package 7 (Migration Health), for actions tackling health inequalities that affect migrants. The scope of this PFA is that it will be the overall guiding document for the implementation of WP7 and in particular provides the rationale and the basis for the Country Assessments. It begins with a review of the 'state of the art' on this topic, examining the inequalities that have been identified and the interventions that have been proposed to reduce them.

WP7 has the advantage that although the systematic implementation of policies on migrant health has lagged behind, a great deal of experience has been gained since the early years of this century with research and practical interventions in this area. This experience has been crystallised in what will be called the 'Road Map' (Appendix 1), a series of 'soft' policy instruments produced by international governmental organisations since 2007. It is therefore unnecessary to carry out a new review of problems and proposed solutions for the purposes of JAHEE. The Road Map addresses both 'downstream' and 'upstream' issues, although most research and policymaking has concerned the former type, focusing on health services rather than social determinants. A brief overview of problems and recommended solutions is given in Table 1.

An important issue concerning the social determinants of migrants' health is related to the influence of socioeconomic position (SEP). One influential school of thought regards differences in migrants' state of health as primarily a reflection of the fact that their SEP is often lower than that of nationals. This would imply that separate interventions aimed at migrants are superfluous, or at any rate have much less priority than actions to reduce inequalities linked to SEP. This PFA argues that although SEP is important for understanding many of the mechanisms underlying differences in migrants' state of health, migrant status remains an important health determinant in its own right. Some differences are not related to SEP, while being a migrant both influences SEP and moderates its effects on health.

The next section deals with the Country Assessments (based on available data) that need to be carried out to identify the best opportunities (entry points) for tackling health inequalities affecting migrants in the 13 countries participating in WP7. Here too, a substantial body of recent work has already addressed this issue, in the form of the 2015 MIPEX (Migrant Integration Policy Index) Health

strand. This instrument was developed to benchmark progress on implementing a key document in the Road Map, the Council of Europe's 2011 *Recommendations on mobility, migration and access to health care.*[2] MIPEX collects data on both 'downstream' and 'upstream' policies, though still (like the Road Map) paying more attention to the former kind. MIPEX data exist for all 13 countries participating in WP7, but they may need to be updated and supplemented by more detailed and wide-reaching information, and some countries may need sub-analysis.

The last section concerns the selection, out of all possible actions, of the ones most suitable for implementation in JAHEE. It first reviews the criteria for making this selection and proceeds to make suggestions, using data from MIPEX, regarding the most suitable and promising areas of intervention. Finally, the opportunities for collaboration between WP7 and other Work Packages are examined.

1. State of the Art: What is known about health inequities linked to migration and measures to tackle them?

During the 20th century researchers and policy-makers in Europe paid only sporadic attention to the health of migrants, but in the present century, as this figure shows, the topic has steadily gained more prominence.

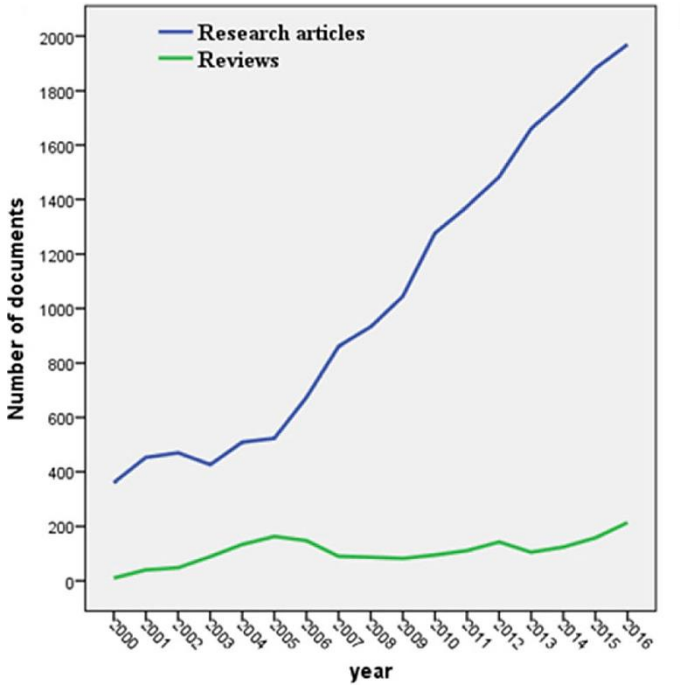


Figure 1. Increase since 2000 in research articles and reviews on migrant health.[3]

Initially the focus of this work was almost entirely 'downstream', i.e. concerned with the provision of health services to migrants. The two main issues problematized were access to care and quality of care. Recommended interventions ('good practices') included:

- improving entitlements
- reducing non-financial barriers to accessing services
- improving the quality of care ('responsiveness')
- providing information, health education and health promotion for migrants
- education and training for (front-line) health workers
- special attention for 'vulnerable groups'.

In the present century, the importance of 'upstream' measures has been increasingly realised. Treating migrants when they become ill is a very limited approach to protecting their health: in Sir Michael Marmot's words, "why treat people then send them back to the conditions that made them

sick?"[4] Already in the 20th century, some researchers had started investigating the social determinants of migrants' health.[5] Upstream measures to tackle these determinants have been prioritised by global and regional governmental organisations (IGOs) from 2007 onwards, though national governments have been slow to adopt them. Some, indeed, still adopt no measures at all in relation to migrant health.

IGOs such as WHO, IOM and CoE have little or no competence to intervene in member states' health policies, while the principle of subsidiarity limits the competence of the EC to certain public health issues. All these organizations have therefore concentrated on providing technical guidance or recommendations (so-called 'soft' policy instruments). A series of documents setting out the main issues concerning migrants' health and the measures required to address them has been published by IGOs from 2007 onwards. Twenty-two of these, from 2007 to 2018, are included in Appendix 1: they include declarations, resolutions, standards, conference conclusions, action plans and frameworks for action.

The reason why such initiatives are mainly taken by IGOs is that at national level, migrants have very little political power. Their voting rights are limited and they usually form only a small minority of the population. The motivation of IGOs is twofold: to defend human rights (which for many of them is a core function) and to further development, to which they regard migration as making a positive contribution. At national level, NGOs may make substantial contributions to aiding migrants, collecting data and advocating for them.

There is a high level of consistency among the documents in Appendix 1. Together they can be seen as a single 'Road Map', each contribution building on the ones that have gone before. The main documents were based on extensive reviews of research evidence, as well as consultations seeking the views of various stakeholders. For the purposes of JAHEE, therefore, there is no need to reinvent the wheel by undertaking a new literature review and synthesis of the state of the art: we can stand on the shoulders of those who have already done so. (Nevertheless, after selecting a particular type of action for implementation, it may be necessary to collect more detailed and specific knowledge about it.)

The main recommendations to be found in the Road Map are summarised below in Table 1. Recommendations 1, 2 and 3 concern upstream measures; it is with regard to these that the IGOs' Road Map departs from received wisdom prior to 2007, which was almost entirely concerned with health services. This shift reflects the broader changes in thinking about health policy that have been promoted by WHO. In addition, since 2007 importance has increasingly been attached to coordinated, structural, sustainable and evidence-based measures, rather than the ad hoc efforts that had traditionally characterised the field of migrant health. This too is regarded as part of 'going upstream'.

Some recent documents recognise that migration does not always affect health negatively, and that migration does not make a person 'vulnerable' in the individual sense. An 'intersectional' approach (not to be confused with 'intersectoral') is recommended, focusing not only on the main effects of migrant status but also on its interactions with other variables. Recognising the enormous diversity among migrants in this way makes it possible to focus on the migrants who are most 'left behind' and most in need of supportive policies. Instead of recycling static notions about who is or is not vulnerable, the selection of groups should be evidence-based.

The same applies to the selection of certain health conditions for special attention; this should not be based on stereotypical notions about health problems thought to characterise refugees and other migrant groups, but on the problems that are actually found.

1. **Data and Research**
   Improve data-collection and research on migrants' health, including health status, health services and background information on the migrant population and its situation in the receiving society.

2. **Governance**
   Strengthen the leadership of efforts to improve health protection for migrants in each country; ensure coordination between stakeholders (including NGOs and CSOs), as well as regional and international collaboration. Raise the awareness of policymakers, managers and professional bodies concerning migrant health. Promote the involvement of migrants in all activities concerned with protection of their health. Encourage community involvements and multi-level initiatives ('top-down' and 'bottom-up' at the same time).

3. **Intersectoral action on SDH**
   Apply an intersectoral, 'whole-of-government' approach to protecting migrants' health, including health impact analyses of policies outside the health sector.

4. **Access to health services**
   Facilitate migrants' access to health services by improving entitlements and tackling both supply-side and demand-side access barriers. These include both internal and external factors to the person seeking help. For example; through better information for migrants about their entitlements, the health system and how to use it; removal of practical and linguistic barriers to access; and ensuring that migrants need not fear being reported to immigration authorities by health services).

5. **Quality of services**
   Improve the appropriateness, acceptability and effectiveness of health services for migrants by adapting treatments and service delivery to their needs, paying particular attention to language or communication barriers and 'cultural competence' or 'diversity sensitivity'. Target preventive activities where necessary to ensure that they reach, and are effective for, all migrants. Ensure migrant participation at service provider level.

6. **Attention for 'vulnerable groups'**
   The term 'vulnerable' can refer either to properties of individuals or of the situation they are in. In the 'road map' these two meanings are seldom distinguished. It is recommended to pay special attention to (in particular) women, children, migrants with disabilities and victims of trafficking. In addition, special attention is often recommended for certain health conditions (such as infectious and non-communicable diseases or mental health problems).

