
Difference Sensitivity in the Field of Migration and Health

National policies compared

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It is a challenging task to realize over a three months period an overview of such a complex topic as comparative national policies in the field of migration and health. In order to do this job, one needs many guides that allow one to see the good mushrooms in the forest. We have mobilized such guides in the whole Europe and we are very grateful for their help (see list of all interviewees in the appendix 1). In particular, we would like to express our gratitude to Dilshad Khan and Kazim Khan for the contact persons they advised and their help in formulating our questions. Thank you also for the comments to Erik Verkooyen, Isabelle Renschler, Daniela Radu, Denise Efionayi-Mäder and the scientific committee who follows the development of a new strategy in the field of migration and health in Switzerland.

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Introduction

The policy field of migration and health has been developed in Europe, for many years as a set of measures of control. Indeed, the question of health regarding migrants was only tackled as a problem of border control during the major part of the 20th century. The control was partially epidemiologically justified (control of Tuberculosis). But the main goal was, and this in particular after World War II, the selection of healthy workers for the Fordist industrialization of Europe. Migrants were accepted as workforce for a limited period – in a certain way the unproblematic period from the health point of view. The “guest workers” or “*Fremdarbeiter*” were healthy and the policies concerning migration oriented on the idea that the stay in the host countries was limited in time. No inclusion policies were the consequent result of such a “referential”¹.

During this period, there was not much research launched concerning the field of migration and health and their main orientation was in terms of class analysis (Castelnuovo-Frigessi 1977) or the study of psychological problems related to migration². The political and scientific awareness concerning migration as an important phenomenon in host societies began during the 1970ies. The economical crisis broke the image of the migrants as healthy workers in short stays in the host countries. Migrants were settled, without jobs, on the problem list of unemployment policies and their children represented a real challenge for the school system (Van Amersfoort et al. 1984). The field of “integration policies” had started to be elaborated and research on the settlements dynamics, on the consequences on the social security system of migrants and the risks for a harmonious internal

¹ We use the concept of “referential” in the sense of Bruno Jobert and Pierre Muller as the value system behind a policy (1987); similar is the concept of “core value” of Sabatier (1999).

² See for instance, on the risks to “being uprooted”, the researches of Abdelmalek Sayad (1976).

reproduction of a society with high immigration rates (the topic of racism and discrimination) were developed³.

The political and scientific description of migrants had begun to be more realistic, indicating in particular the change from a mobile to a more settled existence. In general, the migration in Europe was characterized since the 1960s and until the beginning of the 1980s by a relative homogeneity of national origins⁴, a small phenomenon of asylum seekers, more cyclical than continuous, the organization in large communities of small families and finally by their healthiness. Despite this rising awareness of the migrants’ settlement in the host country, the question of their integration was still grasped as a linear and one way process. For a long time researchers have relayed this process as a normal one, under the concepts of assimilation or acculturation: Time integrates (Hoffmann-Nowotny 1985). These characteristics explain that the first measures aiming the inclusion of migrants have not had relevant elements regarding health, but were more orientated on school and professional training (Mahnig 1998). Other aspects of the everyday life – such as the access to health care or quality of care – are not perceived as needing specific measures. Indeed, it was assumed that they would be resolved automatically in the long run.

The 1980s and in particular the 1990s changed completely the dynamics around migration and migration policy in Europe. A new tendency emerged with the process of the European unification. The coming together of Europe not only diminished disparities and simplified the migration movements inside Europe. It also initiated a process of economical reorganization of the European territory, which grows together following the principles of the selective advantages of a territorially defined division of labour. The new European open space of migration has, through this creation of a unified economical territory, organized by division of labour, spread of wealth, and *diminished internal migration searching settlement solutions* out of their home countries (Buzelay and Hannequart 1994). The potential migrants from the traditional migration countries now find work in

³ See for instance: Hoffmann-Nowotny 1976.

⁴ Created by the main orientation in the decision for a host country, which was family or networks from the same region of origin; see Dahinden 2005a and Dahinden 2005b for an exemplification and discussion of this traditional dynamic.

their own respective countries, or at least they do not see enough advantages to emigrate.

But this process of economic integration in Europe does not completely stop migration. The international reorganization of migration flows leads to divisions between migrants differentiated following criteria of knowledge and working skills, origins and legal status (OECD 2005). In particular the world of asylum seekers is transformed from a marginal and cyclical phenomenon until the 1980s into a continuous flow. Asylum appears to people from the Third World as the only way to enter Europe. (Efionayi-Mäder et al. 2001). This augmenting complexity in the composition of the migrant population leads to views in politics and in the public administrations searching for a new orientation to integrate these differences into concrete policies.

This search for new orientations in the migration policy concerns all European States. Discussions around some new migration laws started with enormous polemics, for instance in Germany, France, Italy or Switzerland. It's a sort of European "Migration crisis", like Weiner (1995) calls it, indicating this difficulty to find viable solutions for new migration regimes. But which solution is actually adequate for this increasingly complex migration? To this question, many local, regional, national and, since the beginning of 2004, international⁵ commissions are searching for answers.