Table 1. Summary of main recommendations in the Road Map (Appendix 1)

One document in the Road Map that represents the latest state of the art particularly well is step 19, the 2017 WHO paper entitled *Beyond the Barriers: Framing evidence on health system strengthening to improve the health of migrants experiencing poverty and social exclusion* (see Appendix 1; available at https://bit.ly/2Dp6cwP). This paper can be recommended because it does not assume that all migrants are poor and socially excluded, but instead adopts an intersectional approach, acknowledging the great diversity within migrant populations. It distinguishes between individual and situational vulnerability and highlights 'resilience'. It describes the usefulness of the MIPEX Health strand for categorising and benchmarking equitable policies on migrant health (see Section 4), and shows how measures for increasing health system sensitivity to migrants can overlap with those that improve inclusiveness towards other groups at risk of being 'left-behind'. It also has a strong human-rights basis and examines issues such as governance, accountability, participation and empowerment, as well the economic and political context of contemporary policy-making.

1a. Improving access to, and quality of, health services

The Road Map pays a great deal of attention to downstream interventions aimed at improving health services, reflecting the fact that most experience has been gained in this area. Many projects (most of which were supported by DG SANCO in the First and Second Health Programmes)[6] have been carried out in Europe to identify problems of access and quality in health service delivery to migrants (items 4 and 5 in Table 1), and to develop and disseminate 'good practices' to address them. Several overviews are available.[7,8,9,10] The current need is not so much to discover new 'good practices' as to ensure that established ones are structurally embedded in policies – i.e. to 'mainstream' migration into health services.

Evaluation of interventions

At present, both the identification of problems in health service delivery and the evaluation of solutions tend to be based on qualitative rather than quantitative data. Quantitative measures of health care utilization by migrants are sometimes available, but these are difficult to interpret because they reflect the combined impact of levels of need, patterns of health-seeking behaviour and barriers to access. Measures of unmet need also contain many methodological weaknesses, especially in relation to migrants.[43] Regarding the effectiveness of interventions, there is a general lack of quantitative studies. If any evaluations are carried out they usually concern 'plan' and

'process' evaluation (how well the intervention 'makes sense' and how correctly it was carried out), rather than controlled trials to measure the effect that was achieved. All evaluation research, especially the latter kind, is expensive and difficult to carry out properly, while adequate funding is seldom available.

It is in any case inherently problematic to calculate the health gain that will result from improving the accessibility and quality of health services provided to migrants. The gain will depend on how many migrants there are, the incidence among them of particular kinds of health problems, the effectiveness of available treatments, and the extent to which the take-up and effectiveness of care is improved by a given intervention. These are not constants, but parameters that vary greatly between countries, migrant populations and health issues. As a result, the health gain from any particular intervention will be different for each health issue, every time and place, and every migrant group.

In any case, the argument for equitable health service provision is not primarily based on the health gain that it can yield, but on considerations of human rights and social justice. Already in 1966, Martin Luther King declared that "of all the forms of inequality, injustice in health care is the most shocking and inhuman".[11] Nevertheless, the potential value of policy improvements can sometimes be quantified: for example, an ingenious study in 2015 used a 'natural experiment' to show that broadening entitlements to health care for asylum seekers in Germany actually leads to demonstrable cost reductions – quite apart from the fact that current restrictions in that country violate international law concerning the right to health.[12]

1b. Tackling social determinants of migrants' health

Less experience has been gained with measures to tackle upstream health threats to migrants, because this is a relatively new policy focus. In this section we focus on work that can provide useful entry points for protecting migrants' health.

Apart from a pioneering article by Bollini and Siem in 1995,[5] most research to identify the links between migration and SDH is quite recent, as Castañeda et al. (2015)[13] point out. Part of the reason may be the reluctance of many researchers on SDH to regard migration and ethnicity as significant health determinants in their own right. Such approaches are especially common in Europe: in the USA, where epidemiologists seem more ready to accept that their society is stratified along ethnic

lines, the term 'health disparities' refers more often to ethnic differences that to socioeconomic ones. (In the USA and UK the variable 'ethnicity' is more often used to disaggregate data than 'migrant status', though lately there is more attention for the latter).

What factors underlie health risks that may be higher for migrants? As for other populations, the main one is often their socio-economic position (SEP), which most researchers on SDH define in terms of the 'capability' approach of Amartya Sen. A higher SEP is one that enhances *agency*, defined as "what a person is free to do and achieve in pursuit of whatever goals or values he or she regards as important" (Sen 1985, p. 230).[14] The usual way of operationalising SEP is in terms of education and income (sometimes adding occupation and/or wealth).

An important motive for migrants is the desire to improve their SEP and/or that of their families – if only in the most basic sense of staying alive. Many migrants arrive in the receiving country with only limited skills to offer on the labour market, as well as disadvantages such as poor language proficiency and lack of social networks giving access to information and influence ('social capital'). For this reason it would be quite misguided to blame their lower average SEP only on the policies of the receiving country. Nevertheless, a country's policies on migrant integration play a major role in determining whether a migrant is given every opportunity to realise their full potential, or instead encounters processes of social exclusion and discrimination.

The level of SEP that migrants are able to reach will be strongly influenced by the barriers that are placed in their way. These barriers vary greatly between countries, as well as between types of migrant (regular migrants, asylum seekers and irregular migrants) and different countries of origin. MIPEX (the Migrant Integration Policy Index) measures the inclusiveness of national policies in eight different 'strands' such as education, labour market access and health.[15] Exclusion restricts the rights, benefits and opportunities available to migrants and thus contributes to locking them into a disadvantaged social position. They are not so much 'left behind' as 'kept down'.

An obvious way to improve migrants' health would therefore be to adopt favourable integration policies, so that they can achieve their highest potential SEP. On arrival, migrants are usually just as healthy, or even healthier, as native citizens (the 'healthy immigrant effect'),[16] but over time their health tends to deteriorate. However there are several nauances between the healthy migrant and the sick migrant. Since 2012, the migrant journeys have become more precarious and

so upon arrival a large number are not in the best of health. In addition, for those coming to Europe from existing refugee camps or conditions (e.g Syrians) their medical needs are complex.

Inability to escape from a disadvantaged social position will contribute to this decline.[17] Often, their offspring (the 'second generation') also experience serious barriers to upward social mobility. The main obstacles to migrant integration lie in other sectors than health itself (in particular education, access to employment and general levels of discrimination and social exclusion). This leads to the paradoxical conclusion that the main opportunities for improving migrant health may lie outside the health sector itself, calling instead for intersectoral action to facilitate migrants' integration.

1c. The complex relation between migrant status, SEP and health

Because low SEP is associated with both migrant status and increased health threats, it is sometimes assumed that the health threats migrants are exposed to simply reflect their lower average SEP. The CSDH report of 2008 made 56 recommendations, but none of them concerned international migrants. Presumably the authors shared this assumption and felt that measures to help the worst off would suffice to reduce the health threats affecting migrants. On this view, discrimination against migrants is 'indirect' rather than 'direct': migrants are at a disadvantage not because they are migrants, but simply because they have lower SEP. We will call this a *'migrant-blind'* approach to health inequalities.

This is a complex issue, which JAHEE provides an ideal opportunity to discuss. In the Road Map (Appendix 1), although an upstream, intersectoral SDH approach to protecting migrants' health has been recommended from 2007 onwards, few steps have been taken to implement it. In particular, hardly any attention has been paid to the question of how effectively migrants' health would be protected simply by reducing health disadvantages for people with low SEP. Appendix 2 shows a version of the familiar 'rainbow diagram' of Dahlgren and Whitehead adapted to migrants' health, which appeared in WHO publications in 2010 and 2017 (listed as steps 7 and 19 of the Road Map in Appendix 1). This diagram makes no distinction between direct health threats for migrants and those that are mediated by SEP. Such a distinction is also very relevant to implementing the SDGs, but it does not seem to have been discussed in that context.

Implicitly or explicitly, a 'migrant-blind' approach to health inequalities assumes that SEP acts as a confounder, producing an *illusory* causal link between migrant status and health. When SEP is controlled for or held constant, the link should disappear. To a certain extent, this is indeed found empirically: but what does it mean? It is a basic statistical principle that a confounder may not lie on the causal path between two variables. If, as we have claimed, exclusionary processes prevent migrants from reaching the SEP they are capable of, SEP will lie on the causal path between migrant status and health and cannot therefore be regarded as a confounder.[18] In that case, it makes no sense to 'partial it out'.

In a perfectly 'migrant -blind' society, without any kind of discrimination against migrants, the only health inequalities between migrants and nationals would be due to health problems that migrants brought with them, aquired in host country, or social characteristics such as lack of skills, language proficiency and 'social capital'. In countries with very high MIPEX scores, such as Sweden or Portugal, migrants should experience few barriers to realising their full potential, so the fact of being a migrant should have less impact on SEP and therefore on health status. Conversely, in countries with very low MIPEX scores such as Turkey, Latvia, Cyprus and Slovakia, migrants will face many barriers and, as a result, health threats. The 'migrant -blind' approach to understanding health inequalities is thus potentially applicable in all societies, but only has effects in 'migrant -blind' societies. Legislation in the EU/EEA aims to 'level up' the position of migrants from other EU/EEA countries to that of national citizens, but does not do this for third country nationals (TCNs) arriving from outside the area. For TCNs facing discriminatory and exclusionary processes, measures to improve the situation of people with low SEPs would certainly help in the short term, but we suggest that such measures would be purely ameliorative and would not get to the root of the problem.

Direct links between migrant status and health status

Above we have argued that links between migrant status and health status may be both direct and indirect (i.e. mediated through SEP). The direct links are easier to analyse and will therefore be examined first, using the following path diagram:

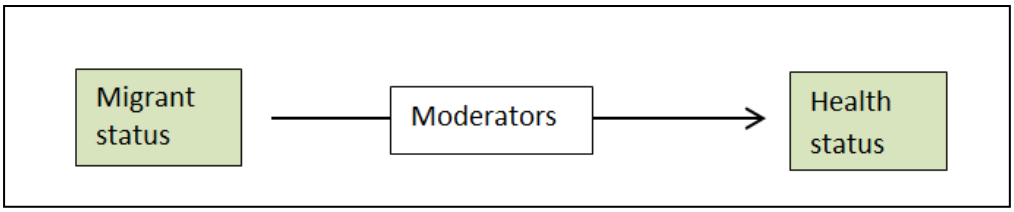


Figure 2. Path diagram for direct links between migrant status and health status

The arrow stands for the causal pathway linking migrant status to health status: SEP is assumed by the authors not to lie on this pathway. Since there are many such links, one should imagine here a bundle of arrows rather than just one.

Migrant status refers not only to whether one is a migrant, but also to variables such as legal status (regular, irregular or transit migrant, asylum seeker or refugee); ethnicity or country of origin; length of time in the country and age at arrival; and so on. These distinctions could also be regarded as moderators, but for simplicity we treat them here as different values of the variable 'migrant status'.

Moderators (sometimes also called modifiers) are factors that can strengthen or weaken the relation between two variables, or even reverse it. In the widely-used model of Diderichsen et al. (2001),[19] they correspond to 'differential exposure' or 'differential vulnerability', i.e. health threats to which migrants have a higher or lower level of exposure than nationals, or which they have a reduced or increased ability to tolerate. An example would be unemployment, which is not only more often found among migrants (exposure), but also has more drastic consequences for them (vulnerability).

Health status can be measured in many different ways, depending on the purposes. General measures such as self-rated health status or mortality rates can be used, or more specific indicators of particular conditions such as clinical diagnoses. The validity of these indicators for different groups must always be critically examined: for example, biases may distort mortality rates for migrants, while controversy exists over the cross-cultural validity of self-rated health and diagnoses of mental disorders.

In what follows we discuss a number of possible direct links, describing the causal mechanisms involved and the factors that may act as moderators.

State of health on arrival

We have already mentioned the 'healthy migrant effect', which refers to the fact that migrants may be more healthy than nationals on arrival. This effect is usually ascribed to self-selection; it may not apply to reunited family members, asylum seekers and refugees, whose physical and/or mental health has often been undermined by adverse events prior to their arrival. It is moderated by length of stay in the country: after some years, the 'healthy migrant effect' may be replaced by what has been called the 'exhausted migrant effect'.

As well as type of migrant and length of stay, the effect of migrants' initial health status may be moderated by demographic characteristics such as sex, age, ethnicity or country of origin. Important in this respect is the sending country's position in the 'epidemiological transition', which refers to the different disease profiles characterising countries at different stages of economic development.[20] In theory, SEP can also moderate the effect of the migrant's initial state of health, but we are defining 'direct' links as those in which SEP does not appear to play an intrinsic role.

Migrants may have a raised prevalence of certain infectious diseases, though a recent ECDC report[21] states that this can only be reliably established for TB, HIV, Hepatitis B and Chagas disease. Even then, the disease might have been picked up after arrival. 'Import diseases' – once regarded as the most important topic in migrant health – are strongly related to prevalence in the country of origin, which is therefore an important moderator. Vulnerability to infectious disease is also affected by the migrant's vaccination status, which will depend on the situation in their country of origin, and their living conditions after arrival.

Genetic or cultural factors that can maintain or undermine health

Before the 'shift upstream', which refocused attention on the social context of migrants in receiving countries, genetic and/or cultural factors were regarded as the main determinants of migrants' health. These more traditional topics should not be ignored.

- Some diseases, such as sickle-cell anaemia and Tay-Sachs disease, are mainly found in particular gene pools. Gene-pool related factors may also affect responsiveness to certain medications.
- Certain cultural traditions that migrants bring with them may undermine their health (e.g. female genital mutilation) or strengthen it (e.g. lower rates of alcohol consumption for religious reasons).

Health system in the receiving country

Migrants' access to appropriate and effective health services is essential for maintaining their state of health. Lack of such access may be an important reason for the deterioration in their health that is often observed in over time. As we saw earlier, health services have been the major focus of migrant health research and policy-making in the past. Restricted service provision is a potent health threat to irregular migrants, who in most countries are only entitled to emergency care (and may even have to pay for it themselves). Lack of access to primary care may result in illnesses being detected only in advanced stages, when they are more difficult (and expensive) to treat.

Such restrictions are often adopted by governments as a form of 'internal migration control', i.e. as measures to encourage irregular migrants to leave and discourage others from arriving. This issue was highlighted in the 2014 *Review of social determinants and the health divide in the WHO European Region,*which concluded: "these measures do not seem to have much effect on the numbers of irregular migrants – their main effect is increased vulnerability to marginalization, destitution, illness and exploitation".[22]

Such 'deterrence' policies may be applied not only to irregular migrants, but even to asylum seekers. In Section 3a we described the restricted access of asylum seekers in Germany to health care. This was introduced in the Asylum Seekers' Benefits Act (AsylbLG) of 1993, which sought to make the country less attractive to asylum seekers following the massive influx in 1992.[23] Apparently this motive was still strong after the 2015 influx, because in spite of objections on human-rights grounds as well as research showing that restricted access actually increases health costs,[12] the main restrictions have not been lifted.

Even migrants whose residence in the country is perfectly legal may be granted less coverage for health care costs than nationals.[24] Whether this is intended to discourage migration is not always clear. In the Czech Republic and Malta, it seems also to reflect a close relationship between health ministries and commercial insurance companies.[25]

Apart from curative care, health services also provide a certain amount preventive care in the form of vaccination, population screening, health education and health promotion. Here, the question is not so much whether the migrant can reach the services as whether the services succeed in reaching the migrant. 'Outreaching' methods may be called for, while methods and materials may need to be specially targeted to increase their effectiveness with migrant populations.[26]

Should barriers to accessing appropriate health services be regarded as direct or indirect? In other words, do migrants experience more barriers because of their lower average SEP? In principle, European health systems strive to offer universal coverage regardless of income, though some inequities linked to SEP remain:

- Out-of-pocket (OOP) payments, i.e. user fees, deductibles and co-payments at the point of supply, clearly undermine universal coverage because they place a disproportionate burden on the poor and the sick. However, in most countries there are ceilings, rebates and exemptions intended to counteract these 'regressive' effects. To the extent that migrants are likely to have less disposable income, they may be particularly burdened by OOP payments – though not necessarily to a greater degree than nationals with the same income.

- Health services are more likely to be responsive to the wishes of the better educated nationals who tend to be over-represented in 'participatory spaces'.[27] As a result, patients with lower SEP may experience less appropriate care. The social distance between doctors and patients may also play a role. When patients do not have the same attitudes and beliefs concerning health as the professionals who treat them, they are often described (sometimes condescendingly) as having 'low health literacy'. Health workers' inability to appreciate the patients' point of view may affect both migrants and low-SEP patients.

Whether barriers to accessing appropriate health services should be regarded as 'direct' or 'indirect' discrimination against migrants will depend on the situation in each country. Where the principle of providing equal health services to rich and poor is strong, disadvantages for migrants will tend to be 'direct'; where health services are much better for people with a higher SEP, it will be mainly 'indirect'.

Finally, we should also bear in mind that variables such as sex, gender, age and type of health problem will also moderate direct barriers to accessing effective health services. For example, many countries allow special exemptions from access restrictions in the case of pregnancy and childbirth, children and other 'vulnerable groups', as well as for health conditions regarded as a threat to public health. All this underlines the need for an intersectional approach, i.e. one that pays attention to the diversity within migrant groups.

Discrimination

Again, we are concerned here with direct discrimination against migrants – racism or xenophobia – rather than the indirect kind, which is mediated by SEP. All migrants may be exposed to *individual* hostility, often called 'race hate', which is known to be capable of undermining physical and mental health.[28] However, direct discrimination can also be *institutional*, i.e. embedded in the policies of organisations rather than the attitudes of individuals.

ne example of institutional discrimination against migrants, leading directly to ill-health, are the inequitable health policies discussed in the previous section. Another example is provided by immigration policies which, like health policies, may be used as a form of internal migration control.[22] The most notorious example is the UK government's 'hostile environment' policy,[29] first introduced by Theresa May, which aims to make living conditions as harsh and unwelcoming as possible for irregular migrants. This is not an isolated case: many other countries operate similar policies, but are more discrete about their aim.

Indirect links between migrant status and health status

The previous section showed that many threats to migrants' health may be in principle unrelated to SEP, thus 'direct' (Link A in Figure 3). We now turn to the more complex question of links between migrant status and health that do seem to be mediated and/or moderated by SEP, i.e. 'indirect' ones. Figure 3 combines these two types of path into a general model.