The most surprising in these discussions is the multidimensional view on migration that can no more be seen as an isolated phenomenon, but has to be inserted in a societal dynamic of differentiation of lifeworlds. Sensitivity to difference is concretely more requested than migration specific knowledge. This sensitivity to difference not only implies different cultural ways of living (Cattacin 2006), but European states are also challenged by the differentiation of social rights affiliations, which are partially de-linked from a specific territory and which are claimed through multiple interlocking relations to local, national and international rights as the

⁵ In December 2003, a new "Global Commission on Migration" was launched by the United Nations. It started working in March 2004 and has presented itself to the international community through a first report in October 2005, later critically commented (GCIM 2005, critical: Bhagwati 2005).

discussion on health services for illegal workers exemplifies it (Chimienti and Cattacin 2004).

It is important to mention that in particular the European level might have given some impulsion in the field of migration and health. On the one hand for the advocacy work (see for example the recommendation of the Council of Europe regarding "health services and multicultural society" (forthcoming 2006) or the EU project on health inequalities,⁶ on the other hand for the collection of data and their comparability among the EU member states.⁷

⁶ See <http://www.health-inequalities.org>

⁷ Three of them are particularly relevant: 1) the European Community Household Panel (ECHP) is a survey based on a standardised questionnaire that involves annual interviewing of a representative panel of households and individuals in each country, covering a wide range of topics: income, health, education, housing, demographics and employment characteristic, etc. The total duration of the ECHP was 8 years, running from 1994 to 2001. In the first wave, i.e. in 1994, a sample of some 60,500 nationally represented households - i.e. approximately 130,000 adults aged 16 years and over - were interviewed in the then 12 Member States. Austria (1995) and Finland (1996) have joined the project since then. Data for Sweden is available as of 1997, and has been derived from the Swedish Living Conditions Survey and transformed into ECHP format (see <http://forum.europa.eu.int/irc/dsis/echpanel/info/data/information.html>). On the other hand we can assume that the recommendation of the European council (published in April 2006) may have some impact on the states. The 'European Community health indicators' (ECHI) is a project coordinated by the National Institute of Public Health and the Environment (RIVM) (the Netherlands), under the EC Health Monitoring Programme. Its objective is to propose a coherent set of European Community health indicators, meant to serve the purposes formulated for the programme of Community action in the field of public health, selected on the basis of explicit criteria, and supported by all Member States.

2) Ethnicity Results of surveys are affected by the cultural, political and economic climates in which they are undertaken. Survey data are not strictly comparable due to the methodological variations. The EMCDDA has produced guidelines for the standardised implementation of five key epidemiological indicators of drug use — drug use, problem drug use, demand for treatment, drug-related deaths and drug-related infectious diseases — to be fully implemented in all Member States at national level in the coming years (see European Commission 2002).

The new migration is in this changing context represented in complete contrast with the old – Fordist – migrants. The national origins are not homogenous anymore and this has as a primary consequence the change from large community organization of the old migration to the new small communities. The acceleration of migration through better communication ways has also as consequence that the settlement and acculturation is no more a question of survival; nomadism, continuous contacts to the home regions, transnationalism and organized diasporas appear as normality. The exception is the will to assimilate to a place.

This complexity as consequence of the inclusion dynamics and policies, which are confronted with the spreading out of migration and diversity in our society as normality, is challenging not only the school system and social security schemes, but also the health system. The health system in particular is confronted with weaker and more differentiated communities, who lose partially their capacity to help themselves because of their weakness. The legal questions related to migration also cause difficulties for the regular service delivery. Illegality introduces barriers to health care access, but also a new precariousness, bad working conditions and risky health conditions. To this complexity, we have to include the dynamics related to the world of asylum seekers, who add other problems to the health system such as the care of traumas of war. In brief, we can state that the healthy migrant still exists, but he or she is no longer the only type of migrant. The unhealthy migrant appears, through the world of asylum or illegality and the health system has to deal with. In this report, we try to describe how in particular the health systems of some European countries react to this cultural and legal differentiation. We shall as a preliminary describe the first reactions of the health systems, then examine the development of policies or ways of systematization of the actions. We shall

3) A non profit initiative from “médecin du monde” is currently assessing in several countries in Europe the level of access of migrants. The focus is on the access of undocumented migrants, asylum seekers and Rom minorities. The aim of the study is to promote better possibilities of access and an observatory of health access in each country (results may be available on autumn 2006). A second study aims at collecting the different entitlement to health care (also forthcoming).

finish with an analysis of the major trends and adaptations, trying to put forward what can be called “best practices”.⁸

Short methodological remark

This report is based on a literature analysis and interviews with experts from different countries. We have chosen to work with countries that are all known for their problem load on migration issues and their organisational and political differences. In addition, the countries are characterised by a sum of developed policies in the field of migration and health. In other words, the countries selected had to be innovative in the field of health and migration and to present a similar socio-economic level as well as a comparable pressure to act in this field as Switzerland. We studied the six following countries: Austria, France Germany, The Netherlands, Sweden and United Kingdom.⁹ The first three as neighbour countries have a large influence of the orientation of the national and counties policies; they would be used as system of references. The Netherlands, Sweden and United Kingdom can give important information for Switzerland regarding of their comparable heterogeneity.