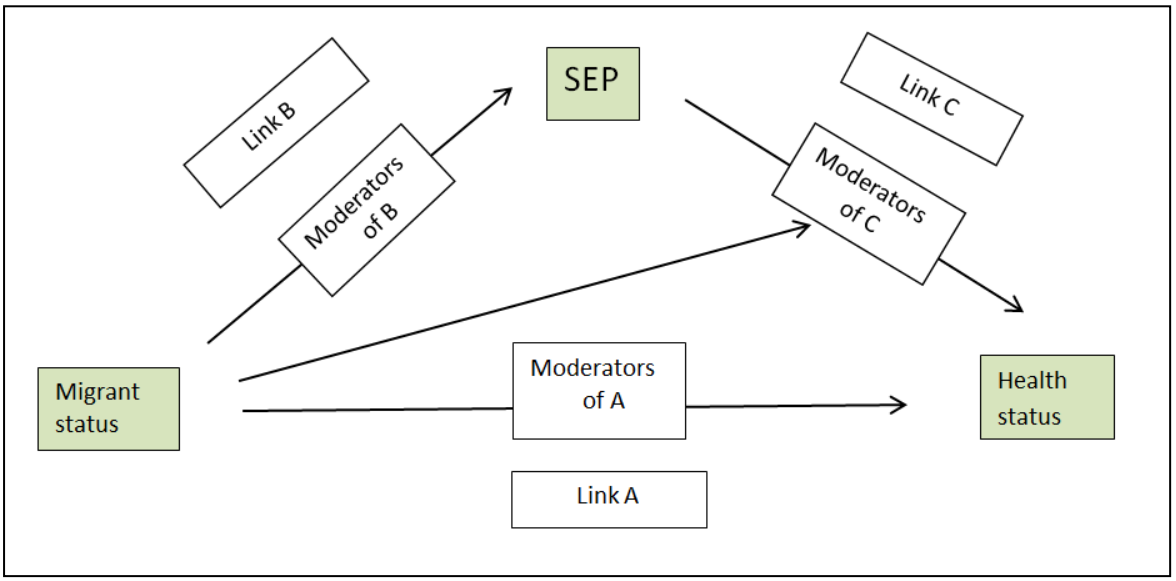


Figure 3. General model for effects of migrant status on health status

Link B (between migrant status and SEP)

The moderators of this link are the barriers that often prevent migrants from reaching their full potential SEP, or – conversely – policies that have been implemented to give migrants a headstart.

Just as for women, older workers or people with disabilities, many forms of discrimination and exclusion stand in the way of migrants, requiring them to make more effort than others in order to reach the same level of SEP. However, in such cases measures are often taken to promote 'equal opportunities'. These may take the form of additional support, positive discrimination or affirmative action (for example, quotas for minority personnel).

Applying such measures to migrants is associated with 'multicultural' policies, which have however become increasingly unpopular with voters since the end of the 20th century. Nationals with lower SEP, in particular, may regard such policies as inequitable – which they may be, indeed, if nothing comparable is done for nationals. Policies relating to opportunity barriers for migrants are captured by the country's overall MIPEX score; the effects of such barriers are reflected by the EU's 'Zaragoza indicators', introduced in 2010.[30]

Below we discuss further the main pathways that could make up link B or C.

Access to the labour market

Data from Eurostat[31] show that across a range of indicators, the position of non-EU migrants on the labour market is far weaker than that of EU migrants or nationals: they are less likely to be economically active and more likely to be unemployed. Migrant or ethnic minority youth are a particularly vulnerable group, with unemployment rates sometimes twice as high as those of nationals – another reason for being concerned about the 'second generation'. This is not simply a reflection of lower levels of skill that migrants bring with them: discrimination on the labour market is common and measures to tackle it are often weak.

The jobs that are likely to be available to migrants tend to be those that native citizens are unwilling to take, because they are underpaid and/or 'dirty, dangerous and demeaning' (3D). Refusal to

recognise prior educational qualifications also forces many migrants to work below the level for which they qualified. All these factors will undermine their SEP and thus, ultimately, their health.

Another aspect of the work that migrants often undertake is that it is precarious. Neo-liberal policies have reduced job security for all workers, especially low-paid ones, but migrants are particularly strongly affected because they are usually unable to fall back on the safety-net of unemployment benefits and other measures to prevent falling into a 'poverty trap'. Worse still, losing their job may take away their entitlement to health care and even their right to remain legally in the country.

Measures to create a 'level playing field' for migrants may include training programmes (sometimes prior to departure) to ensure better matching of their skills with employers' requirements, as well as policies to encourage recognition of migrants' qualifications. Such schemes exist, for example, for health workers, who are often in short supply in receiving countries: whether migrants' skills are in demand is therefore a likely moderator of link B. Assistance with language learning and integration can also be crucial. In the Netherlands government support for these courses was abolished in 2013, which has reduced the ability of less well-off migrants to improve their position on the labour market.[32]

Access to appropriate education and training

This is another important aspect of migrant integration, which may affect both children and adults. There may be barriers to accessing education, while its content may be inadequately adapted to the needs of migrants. For example, the OECD's PISA programme has found that migrant children achieve higher qualifications when the education system allows them the extra time they need to learn the language and become acculturated.[33] Special measures may also be needed to prevent dropout.

In the field of education there may be interactions with sex or gender. Of particular note is the fact that in several countries, migrant girls (as well as those of the 'second generation') do better in the educational system and on the labour market than boys. Age is another important moderator: it is advantageous for a migrant child to enter a new education system at an early age rather than later.

Inadequate access to appropriate health services

This issue has been treated as a direct link between migrant status and health, but it may also function as a barrier to integration: untreated illnesses may undermine migrants' ability to realise their full potential. "Illness exacerbates marginalisation and marginalisation exacerbates illness, creating a downward spiral".[34]

- Other factors on this link: Need for interpretation services limiting access to meaningful consultations.
- Migrant person not knowing how to navigate the system, what their entitlements are/are not.
- Fear of being identified by authorities if irregular migrant.
- Fear that being identified with a contagious disease may affect asylum claim for some.
- Hostility/Welcoming attitudes by health care staff.

Other barriers to integration

Finally, there are many other kinds of diversity in migrant populations (religion, outward appearance, country of origin, etc.) that are likely to moderate barriers that prevent them from realising their potential. Barriers are likely to be particularly high for some groups that are more disadvantaged.

Before leaving this subject we should note that there is an important difference between *reducing barriers to social mobility* and *flattening the social gradient*. In this section we have only discussed migrants' ability to realise their potential, i.e. their social mobility: where there are many barriers to integration, the receiving society is for them not a meritocracy but a closed stratification system – like a caste system – with many migrants (especially irregular ones) trapped at the bottom. Conversely, policies that ensure equal opportunities for migrants make create more of a meritocracy for them. However, whether a society is a meritocracy or a closed stratification system says nothing about the size of inequalities within it, as measured (for example) by the Gini coefficient. The SDH movement tends not only to argue for equal opportunities, but also for reduction of the size of inequalities. When discussing policies to tackle health inequalities/inequities for migrants, it should be borne in mind that these are two different issues.

Link C (between SEP and health status)

The processes that mediate this link have been explored in many studies on SDH. Again, there are many such processes, so there should be many lines in Fig. 1. The fact that migrant status often moderates these links (as shown by the diagonal arrow from Migrant status to box C) shows that the relation between SEP and health status cannot be understood without taking migrant status into account. Usually, low SEP produces more severe disadvantages for migrants than it does for nationals.

Health and safety at work

A major review of this area in 2018[35] concluded that migrants receive less pay, work longer hours and experience worse conditions than non-migrants. This is not simply a matter of lower occupational status: they are often subject to human rights violations, exploitation, abuse, human trafficking and violence. Their less favourable working conditions and other problems (such as language barriers) lead to poorer health outcomes, including more workplace injuries and occupational fatalities.[36] As already mentioned, precarious employment is even more disadvantageous for migrants than for nationals, because they are less well protected by 'safety-nets' in the form of unemployment benefit, etc. Better regulation of labour to promote 'decent work' would help all workers,[37] but it appears to be even more important for migrants than for national citizens.

An interesting sex difference was noted by the authors of second study cited above.[36] Male migrants experienced more negative working conditions than nationals, but no difference was found among females. Outside Europe, acute health risks (including rape, torture and murder) may be experienced by female domestic workers whose residence permit obliges them to stay with a single employer, but the worst of these horror stories tend to come from South-East Asia and the Gulf States: in Europe, such abuses do not seem more common among migrant women than among nationals. However, as the authors of the study point out, migrant women may simply be more reluctant to complain about their working conditions, for example because they are more vulnerable to losing their job.

Access to appropriate health services

This topic has already been examined in relation to links A and B. The question here is whether migrant status moderates the influence of SEP on service provision, i.e. whether differences in health services that are linked to SEP affect migrants more strongly than non-migrants. It should be noted that MIPEX defines health equity for migrants only in terms of differences between migrants and non-migrants. If migrants and non-migrants with low SEP are equally poorly served by the health system, MIPEX will consider this as equitable for migrants. Conversely, if special measures are taken to improve health services in (for example) disadvantaged neighbourhoods, these will probably benefit migrants and non-migrants alike.

Healthy living environments

Migrants generally live in areas of cheap housing, which tend to have fewer amenities and to provide less healthy living conditions. Public transport, on which migrants may rely heavily, may serve these areas less well although in some countries may be enhanced. The main reason for this inequality is that migrants cannot afford to live in the better areas. However, this is unlikely to be the whole story. Even if a migrant could afford to live in a better area or building, discrimination by house agents or landlords may deny them access to it. Migrant status thus exacerbates the negative effect of SEP on health.