The data is based on the one hand on telephone interviews with experts: representatives from the state level, researchers, as well as for some countries members of non-profit sectors (see appendix 1). The mean duration of each interview was 45 minutes. On the other hand we collected and used several documents and literature given by our interviewees or found on the web site of the organisations (state, institute of research or non-profit organisation) of each country in task of the field of ethnicity and health (appendix 2). The data were collected in February 2006.

⁸ In a complex world, best practices in the social science discourse do not exist. The best we can find is practice, compared to policy vacuums. Practices and their judgement as best is extremely morally connoted and depend from the reference system of the policy field. Good practice is for example for the actual Government in the United States to promote sexual abstinence for youngsters as measure against the spread of HIV.

⁹ We worked in other words in a comparative framework of the “most similar system design”; Przeworsky 1970.

1. Migrants as a health problem - the development of policy answers

Policy answers regarding migration and health are related to the general logic of the health system, which combines a framework of values (the referential) and an organizational structure, based on organizational traditions (the “path dependency” argument; see for instance Merrien 1990). This is in particular true when new policies are produced. A first distinction concerns the insurance scheme in the health system, which can be divided into more universalistic oriented systems (with tax based financing and open access to health services) or more categorical systems (based on individualized insurance schemes and a means tested access to health). As Ferrera points out, the two system logics are today often mixed, but the first decisions on how the system has to rule is always influencing and structuring the future developments (Ferrera 1993). This distinction is important for our purpose because universalistic systems are oriented on egalitarian access, while categorical systems reproduce societal differentiations (in particular class differentiation) inside the health system. For example, even though it is obliged in Switzerland to be affiliate to a health insurance, the financing of the health insurance through insurance fees reduce the consumption of services for lower salaries (Knüsel 2002).

The second distinction is related to the general value systems framing the inclusion of differences: we distinguished systems that are based on a communitarian approach of diversity (difference based) and systems that are based on republican approach (difference “blind”). Table 1 indicates where the analysed countries are placed in this logic.¹⁰

¹⁰ Bollini (1992) who studied the policy regarding Migration and Health in seven industrialized countries (France, United Kingdom, Switzerland, Italy, Sweden, United States and Canada) already indicated that these countries can be divided into two groups: those which have a passive attitude, that is, which expect immigrants to adapt to the health system designed for the native population (Italy, France, Switzerland and the United States); and those which have acknowledged the health problems posed by immigrant groups and who have actively tried to provide alternative solutions, for instance by providing interpreter services during medical encounters (United Kingdom, Sweden and Canada). Our article confirms

Table 1 : Health structures and value system of differences

Health structure Value system of differences	Universalistic approach* (Tax based)	Categorical approach** (Insurances)
Difference sensitive (Communitarian)	UK	Netherlands Switzerland
Difference “blindness” (Republican)	Sweden	Austria France Germany

*Often also called “Beveridgian System”

** Often also called “Bismarckian System”

Table 1 permits already a first analysis concerning migration and health. In fact, the UK is fundamentally the best-prepared nation to include migrants in the health system, because of its openness and its structural sensitivity to differences (the inheritance of the Commonwealth). We call this case “liberal universalism”, because the framework is difference oriented (in the sense of liberal acceptance of differences) and egalitarian in the access to health. The egalitarianism is nevertheless based on the logic of minimal appropriate services, corresponding to the liberal ideal of health for all, but only for basic services.

The second case is represented by Switzerland and the Netherlands. This case gathers societal systems with a categorical background in the social security system (Cattacin and Tattini 2004) that are structurally and ideologically open to resident migrants and their needs. The affiliation to the insurance scheme is in fact guaranteed by the liberal orientation of the health system which gives access rights for whom is paying fees. Though, in order to include people who are outside the regular insurance system (and not only the health system), categorical systems identify target groups (like undocumented migrants). Inclusion is then possible when people declare their socio-economical status (means test based measures) or if services are created that focus on a specific (target) group (and are only accessible for them).

this distinction but we tried to go a step further explaining the policy of each country in a more sensitive way taking into account not only the value regarding differences but also the health care system. This double perspective proposed a more precise categorization distinguishing four types of policies.

These systems are for instance obliged to create parallel structures for specific needs outside the normal insurance schemes. These structures are largely recognized as complement to the system and generally subsidized by the State. The Netherlands have a particular openness related to its history of religious pluralism (the “pillarized system”; Kriesi 1990 and the colonial background). We call this case “liberal selectivity”.

The third case contrasts the societal model. In fact Sweden works on the basis of openness to residents, but because of the high level of social security in Sweden and the high homogeneity of the population (for Sweden in a comparative view: Lijphart 1984), they distinguish strongly between insiders and outsiders (Olsson 1993). In this context, inclusion of difference is organised by parallel systems outside state institutions (NGOs), lacking state legitimacy. We call this case “socialist universalism” indicating an egalitarian ideology in a context of facilitated access to high level health care services for the insiders.