Encouraging healthy lifestyles

Migrants with low SEP may not be able to afford healthy food, or have enough time to prepare it, and it may not be available in the neighbourhoods where they live. It is not clear whether this health threat differs between migrants and non-migrants. However, campaigns to increase awareness about healthy eating may reach migrants less effectively, and are often inadequately targeted in terms of language and content.[38]

As mentioned above in relation to nutrition, health promotion campaigns may reach migrants less effectively and be insufficiently targeted. It is important to increase awareness among migrants of the unhealthy aspects of 'Western' lifestyles (the effects of which some may be more susceptible to eg South East Asian migrants have higher rates of type 2 diabetes if follow Western diet) and ways to avoid them. Of course, influencing lifestyles alone is only part of the problem: the underlying causes of unhealthy lifestyles must also be tackled.

2. Country Assessments

The country assessments will be done by using existing or available data. It is beyond the scope of this WP to conduct any new studies or generate new research. The choice of activities to be carried out needs to be based on reliable information about the migrant population, national policies on migrant health and attitudes to migration, and particular problems that have been identified in the health field. This information will be part of the general assessment to be made for each country. Therefore the importance of this step cannot be overemphasized. A common thread running through the Road Map in Appendix 1 is that without a solid evidence base, attempts to improve health equity for migrants cannot succeed. In some countries, simply taking steps to promote the collection of such data might be the most useful contribution JAHEE can make. (In countries where few policies on migrant health exist, another necessary first step would be to identify stakeholders to be brought together to form a coalition to give leadership, create synergies and promote joint action.)

Background information on the migrants in a country is particularly important for estimating the kinds of demands that health services will face. Some countries have a migrant population dating back to the Western European economic boom of 1950-1973: in these populations, ageing will be a major issue. In other countries, especially those with low GDP and poor opportunities for migrants, 'transit migrants' predominate (migrants trying to make their way, often clandestinely, to more prosperous parts of Europe): Serbia is a good example of this.
In Greece and Italy, large numbers of migrants who arrived without authorisation by sea reside as asylum seekers or irregular migrants, with few possibilities of onward travel.

When it comes to mapping the policies on migrant health in partner countries, WP7 has a headstart: a major project has been carried out to benchmark progress on the list of measures regarded by the Council of Europe (2011, step 9 in the Road Map) as necessary for achieving health equity for migrants. The MIPEX Health strand is based on this list and analysed 38 indicators in 31 EU/EEA countries plus Bosnia-Herzegovina, FYR Macedonia and Turkey, as well as the USA, Canada, Australia and New Zealand. The reference date was the beginning of 2015. Results were published in a 102-page *Summary Report*[24] and a five-page overview article in the *European Journal of Public Health.*[39] Using these data, Country Reports have been written for the first 34 countries named above, which provide background material together with a narrative account of the quantitative data and

explanations of how the scores were arrived at.[40] Since 2015, data have also been collected in Serbia, Montenegro, Albania, Moldova, Russia, Georgia and Israel (though as yet without Country Reports), bringing the total of European countries covered by the MIPEX Health strand to 45.

This extensive data source provides a solid foundation for the Country Assessments required for WP7. Just as the Road Map provided a ready-made overview of the problems and solutions that IGOs have identified in the field of migrant health, so does the MIPEX Health strand provide a matching database for European countries. In both cases, there is no need for JAHEE to repeat this work, although detailed in-depth information may be needed to shed more light on certain topics.

As noted earlier, upstream approaches to migrant health have only recently started to be applied, despite having been recommended for over a decade. Most interventions focus on treatment or relatively 'proximal' forms of prevention such as vaccination, rather than tackling the underlying determinants of health. As a result, both the Road Map and the MIPEX Health strand pay much more attention to service delivery than to upstream issues (topics 1-3 in Table 1).

We give here an example of the information that MIPEX can provide, which is supplemented in Appendix 3 by an examination of detailed scores. Table 2 below shows background data and MIPEX summary scores for the 13 countries participating in JAHEE. All scores have been ranked using the following procedure: scores from the full sample of 34 European countries plus Serbia were ranked, then divided into five groups of seven countries each and given a number from 1 to 5 (highest score).

The background data relate to 2014: like the MIPEX scores, they may need to be updated. **Numbers of non-EU/EEA migrants** (TCNs) are expressed as a percentage of the country's population. As in the rest of MIPEX, only TCNs are considered: for EU/EEA citizens, health care coverage – like other important benefits – remains in principle the same when they move to another Member State. The table gives absolute **numbers of asylum seekers**, but these are ranked as a percentage of the population in order to take account of differing country sizes. Next, the country's **GDP per capita** (in euros, adjusted for purchasing power) is given, followed by **health expenditure per capita**, which is closely related. Countries are ordered from top to bottom of the table in order of their GDP. Since wealthier countries tend to have higher scores on most MIPEX indicators, this makes it easy to see where a country's strong and weak points lie after allowance is made for its GDP. It can be seen that

Norway's GDP in 2014 was almost five times higher than that of Serbia, so the 13 countries participating in WP7 cover a very wide range of economic levels. Nevertheless, the average GDP (96.9) of WP7 participants is close to that of the other 23 countries (95.3).

Country	% non-EU/EEA migrants 2014	asylum applications 2014	GDP 2014	Health expendi-ture per capita	Other MIPEX strands	Health strand total	A Entitlements	B Accessibility	C Responsive-ness	D Achieving change
Norway	7,4	11.480	179	4.313	5	5	4	4	5	5
Germany	7,3	202.815	124	3.665	5	3	2	1	5	3
Sweden	10,1	81.325	124	3.012	5	5	5	4	5	4
Finland	3,4	3.625	110	2.591	5	4	3	5	4	3
United Kingdom	8,1	31.945	108	2.384	4	5	2	2	5	5
Italy	6,1	64.625	97	2.255	4	5	5	5	4	5
Spain	8,3	5.615	93	2.074	5	4	2	4	3	5
Cyprus	9,3	1.745	85	1.631	1	2	1	3	2	2
Czech Republic	2,3	1.155	84	1.548	2	3	3	3	3	3
Portugal	6,0	445	78	1.834	5	3	1	4	3	4
Slovakia	0,5	16.412	76	1.512	1	2	3	2	2	2
Greece	8,4	9.435	72	1.911	3	2	5	1	1	2
Serbia	0,2	388	37	995	2	1	1	1	1	2

Table 2. Selected background scores and MIPEX Health strand scores

Colours reflect score values. Grey is average, green is above average and red is below average. Darker shades reflect more extreme scores.

The right-hand side of Table 2 contains summary MIPEX scores. The first column shows the **average of all strands other than Health**, which reflects how favourable the country's policies on integration are outside the health system. This is followed by the **Health strand total score** and the scores on **Entitlements for migrants** (Section A), **Accessibility of health services** (B) and **Responsiveness of services to migrants' needs** (C). These correspond to the 'downstream' issues (4, 5 and 6) in Table 1. The upstream issues (1, 2 and 3) are dealt with in Section D, labelled **Achieving change.** From this we can see that 'downstream' issues are covered in three times as much detail as upstream ones, which reflects the current state of the art in this field.

The tendency for green cells to be concentrated at the top of the table and red ones at the bottom reflects that fact that all the variables in this table are positively correlated, to some extent, with GDP. Total scores on the Health strand are similar to the average of those on other MIPEX strands, with some conspicuous exceptions: Portugal scores much lower on health, largely as a result of austerity measures in the health system implemented during the financial crisis. Germany also scores lower, mainly reflecting access barriers.

Appendix 3 gives us deeper insight into these scores by showing how countries performed on the indicators that made up each scale. This enables us to locate more precisely the country's strong and weak points. Adjustments will need to be made to the UK scores to take account of different policies in Wales; in all countries, since the data are already four years out of date, some data will have to be updated.

Of course, this information does not give answers to all possible questions about migrant health policy. For a start, only policies are covered, not outcomes. However, it provides a good starting-point for identifying areas of strength and weakness. The instrument has been recommended by the Global Migration Group as a good practice for measuring inequities in health policies in the context of the SDGs.[41] It is also referred to in the *Proposed Health Component in the Global Compact for Safe, Orderly and Regular Migration*, jointly issued by the IOM and WHO,[42] as well as the report Benchmarking Access to Healthcare in the EU by the Expert Panel on effective ways of investing in Health (EXPH).[43] Its unique advantage is that it contains a large, uniform collection of carefully standardized and operationalised indicators, enabling comparisons to be made between countries and between countries at different points in time (MIPEX is a longitudinal survey, new data being collected at four- or five-year intervals).

3. Selecting actions for implementation in JAHEE

The choice of actions to implement will depend on what is useful and feasible in each country. This will depend in turn on:

- Need: which problems be identified during the Country Assessment for which promising interventions exist and have not been tried? 'Problems' can either refer to poorer health status observed in migrants, or to poorer access to appropriate health care. 'Need' will also depend on the numbers of migrants present in a country who experience the problem in question, and the extent to which measures have not been taken to tackle it.

- Are the resources that are available in the context of JAHEE sufficient to implement this intervention? The number of person-hours available, the duration of activities, the skills and interests of participants and their ability to involve other people and organisations in the interventions all need to be borne in mind.

- All interventions require the cooperation of those responsible for the activity in which it is proposed to intervene. Nothing can be undertaken without approval from the relevant authorities in a country. A collaborative approach is preferable, in which even the choice of interventions is discussed at an early stage with the relevant authorities.

- Interventions should have some lasting value, either because they generate new knowledge about the usefulness of an innovative practice or because they fill a gap in a country's health system in a way that leads to permanent, sustainable change. They should not simply fill in gaps in government policy in the manner of NGOs.

3a. Possible actions to be implemented

Actions are ordered by the topics listed in Table 1. This list is not exhaustive and will need to be supplemented as the project proceeds.

Data and Research

Medical databases or clinical records should register the migrant status, country of origin and (where this classification is used) ethnicity of each individual. For migrants, this information should include the year in which they arrived in the country, so that their age on arrival and length of

residence can be calculated. Alternatively, it should be possible to link medical databases and clinical records to other sources containing this information.

This information is important for disaggregating migrants in epidemiological and health service research, and to provide information to health professionals about migrant patients. Among participating countries the need for better data collection (according to MIPEX) is greatest in the Czech Republic and Serbia, but there are also shortcomings in Germany, Finland, Spain, Cyprus, Portugal and Greece (see Appendix 3).

Public authorities and health service providers are the point of entry for improving data collection. Successful interventions have recently been carried out by the Scottish Government to promote data linkage[44] and increase recording of ethnicity data in hospitals.[45] (Note that in the UK ethnicity receives more attention than migrant status.) Whereas in Scotland and most Scandinavian countries the use of data on national origin or ethnicity is routine, in some countries ethical and political objections may be raised.

Health data on migrants also needs to be supplemented by background information on the migrants in each country – their numbers, history, origins, demographic profile, geographical distribution, main occupations and so on. Where such data are lacking, efforts should be made to encourage governments and research centres to collect it.

Data, or course, are not enough: research is also essential in order to make the data 'speak', i.e. to reveal their implications. To avoid fragmentation of effort, setting up centres of expertise in research on migrant health is recommended, together with networks for bringing researchers together at national, European and global level. The project MIGHEALTHNET[46] (2007-2009) set up a network of websites throughout Europe ('wikis') in many different languages, on which information and materials were collected related to migrant health. Although the project proved unsustainable after 2009 due to lack of funding (expect for the wikis in Norway and the Netherlands), it could be revived on a national basis.

Governance

Instead of being sporadic, spontaneous and unsustainable initiatives, good governance requires that measures to protect the health of migrants should be structural, system- and organisation-wide

('mainstreamed'), and embedded in policies. Many stakeholders need to become involved, since a wide range of bodies can influence policy and practice: national, regional and municipal governments, IGOs, service provider organisations, professional bodies, educational and research institutions (universities), health insurers, accreditation agencies, private companies, as well as NGOs, CSOs and advocacy groups (in particular, those representing migrants). Good contacts with the media and effective use of internet (social media) are also important. An excellent example of health risk reduction achieved by a broad coalition is the successful campaign in Britain to cut back the traditional Coca-Cola Christmas stunt, in which sugary drinks are handed out free.[47]

Leadership is required in order to foster collaboration and synergies between all these stakeholders. The opposition between 'top-down' and 'bottom-up' initiatives is illusory; in any case, there is seldom a clear hierarchy of stakeholders. Effective action requires a sense of involvement and ownership among all concerned. Community involvement is particularly important in the health field: local authorities often display a more energetic approach to migrant issues than national government. And, of course, every opportunity must be taken to involve migrants themselves.

In every country there is room for initiatives to strengthen governance on migrant health, since even when leadership exists it may have shortcomings. Where there is at present little or no action, NGOs, CSOs and local IOM offices may be the best place to start building up a coalition to get it off the ground.

Intersectoral action on the social determinants of health

Although action to tackle the social determinants of migrant health outside the health system has been urged for many years, the traditional preoccupation of health systems with health service provision has diverted attention from such approaches. Only in 7 of the MIPEX sample of 34 European countries is there "consideration of the impact on migrant or ethnic minority health of policies in other sectors than health". In the UK this is done on a mandatory basis (the 'Public Sector Equality Duty'), in the other 6 countries only *ad hoc.* Yet, as we saw in section 3b, there are many areas in which migrants appear to be more vulnerable to health risks than non-migrants. This must be a field with obvious issues that could be tackled ('low-hanging fruit'). The question remains, however: how? On this matter, the expertise of WP9 will be invaluable.

At the outset, it is clear that the HiAP principle and the notion of 'intersectoral action' can be interpreted in either a narrow or a broad sense. In the narrow sense, these terms apply only to government policies: sectors are identified with ministries, while intersectoral action refers only to collaboration between ministries. This interpretation, however, ignores the phenomenon of 'multi-level' governance and the broad ensemble of stakeholders that may be involved in policies that affect migrant health, as we saw in the previous section. 'Health in all policies' is hard to achieve in a purely top-down way.

Two main factors stand in the way of more energetic protection of migrants' health. One is the current European resistance to immigration that has been so effectively exploited by populist politicians in recent years, which makes national governments increasingly nervous about appearing to be too 'migrant-friendly'. The other is the vested interest that employers have in maintaining the supply of undemanding, flexible and easily disposable labour that migrants provide. Although these two factors are in conflict with each other, they are united in opposing outright improvements to the rights and benefits of migrants.

The most effective arguments for improving the social conditions of migrants therefore do not confront xenophobia and business interests head-on, but instead look for changes that can be framed as 'win-win' situations. For example, policies that attempt to exert 'internal immigration control' through punitive or deterrent measures can be opposed as needlessly divisive and unjustifiable in cost-benefit terms. Everybody would benefit by phasing them out. Likewise, unsafe working practices impair productivity and create unnecessary social costs. Not allowing migrants to realise their full potential impoverishes the whole society, just as the exclusion and disempowerment of women does. Underlying all these is the fundamental principle of the SDH movement, that health inequities undermine the interests of society as a whole.

In Section 3b, the following types of **direct** link between migrant status and health – links that are not intrinsically mediated by SEP – were identified:

- State of health on arrival
- Genetic or cultural factors that can maintain or undermine health
- Health system in the receiving country

- Discrimination (individual and institutional)

Perhaps the most fundamental of these is the last, which involves strengthening existing measures against discrimination. It is here that actions to change public attitudes and legal practices would probably have most effect. The question is whether in a project such as JAHEE, which mainly brings together experts in epidemiology and public health, there is enough competence regarding advocacy, attitude change, legal systems, media studies, political science and other relevant disciplines to devise and implement such actions.

Section 3b also identified two types of **indirect** link:

- Barriers to integration, especially in education, the labour market and health services.
- Increased exposure to health threats for migrants in the fields of health and safety at work, healthy eating, health services, living environments and lifestyles.

Again, JAHEE could put its weight behind actions to remove barriers to integration for migrants, but the main field in which it is competent to implement actions is – once again – that of health services. Regarding the fields in which migrants may be exposed to increased health threats, public health bodies do experience on health and safety, healthy eating and so on. We would suggest the formation of task groups within JAHEE to explore the possibilities for action in each of these fields.

Access to health services

Access barriers for migrants have been extensively studied and numerous 'good practices' have been devised to address them. There is no space to do justice to this topic here, but references 4-7 provide extensive overviews. Concerning entitlements, evidence-based advocacy of the kind that IGOs, NGOs and professional bodies undertake can be deployed to get them changed eg Data sharing between Health and Immigration authorities: actual policy changes can only be undertaken by national (or in some cases, local) governments. The data from MIPEX increase the scope for this type of action.

One central issue concerning entitlements is the myth that 'emergency care' is a meaningful basic level of health care provision. It is not, of course, for the simple reason that waiting until a health problem causes an emergency guarantees that treatment will be less effective and more expensive. Particularly inhumane and irrational is the use of contacts with health service providers to pass on

information about irregular migrants to immigration authorities. Even migrants entitled to emergency care may not seek it if they fear it could result in deportation.

Concerning other types of access barrier, Appendix 3 shows that information for service providers on migrants' entitlements is often woefully inadequate; information for migrants themselves is often better. New opportunities are currently being discovered for using internet and mobile phones (eHealth and mHealth) to provide migrants with not only this type of information, but other useful advice on health and how to maintain it. Already in 2015, websites were the most frequently used medium for disseminating information about health services to migrants.[24]

Quality of services

Language barriers can undermine the accessibility of health services for migrants, but their most serious consequences are in the field of treatment. Where verbal communication is inadequate, the type of care that can be provided is degraded to the level of veterinary medicine. MIPEX shows that an astonishing number of countries make no provision for the need for interpretation in health care (see Appendix 3). When it is available, patients often have to pay for it themselves.

Many of the adaptations of health service delivery that may be necessary for migrants fall under the heading of 'cultural competence'. (The term 'diversity sensitivity' is sometimes preferred, because cultural differences among migrants are not the only type of diversity that service providers must take account of if they are to provide 'patient-centred' health care.) Standards in this area are seldom adopted, though training and education are often available. Not only treatment, but health promotion (including prevention) and health education often have to be adapted in order to be effective with migrants. Finally, migrants themselves should be involved in a variety of ways to improve service delivery, but they seldom are.

Attention for 'vulnerable groups'

Because migrants encounter so many barriers to accessing appropriate care, there is a real danger that those most in need may not be reached. MIPEX showed that exemptions to restrictive policies – a kind of back door into the health system – were available in most countries for 'vulnerable'

groups. These are usually defined as women, children, the elderly, migrants with disabilities and victims of trafficking. In addition, there are exemptions for children and female migrants before, during and immediately after childbirth, as well as people who may have infectious diseases or serious mental health problems. Policies on exemptions in each country need to be critically examined in order to determine whether they are adequate and effective. Even when migrants' access to health care is not restricted, special attention should still be paid to the most vulnerable.