The fourth case indicates a combination of a categorical system – with all difficulties to get into an affiliation scheme without a resident permit – and difference blindness, resulting from the republican tradition in France and the relative homogeneity of Austria. Migrants – or people with a migrant background – have in these cases also difficulties to find appropriate care – difference sensitive care – when they are normally announced or even citizens. The pressure on migrants and minorities to assimilate to a model of normality (which is a construction in the two cases) creates not only structural barriers, but also moral barriers for a system change in the direction of more sensitivity for differences. In these systems, parallel initiatives of the state are the general answer to its lacking capacity to read and intervene in a pluralistic society. Adaptations are in these systems not only challenging the logic of the health system, but the general model of welfare provision. They are highly controversial. We call this case “socialist selectivity” indicating an egalitarian orientation regarding the population in a highly selective framework of access to health.

This rather simple first typology – combining structure and referential¹¹ – permits nevertheless to understand why the measures taken in the different countries to act in the field of migration and health are so different. In the following paragraphs, we want to concretize this model through the short presentation of our analyzed countries.¹²

Liberal universalism

United Kingdom. 4.2% of the UK population in 2000 was considered as foreigner. The majority are ex-colonials and labour migrants from Pakistan, Somalia, India and Nigeria. The National Health Service (NHS) employ 1.3 million people, 40% of them have a black and minority communities’ background.

The National Health Service is financed at 80% by taxes. In this universalistic health care system, all people are entitled to basic health care services. The access to general practitioners is free for people living in the UK for at least one year and who applied on the list of patients (this is the case also for undocumented migrants). For the prescription, 9 euros are in charge of the patient independently of his or her financial situation. Nevertheless, since the neo-conservative political change, contracting-out models (for wealthy people) have been established, permitting to chose private insurance schemes completing the universal basic health care services with private providers.¹³

Undocumented migrants have no rights to be insured, but the National health service (NHS), as well as the service for general practitioners, are

¹¹ From the analysis of welfare State’s point of view, we have simply tried to combine a structural logic à la Flora or Ferrera (Flora 1985; Ferrera 1996) with a political process analysis à la Esping-Andersen. See conceptually also Cattacin 1996b.

¹² Presenting the countries and to facilitate the reading, we will not cite systematically the documents used. They are in the bibliography organized by countries.

¹³ In 1998, 11% of the population was covered by a private supplementary health care insurance (Robinson and Dixon 1999).

accessible for undocumented migrants (free of charge)¹⁴. Before April 2004 they had also a free access to specialists, which is no more the case. However some treatments are free for everybody (emergencies, some mental disease, STI but not HIV). Pregnancy and HIV treatment (except the test) are not taken into care free for undocumented migrants.

Compared to other countries UK propose an extended humanitarian protection for a maximum of three years if the person risks to be killed or tortured in his or her country of origin; as well as a discretionary authorisation for acute medical troubles in exceptional cases for three years, which can be renewed. After 6 years, it is possible to ask for a permanent permit of stay. It is interesting to notice that seropositive people cannot get this authorisation.

The main actor in the field of migration and health is the Department of Equality and Human rights situated in the Department of Health. It has a long history: it started as a “women and equality” unit supervising the employment polices in the sense of gender mainstreaming and the service provision in a logic of gender sensitiveness; then it enlarged its orientation to ethnic minorities and human rights. The main goal is to supervise employment strategies and representativeness of differences in the health service professions and difference sensitivity in the service delivery.

The work of this unit with migrants and ethnic communities started in the 1980s on employment issues. First of all gender issues were addressed, because women were underrepresented in several positions of health services (only 25% of the executive directors were women and today they are 43%). The claim for ethnic recognition started from black and other minority groups.

The first actions focused on the right to have systematic information about employees, which was implemented by data collection (monitoring) in order to deal with the situation in a systematic way. A policy was then developed that tried to tackle these issues by creating a commitment of people working in the NHS. The Department of Equality and Human Rights today produces guidelines (responsibilities for national and local level),

¹⁴ With the general practitioners, it depends on the individual doctor whether she or he takes someone on as his or her patient.

guides and helps for the 28 local authorities and coordinates them, monitors and publishes different information (disease, demographic, etc), develops an equality impact assessment on equality issues (age, gender, sexual orientation, race) and gives public health messages.

In 2000, a new legislation was decided with the new amendment “Race relation” that set up an Action plan. As a result, every service and organisation in the country that works in health has had to drop an Action plan that tells what they would do to tackle the discrimination and the inequalities. That is now a legal requirement but the local organisations can choose the way they want to implement it.

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

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

The new legislation will also empower Ministers to extend the list of public bodies that are covered by Act (as amended) and to impose specific duties to ensure compliance and better performance. The Act gives to the Commission for Racial Equality (CRE) power to enforce specific duties to promote race equality and to influence codes of practice to provide guidance to public authorities on how to fulfil their general and specific duties to promote race equality.