3b. The relation between actions carried out by other WPs and by WP7

When it comes to 'downstream' actions focusing on health service delivery for migrants with health conditions, the task of WP7 does not overlap with that of any other WP. However, we have noted above that there may be similarities between the problems of various kinds of 'underserved' groups: policies for Roma, for example, can be viewed through the same lens as those for migrants. (Indeed, there exists an instrument – RHIPEX, or the Roma Health Integration Policy Index[48] - that adapts the MIPEX Health strand for Roma.) There is thus good reason for collaboration between WP7 and WP8.

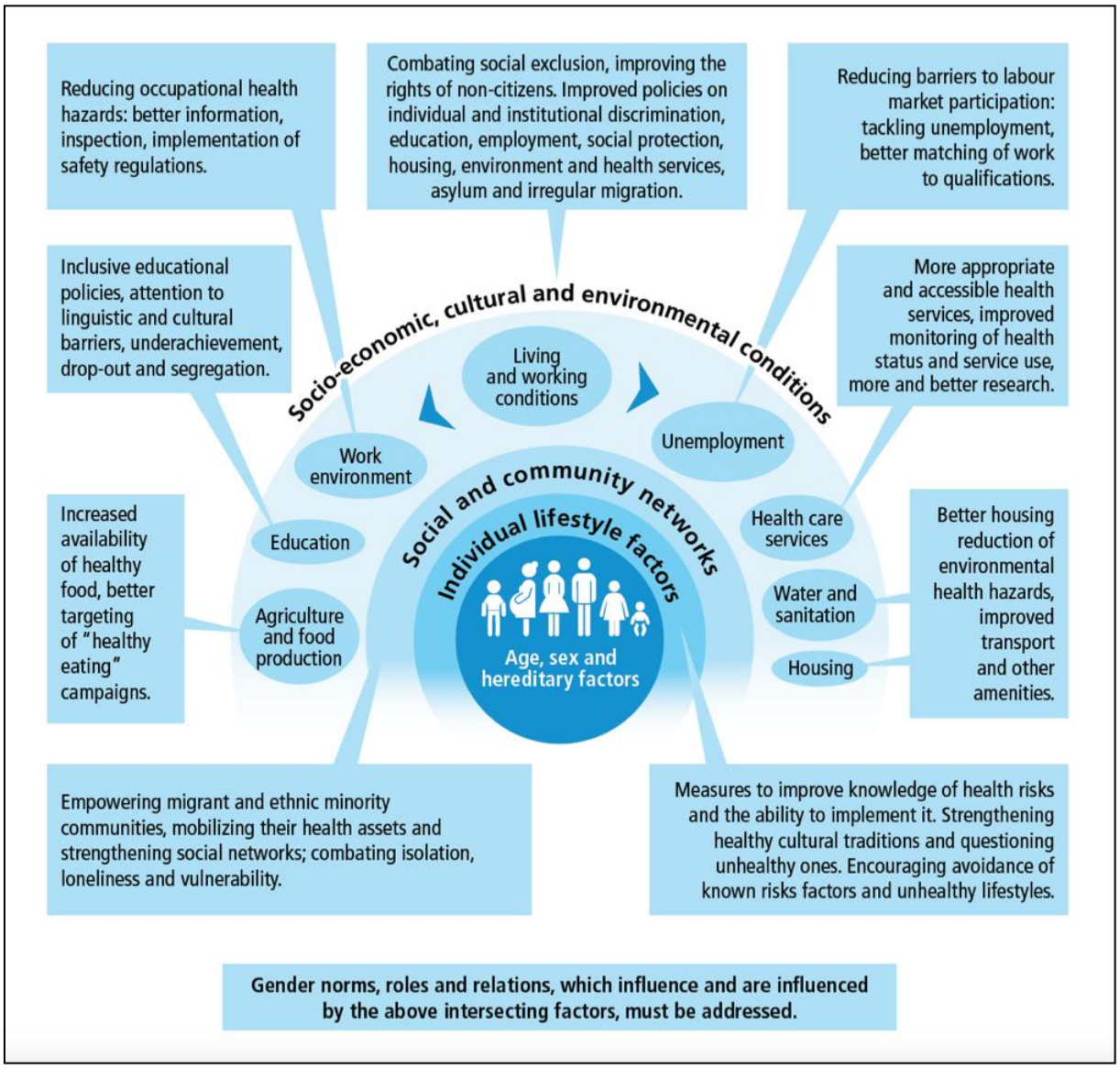
Concerning upstream actions that go beyond health service provision, there is overlap with all other WPs. As we saw in Section 3b, both direct links between migrant status and health status, and indirect ones mediated by SEP, need to be examined. The direct links (A in Figure 3) concern only WP7, but the barriers to successful integration that may undermine migrants' SEP (link B) are relevant to all WP's concerned with the link between SEP and health. WP9 on governance is of special relevance to action on the social determinants of migrant health.

Appendix 1. 'Road map' of soft policy instruments on migrants' health

No.	Date	Organisation	Title	url
1	2007	Portuguese EU Presidency	Conclusions of Conference on Health and Migration in the European Union	https://bit.ly/2zWgRwL
2	2007	Council of Europe	Bratislava Declaration on health, human rights and migration	https://bit.ly/2OJzht1
3	2007	Council of the European Union	Draft Council Conclusions on Health and Migration in the EU	https://bit.ly/2pKebwq
4	2008	World Health Assembly	Resolution WHA61.17 (Health of Migrants)	https://bit.ly/2RwwcLg
5	2009	International Organisation for Migration	Consultation on Migration health: Better health for all in Europe	https://bit.ly/2y7LVZr
6	2010	WHO and IOM	First Global Consultation on Migrant Health, Madrid	https://bit.ly/2RxnwUW
7	2010	WHO Euro	Policy Briefing: How health systems can address health inequities linked to migration and ethnicity	https://bit.ly/2zCe2ls
8	2010	European Commission	Communication on Solidarity in Health: Reducing Health Inequalities in the EU	https://bit.ly/2Psxky0
9	2011	Council of Europe	Recommendations on mobility, migration and access to health care	https://bit.ly/2qJ5u8a
10	2014	WHO Euro HPH-Task Force MFCCH	Equity standards in health care	https://bit.ly/2upRq1V
11	2015 - 2018	WHO Euro Health Evidence Network (HEN)	Nine synthesis reports on migration and health	https://bit.ly/2RAjlYL
12	2016	United Nations	New York Declaration for Refugees and Migrants	https://bit.ly/2cUNoqS
13	2016	WHO Euro	Strategy and Action Plan on Refugee and Migrant Health	https://bit.ly/2dfcqRB
14	2016	WHO and IOM	Second Global Consultation on Migrant Health, Colombo	https://bit.ly/2kv0obL
15	2017	WHO	Framework of priorities and guiding principles on Promoting the Health of Migrants and Refugees	https://bit.ly/2Kq9yEw
16	2017	WHO & IOM	Proposed health component, Global Compact for Safe, Orderly and Regular Migration	https://bit.ly/2OIiZAI
17	2017	IOM	Migration Health in the Sustainable Development Goals	https://bit.ly/2u46AJA
18	2017	World Health Assembly	Resolution 70.15 on 'Promoting the health of refugees and migrants'	https://bit.ly/2D6itXD
19	2017	WHO	Beyond the Barriers: Framing evidence on health system strengthening to improve the health of migrants experi-encing poverty and social exclusion	https://bit.ly/2Dp6cwP
20	2018	IOM and Swiss Agency for Cooperation and Development (SDC)	Migration and the 2030 Agenda	https://bit.ly/2Pplo01
21	2018	United Nations	Global Compact for Safe, Orderly and Regular Migration (Final Draft)	https://bit.ly/2zuZ8yj
22	2018	United Nations	Global Compact on Refugees	https://bit.ly/2ATrj5o

Appendix 2. Diagram illustrating social determinants of migrants' health

Source: Step 7 in the 'Road Map' (WHO Euro 2010, page xxx), redrawn in Step 19 (WHO 2017, page 2)



Appendix 3. MIPEX scores of countries participating in WP7

This appendix contains a more detailed breakdown of scores on the MIPEX Health strand, examining them at the level of individual indicators rather than summary scores. It starts with Entitlements (scale A), in which legal migrants, asylum seekers and irregular migrants are distinguished. Two scores are given – firstly, entitlements according to the law and secondly, the amount of freedom from administrative barriers that can prevent migrants from obtaining these entitlements (i.e. demands for documents that are difficult for migrants to produce and decisions that are subject to administrative discretion, usually concerning the urgency of the treatment). Both scores are given equal weight, though the first has more gradations. Table 3 shows clearly how entitlements for the three groups of migrants decrease, and administrative barriers increase, as we move across from legal migrants to irregular migrants. (Full details of the scoring system used can be found in the Summary Report and the Health strand questionnaire.) The scores in Table 3 are rating scales rather than ranks.

Country	Legal migrants		Asylum Seekers		Irregular migrants	
	Entlitlements	Freedom from barriers	Entlitlements	Freedom from barriers	Entlitlements	Freedom from barriers
Norway	4	3	5	2	1	2
Germany	5	3	2	1	2	1
Sweden	5	3	4	2	4	2
Finland	3	3	3	2	2	1
United Kingdom	4	1	5	1	2	1
Italy	5	2	5	2	4	2
Spain	4	1	5	2	3	1
Cyprus	1	1	3	1	2	2
Czech Republic	3	2	3	3	0	2
Portugal	4	1	3	1	2	1
Slovakia	2	3	1	3	0	1
Greece	4	2	4	3	2	1
Serbia	5	1	1	1	0	1

Table 3. Scores on scale A (Entitlements)

Scale B concerns other barriers that make it difficult for migrants to reach the care they need.