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

Liberal selectivity

Switzerland. The foreigners in Switzerland represent about 20% of the whole population. The majority comes from Europe with the former Yugoslavia, Italy, Spain and Portugal as principal origins. The access to the health system is guaranteed by the obligation to contract a private health insurance. In general, the insurance is open to all residents, asylum seekers included. But, in fact, there are different schemes and situations, going from a liberal position like in Geneva, permitting undocumented migrants to contract an insurance, to other parts of the country in which insurances can refuse undocumented migrants and in which a gate keeper model regulate the access to health for asylum seekers.

The first initiatives were taken in urban contexts trying to give better information to migrants. A approach of information, trying to explain the main elements of the HIV/Aids prevention strategy to the principal established communities, has been developed since the beginning of the 1990s on the national level. This program was transformed at the beginning of this century into a program with a larger view, still based on a pragmatic ground, that many health questions are related to migration and need a specific answer in terms of sensitivity of institutions and particular projects.

The program tries in particular to put forward decentralized initiatives and to create sensitivity in all health institutions for the topic of migration and health. A small unity at the Federal Office of Public Health has the function to stimulate initiatives and learning processes on this topic. The orientation is similar to that of subsidiarity in Germany. But, like in other policy domains, subsidiarity is interpreted as a more dynamic concept permitting the national level to activate civil society organisations, local and regional government to act in a coordinated way and to introduce new regulations. These activating state policies can be based on an innovative dynamic in the urban centres of Switzerland, in particular Geneva.

The Netherlands. 4.3% of the Dutch population were considered in 2003 as foreigners and 9.6% in 2002 was foreign-born (ex-colonials and labour migrants): at present, the largest ethnic minorities are those originating from Turkey, Surinam, Morocco, the Antilles and Aruba. Since the 1970s, the Dutch policy has been restrictive on admitting non-Western labour migrants, but during the 1990s the country was a major receiver of refugees.

Since the year 2000 there has been a sharp fall in immigration from this source.

The Netherlands have a fee based insurance system for health. Recently (January 2006), the Netherlands introduced an obligation for residents to be insured. For the poorest a possibility to get reimbursed exists, but it implies an administrative process of registration and means testing. Since then health care is structured according to the type of insurance (it means that some treatments are not covered by the basic health insurance any longer).

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

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

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

At the present time, the awareness that there are important problems in this area is fairly widespread. However, a small but highly active group of concerned professionals has been calling attention to the problems of service provision for migrants and ethnic minorities since the late 1970s. This movement is particularly active in the field of mental health. It is only

recently that these problems have begun to receive *structural* attention in the form of education, research and policy changes.

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

But the opposition to cultural pluralisation has been increasing. In the Netherlands this started in the early 1990s, though it did not become a major political theme until the end of that decade: ‘9/11’ and the assassination of Pim Fortuyn in 2002 – and even more by the assassination of the film producer Van Gogh in 2005 – contributed to a hardening of public attitudes and a renunciation of multiculturalism by the government. On the health sector, this modification of the orientation has had as consequence a diminishing financing for projects in the field of migration and health, while structural established services were not touched by this political change.

Socialist universalism

Sweden. Sweden has 9 million inhabitants and more than 1 million persons were born in another country. 800.000 persons were born in Sweden with one or both parents from another country. Taken together, 20% of the Swedish population has what is called a “foreign background”. Until the 1930s Sweden was a country of emigration. Between 1945 and the 1950s refugees mainly came from Baltic and Nordic countries. In the 1950s and 1960s, a large-scale Nordic (Finland) and Non-Nordic labour migration,

mainly from Southern and South-eastern Europe (Yugoslavia, Greece, Turkey) came to Sweden. By the mid 1970s the labour migration ceased due to regulations. The 1960s and 1970s refugee immigration arrived mainly from Latin America (Chile), in the 1980s family reunion and refugees from Middle East (Iran, Iraq) and 1990s from former Yugoslavia were the most important migrant flows. Currently, only regulated refugee migration (asylum) and family reunion migration take place along with controlled labour migration. For non-EU citizens a work permit is requested before entrance. Since 1996, the amounts of asylum seekers have decreased. In 2005, 17.530 were applying for asylum (mainly Serbia and Montenegro, Ethiopia and Iraq). The same year 2838 people were granted asylum (13%) and in 2005, 1268 people according to the UNHCR Quota.

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

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

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

The first developments in the field of migration and health take place in the 1960s. Migrants were then identified as a welfare target group and officially acknowledged in an 'Inquiry of Immigrants' in 1968 in general socio-economic terms of "getting satisfying social and cultural services" and equal living conditions as the majority of the population and in terms of health care, education and social services. The responsibility was referred to the general authorities and institutions within the welfare system as explicitly opposed to special provision. This process can be understood as a result of a trade union movement standpoint – the Marshallian perspective – since the mid 1950s against the guest worker model as a political strategy.

In 1975, a new Immigrant Policy was stated, based on the former one and expressing a 'multicultural' strategy regarding immigrants and minorities. Focus was equality in terms of access to cultural goods (language, education, culture) aiming at maintaining language and cultural identity, but with the final goal of inclusion of differences in the overall society. Issues on health were not explicitly addressed but were implied in general welfare solutions.