Country	Inform-ation for service providers	Inform-ation for migrants	Languages available	Groups reached	Health education and promotion	Languages available	Groups reached	Cultural mediators	Groups reached	Reporting irregular migrants	Sanctions against helping
Norway	2	3	3	2	2	3	2	1	1	3	3
Germany	1	2	2	2	2	2	2	2	2	1	1
Sweden	2	3	3	2	3	3	3	2	1	1	3
Finland	3	2	3	2	3	3	3	1	2	2	3
United Kingdom	2	2	3	1	2	3	3	1	1	1	2
Italy	2	2	3	3	2	3	3	2	3	3	3
Spain	2	3	3	3	2	3	3	1	1	3	3
Cyprus	2	3	3	2	2	1	2	1	1	2	3
Czech Republic	2	3	2	2	1	1	1	2	2	3	3
Portugal	2	3	3	3	3	3	3	1	1	3	3
Slovakia	1	2	3	2	2	1	3	2	1	2	3
Greece	2	2	3	2	1	1	1	1	1	2	1
Serbia	1	1	1	1	1	1	1	1	1	2	3

Table 4. Scores on scale B (Accessibility)

In Table 4 it is noticeable that relatively little effort seem to be made to inform service providers about migrants' entitlements – an obvious opportunity for improvement. In some countries there are gaps in the provision of health education and promotion for migrants, as well as the use of 'cultural mediators'. (However, cultural mediators bridge, rather than reducing, the gap between migrants and the health system; they act as brokers between the two sides, but they do not necessarily bring them closer together.) Obligations to report irregular migrants to immigration authorities or police, as well as possible sanctions against health workers providing care, are fortunately quite rare in Europe, but where they exist they can create serious barriers.

Concerning the responsiveness of services to migrants' needs (scale C), a very clear relationship with GDP can be seen (cf. Table 2). This overlaps to a large extent with the distinction between EU15 and EU13 countries (those that joined the EU from 2004 onwards). Apart from Malta and Cyprus, the EU13 comprises Eastern European countries; the latter countries have low MIPEX scores, with the exception of the Czech Republic, which has a higher GDP than other East European countries as well as higher MIPEX scores (see also Table 2). Standards for 'cultural competence' or 'diversity sensitivity' are not widely known or implemented among countries participating in JAHEE, while migrants are not often involved in service delivery. Diversity among health staff, so that they form a better reflection of the population they serve, is seldom encouraged.

Country	Availability of interpreters	Number of methods used	Cultural competence standards	Training and education	Involve-ment of migrants	Encouraging diversity	Develop-ment of methods	Types of methods
Norway	3	3	1	3	2	2	2	2
Germany	3	3	2	2	2	2	2	2
Sweden	3	3	1	2	2	3	2	2
Finland	3	3	2	2	2	1	2	2
United Kingdom	3	3	2	3	3	3	3	3
Italy	3	3	2	2	2	1	2	2
Spain	3	2	1	2	2	1	2	2
Cyprus	1	1	1	2	1	1	2	2
Czech Republic	2	3	1	2	2	1	1	1
Portugal	3	2	1	2	1	1	2	2
Slovakia	1	1	1	1	1	1	1	1
Greece	1	1	1	1	1	1	1	1
Serbia	1	1	1	1	1	1	1	1

Table 5. Scores on scale C (Responsiveness of services)

Table 5 provides detailed scores on the upstream policies measured in Scale D. These correspond to topics 1,2 and 3 in Table 1 (data and research, governance, and intersectoral action on SDH). Support for data collection and research is generally good, as can be seen from the many green cells in the second column: in fact, the 13 countries participating in WP7 score slightly better on this indicator than the other 23 European countries in MIPEX (Goodman and Kruskal's Gamma = .55, *p* = .04 one-tailed). However, a HiaP approach is applied by only two WP7 participants, Finland and the United Kingdom, and in only 5 of the other 22 countries): this shows how rare the approach is. The last three columns concern governance, on which Norway receives the highest scores. Again, the precise meaning of these scores is explained in the Summary Report:**Feil! Bokmerke er ikke definert.** more details are contained in the Country Reports and the MIPEX Health strand questionnaires containing the raw data.

Country	Collection of data on migrant health	Support for research on migrant health	"Health in all policies" approach	Whole organisation approach	Leadership by government	Involvement of stakeholders	Involvement of migrant stakeholders
Norway	2	2	0	2	2	2	1
Germany	1	2	0	0	0	1	1
Sweden	2	2	0	2	0	0	0
Finland	1	2	1	0	0	0	0
United Kingdom	2	2	2	2	1	1	1
Italy	2	2	1	1	0	1	1
Spain	1	2	1	1	1	1	1
Cyprus	1	1	0	0	1	0	0
Czech Republic	0	2	0	0	1	1	1
Portugal	1	2	0	0	1	1	0
Greece	1	1	0	0	0	0	0
Bulgaria	2	2	0	0	0	0	0
Serbia	0	0	1	0	1	0	0

Table 6. Scores on scale D ('Achieving Change')

Appendix 4. Lancet Commission Migration Health

Commission page on thelancet.com

www.thelancet.com/commissions/migration-health

The UCL–*Lancet* Commission on Migration and Health: the health of a world on the move
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32114-7/fulltext

KEY RECOMMENDATIONS

1- Dedicate political capital, financial, and human resources to fulfil global commitments to secure healthy migration and improve the security and wellbeing of mobile groups, especially the most marginalised.

2 - Re-balance policy making in migration, trade and environment, and foreign affairs to give greater prominence to health. Foster cross-sector, complementary decision making that integrates health considerations across policies and services that determine the health of migrants.

3 - Confront urgently, vigorously, and persistently divisive myths and discriminatory rhetoric about migrants.

4 - Advocate for and improve the rights of migrants to ensure safe and healthy educational and working conditions that includes freedom of movement with no arbitrary arrest.

5 - There is an urgent need to ensure adequate monitoring, evaluation, and research to support the implementation of the Global Compacts.

Commission Chair, Professor Ibrahim Abubakar

"Migration is the defining issue of our time. How the world addresses human mobility will determine public health and social cohesion for decades ahead. Creating health systems that integrate migrant populations will benefit entire communities with better health access for all and positive gains for local populations. Failing to do so could be more expensive to national economies, health security, and global health than the modest investments required to protect migrants' right to health, and ensure migrants can be productive members of society."

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MIGRATION AND HEALTH

In a time of unprecedented internal and international migration, and their relative public health impacts, the UCL-*Lancet* Commission on Migration and Health provides a foundation for policy makers, advocates, health systems and communities to improve migration and health locally and globally. The Commission is the result of a two-year project led by 20 leading experts from 13 countries, and includes new data analysis, with two original research papers, and represents the most comprehensive review of the available evidence to date. The report, including its recommendations to improve the public health response to migration, will be launched on 8th December at the UN Intergovernmental Conference to adopt the Global Compact for safe, orderly and regular migration in Marrakech.

KEY MESSAGES

- We call on nation states, multilateral agencies, non-governmental organisations, and civil society to positively and effectively address the health of migrants by improving leadership and accountability.
- International and regional bodies and states should re-balance policy making in migration to give greater prominence to health by inviting health representatives to high level policy making forums on migration. Health leaders and practitioners should fully engage in dialogues on the macroeconomic forces that affect population mobility.
- Racism and prejudice should be confronted with a zero tolerance approach.
- Universal and equitable access to health services and to all determinants of the highest attainable standard of health within the scope of universal health coverage needs to be provided by governments to migrant populations, regardless of age, gender, or legal status.
- This Commission argues for a paradigm shift in research on migration and health, with a deliberate effort to enhance the funding mechanisms and networks supporting this change. Collaborative work is needed that links academia, policy, and front-line health and humanitarian workers.

REPORT FINDINGS

- A new, comprehensive systematic review and meta-analysis concludes that international migrants in high-income countries have lower rates of mortality compared to general populations across the majority of disease categories.
- There is no systematic association between migration and importation of infectious diseases, and the evidence shows that the risk of transmission from migrating populations to host populations is generally low.
- The Commission points to a growing trend of states limiting access to health care for migrants. Despite widespread recognition of the numerous migration related health risks, mobile populations—even forced migrants who are fleeing for their lives—are often met with punitive border policies, arbitrary detention, abuse and extortion, and are commonly denied access to care.
- States are increasingly treating unauthorised border crossings as a criminal offence, leading to detention, at times indefinitely. Detention poses clear violations of international law, and findings from a systematic review of 38 studies shows that detention is associated with negative health outcomes, especially mental health.
- An overwhelming consensus of evidence exists on the positive economic benefits of migration, which is insufficiently acknowledged. In advanced economies, each 1% increase in migrants in the adult population increases the gross domestic product per person by up to 2%.
- Migrants constitute a substantial proportion of the health care workforce in many high-income countries. Rather than being a burden, migrants are more likely to bolster services by providing medical care, teaching children, caring for older people, and supporting understaffed services. In the UK, 37% of doctors received their medical qualification in another country.

Website: www.migrationandhealth.org *Email: info@migrationandhealth.org*

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