Socialist selectivity

Austria. 8.9% of the Austrian population in 2001 were considered as foreigners. The main countries of origin were Turkey and the former Yugoslavia, with a continuous increase of migration from Eastern Europe and Africa. The health system organizes the inclusion by a categorical system, linking the social security to a residence and a work contract (Bismarckian system). The resident population is at 98% covered by health insurance. The remaining 2% are undocumented migrants. Labour migrants and Asylum seekers have full access to health care. The undocumented migrants have not a guaranteed access to free health. They still can be private patients but the costs are high. Some non-profit organisations try to meet their needs or to intervene when a bill cannot be paid, either to get it cancelled or to get it reduced. Health care professionals have no duties to report undocumented migrants to the authorities.

There is not any specific office responsible for migration and health issues (only the Ministry of the Interior). The Ministry of Health does not have this task even though some initiatives (researches, working groups) were financed by it. The general organisational orientation is in fact

subsidiarity; initiatives have to be taken in a bottom up logic. That clarifies why the main interventions are provided by civil society organisations and only on the local level.

This lack of responsibility on the national level explains why it is in particular the local level that reacts with pragmatic initiatives to migration and health problems. In urban areas where there is a history of how to deal with diversity, some specific services have been created. A first pilot project was developed in Vienna in 1994 concerning community interpreters in hospitals and in social services paid by the city, while on the national level we have to wait until 2005 for a more symbolic act, i.e. the creation of a working group of experts by the Ministry of Health, which aims at analysing the main problems and deficits in medical treatments for migrants. The focus of this commission is on three aspects:

- a) medical services within hospitals,
- b) medical services outside the hospitals (general practitioners),
- c) medical services in psychosocial services (mental health).

The result of the commissions work is a recently published report, "*Interkulturelle Kompetenz in Gesundheitswesen*", which gives information of what should be done, but without neither indicating who has to do it, nor the resources that should be allocated for these initiatives. The answer to migration and health in this categorical system continues to be blind concerning differences, which are not associated to traditional categories of organization. Undocumented migrants are the excluded category; the other migrant groups are included following their status, but not specifically recognized as migrants with their own lifeworlds and their own needs.

Germany. 8.9% of the German population in 2001 was considered as foreigner. The main countries of origins are Turkey, EU countries, ex-Yugoslavia, Poland and the Russian federation. Before 2000: citizenship was based primarily on German ancestry (exception: naturalised citizens). - 2000: new naturalization policy (automatic citizenship for migrant children who are born to 5 year residents in Germany), so the statistics based on the previous categorisation are no longer comparable.

96% of the population are associated to work or status (a categorical system) in the health insurance scheme. Germany differentiate in health care system between asylum seekers and citizens: asylum seekers have a similar access to health care compared to other citizens after 36 months of residence in the country. Meanwhile they can only be taken care of in case of acute

illness or pain.

Undocumented migrants can in theory get private insurance, but since they have to show a passport they do not use this right. They have access to health care in case of emergency but in practice, this right is difficult to fulfil since public officials have a duty to report any information they obtain on undocumented migrants during their duty to the Foreigners' Office. There is no access to a provisional permit of stay in case of acute illness either.

It is difficult to evaluate a starting point of German policies in the field of migration and health, because there is no national policy or initiatives yet; there are several local initiatives which started in the late 1980s by communities or local institutions, but at the national level the position was always the same: As migrants could be insured, it was supposed to be enough. Outcomes were not studied. The focus was on the reunification of Germany. For the other problems, Germany referred to subsidiarity. Bottom up initiatives have to solve them. The initiatives have to come from the communities and a national policy is not asked until a systematic failure of these initiatives is recognized.

So it is not surprising that the topic of migration and health is taken up by some local activities (for instance, the *ethnomedizinische Zentrum Hanover* since the late 1980s; the project for migrant women in Berlin paid by the local state; community interpreters service in Berlin financed by the European Union and the state of Berlin for six years; some initiatives from immigrant groups like the *Deutsch Türkische Stiftung*), but also from the regions (*Länder*) since 2000. Some regions have in fact developed "integration" concepts as a consequence of the new law on integration, which sometimes include the question of health, but not real measures (asylum seekers and undocumented migrants are not included in these concepts).

At the national level, it is only in 1995, that an unofficial working group was created, composed by people concerned by the topic (experts or representative). The working group is situated in the office of the Federal government commissioner for migration and refugee affairs. Being unofficial it gave the impression to be freer. The experts are not paid, only the person who coordinates the group is paid. The group is working on ways to opening institutions to the needs of migrants (the main activities are meetings, conferences, some researches and publications). Migrant health is

still not on the political agenda and migration is seen more from the point of view of problems related to criminality. The knowledge about health issues is weak.

France. 5.6% of the French population in 1999 were considered as foreigners. The main countries of origin were Portugal, Morocco, Algeria, with an increase of people coming from West Africa. The social security for all regular residents covers 70% of the population. As an originary categorical system, the employed people get access to insurances ("*mutuelle*") in order to be covered in the case of sickness. Today, this system has also integrated universalistic elements. Unemployed people enter in an insurance scheme through a complementary financing (the "*couverture médicale universelle complémentaire – CMU*", which covers 30% of the costs of the regular insurance scheme). Asylum seekers can get the CMU as soon as they apply for asylum.

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

The Direction of the population and migrations is responsible for the development of a strategy in the field of migration and health, able to enhance the interface around health questions with the General department of public health and the Department of public liberties and judiciary affairs (Ministry of the Interior). Some initiatives of outreach work are taken also on the regional level ("*département*"), but in a logic of acting in the field of marginalized people.

In contrast to the selective model of Austria, France has taken the question of migration and health more seriously, following a policy of inclusion in the general schemes of the health systems (through subsidizing insurance fees or through the minimal guaranteed health services). The working group created by the Ministry of health in 1993 formulated for instance an action plan, which was partially implemented. On the legal level and based on the recommendation of the working group, the policy of admission and stay took in fact for the first time only in 1998 into account the question of health with the possibility to get a provisional permit of stay

and work for people with an acute illness and without the possibility to be cared in their home country. This “republican” model chooses the blindness towards difference as strategy of inclusion. As we shall see later one, difference will be imposed with the HIV/Aids epidemic.

Intermediary conclusions

The description of the first measures and the systemic logics of the different analysed countries reveal that choices have to be analysed as embedded in a society’s history and contemporary situation. There seems to be no model case, each case has its strengths and weaknesses. The analysis says nothing else. This is the first point to show. The second argument relies to the fact that in a differentiated world, importing and diffusing experiences from one to another country could be possible, when similar paths exist. But this is the exception. In other words, we have to be cautious to introduce a simplistic learning perspective and put forward the idea that each measure can be understood, but an application in another context has to be done very carefully and with the knowledge, that it has to be compatible with the dimensions characterizing a concrete system (as Badie 1987 advises). We will return at this point in the end of the text.

In the following chapter, we shall increase the analytical complexity by trying to understand how the different countries have changed their policy in the field of migration and health and what the specific challenges of each one of these countries really are.

2. Changes and trends

The first decisions are structuring, as Rokkan said (1970). They always have somehow an implication in the future development. Social and structural changes are related and structures fight against change by compromising themselves when they are confronted to new ways of life, new hegemonies, new movements (Cattacin et al. 1997). Only through compromises (new structurations, like Giddens says; Giddens 1984), systems can endure. As we have described it earlier, health systems of the different countries decide how to act with a double orientation on the tradition of the system (the path dependency) and following their hegemonic values (concerning the inclusion of differences). It means that different

types of structure (in this case health structures divided into tax based universalistic systems or categorical insurances based systems) and values (in this case values regarding diversity which we divided into communitarian or republican values) can encounter the same type of development and challenges. This type of change is in a certain way a historical hazard that has to be faced by the state. But the way, the state will face it, is determined by its structural and political embeddedness.

In this sense change is related to challenges. We have identified in the different countries such – historically contingent – key moments, which determine the adjustments of health systems to a higher awareness of migrant or ethnic specificities. We can distinguish:

- The Aids Crisis and the necessity to develop projects for migrants and ethnic communities since the 1980s (France, Switzerland);
- the pressure on the local level – in cities – to act in a context of increasing and differentiated migration since the 1980s (Austria, Germany and Netherlands);
- the organisational challenge to pluralism, after the cultural revolution of 1968 movement and the related discourse on “multiculturalism” and gender equality since the 1970s (Sweden, United Kingdom).

These three motors of change are situated on different levels and imply other adaptations. If HIV/Aids creates specific programs as answer, the local (and communitarian) dynamics parallel systems and the equality/pluralism discourse institutional change the general system is affected in different ways and the institutionalisation of difference sensitivity follows other paths.

We can in fact distinguish the Aids path, going from a specific initiative to the generalization of instruments. The challenge is linked to the question as to how to convince the health system that the particular problem is not unique, but relevant for all the system. We can call this way “disenclosure of migration and health”.

The second way of generalization is characterised by a bottom-up logic. This logic appears typically when urban contexts have to face virulent social problems (like a large concentration of undocumented migrants). In these realities, the main challenge is to organize the diffusion of the practices at the local level in order to avoid attracting effects (pull factors) and to mobilize parallel financing. It means to implicate the state in the organisation (in order to get an overview, to standardise, to professionalize

and to assure the sustainability of the actions). We call this way the “diffusion of migration and health”, implicating also the multi-level organisation of the health system.

The third way is oriented to difference as normality. But the model of difference is based on the hypothesis that difference has to be reduced by equality policies (Marshall’s argument; Marshall 1965). Only the crisis of the multicultural model and the gender claim for equality open this model from dealing differences through uniformity to pluralism. The challenge is to create equality not in creating uniform ways of response regarding differences (a dedifferentiation of diversity), but to differentiate inside a framework of equity (to be understood as a model of equal chances to access to a better position in the society).¹⁵ We call this path the “specification of migration and health”.

These paths can be understood analytically as sectorial referential and are, like the general referential, influencing the policy results and the room for manoeuvre. If the general and the sectorial referential go in the same direction the consequence is the reinforcing of a political choice¹⁶. This conceptual framework leads to put in the centre of the analysis these coordinating elements and the reconstruction of the sense of a concrete policy (Faure et al. 1995). It is important to highlight that the referential is not structurally defined but depends on political choices. Indeed the referential is the result of a fight for a (hegemonic) interpretation of a policy orientation, which permits to change and to adapt policies (Majone 1989).

In the next paragraphs, we shall try to describe this game of sense coordination for the different analysed countries.

¹⁵ In a certain sense, we claim that difference and equality oriented systems like Marshall described has and (are on the way) to be transformed in difference and equity oriented systems like Sen figure out (Sen 1992).

¹⁶ Like Döhler 1991 demonstrates in her analysis of the influence of the neo-conservative change on health policies. Theoretically: Majone 2002.

Disenclosure of migration and health

France. The first measures specifying migration as a target group were taken during the HIV/Aids epidemic, because of the publication of epidemiological data showing a gap between migrants and autochthones and the mobilisation of migrants advocacy associations asking for specific measures for migrants to prevent the expulsion of ill one. Measures were in a certain way the result of a parallel bottom up and top down strategy, which was quickly coordinated. But in fact, this partnership of advocacy association (today this network is called “*observatoire du droit à la santé des étrangers*”) and state institution is primarily based on the development of a legal framework instead of a health strategy.

Only later, HIV/Aids was addressed in a prevention logic, following the publication in 1999 of alarming epidemiological data which were asked by civil society organizations. But only in 2004, the program on HIV integrated a special focus on migrants¹⁷ (which is unique and does not exist for other diseases). Three million euros per year were set aside for HIV and migration, corresponding to 3.2% of the budget for HIV in 2003 (it is the sole specific budget regarding Migration and health).

The program opens the door for other initiatives like the publication of a guide for the psychiatric care of migrants addressed to health professionals (in 2004) and the recently published guide on the French health system translated in 25 languages with broad information on the structure of health care, and about diseases and their prevention, as well as legal information about the permit to stay. Concerning services, there are only a few specific services for migrants lead by the state, such as the first medical visit at the entrance and some exceptions like mental health service.

A typical spill over of the HIV/Aids policy is also the interpreting services. Since 1995, there are trainings for community interpreters (organized by an association by phone or face-to-face) and paid by the state. Since 2001, 400 interpreters are active, but paid only for HIV consultations and in order to make advertising for such services in hospitals. But there is

¹⁷ With specific messages of prevention for North and West Africans adapted culturally and in their languages.

no real policy or initiative to pay such services on a larger basis. Each hospital can choose to propose such a service or not.

In the last years, the migration policy is more restrictive and a wider development has become difficult. There is a critic concerning the risk of stigmatisation, indicating the difficulty in France to make particular groups visible.

Switzerland. Switzerland is an example of a successful disclosure strategy. Coming from the HIV/Aids field, the topic of migration and health was enlarged first to other health questions (drug abuse for instance), then to a more structural view (opening of institutions) and finally to a general approach to differences including also a gender perspective. The diffusion of the topic was possible because the policy was systematically evaluated and consequently politically legitimated on a knowledge-based judgment. The strategy to link the many actors in this field through a concrete unity in the Federal office of public health receiving a coordination mandate and seed-money to finance initiatives has permitted the continuous enlargement of the intervention field. Today's main challenge is the structural establishment of this intervention field, which is always project and not structurally based and relatively fragile, despite the important dynamic it creates.

Diffusion of migration and health

Austria. Nowadays the ministry of health (*Bundesministerium für Gesundheit und Frauen*) is assessing and collecting, through a working group of experts, what are the specific initiatives in the field Migration and health. The idea is then: 1) to create a data base to inform migrants about specific offers and general services; 2) to improve health access and health care. The outcome of the working group concerns four priority areas of intervention, which are: 1) Communication: information about the specific services and language barriers; 2) awareness and sensitivity in hospitals to cultural diversity; 3) diabetes and 4) reproductive health. Within these fields, no target group among the migrants is defined from the legal status point of view. The paradox situation in Austria is related to the fact that information exists about what should be done (priority, main obstacles and how to deal with these obstacles) and how to do (for example the knowledge on how hospitals can integrate interpreters in their routines). But

currently, there is no initiative going further than information spread by the nation-state and civil society organizations. Communal initiatives fill the gap as well as they can. These initiatives are not interconnected so they cannot develop synergies and remain isolated. The problem of sustainability of the projects is also real, because they are linked to the involvement and to the goodwill of somebody. The challenge is not to reinvent the wheel all the time, to stabilize the initiatives and to change the political referential in the sector, introducing migration and health as a relevant field of action. Migrant health is still not on the political agenda and the relevance of the topic has not yet been seen.¹⁸

Germany. Like Austria, Germany has no policy in this field. The unofficial working group at the national level tries to heighten public awareness through information and publications about the topic. The current aim of the working group is to publish a book with good examples of projects and guidelines about what it is necessary to do for the migrants. There are now more than 70 local initiatives and the main challenge will be to evaluate these initiatives and to spread the information about their practices in the country. Subsidiarity as a logic nevertheless keeps the nation-state financing limited. The state confines the field of migration and health to the civil society and the lower levels of the federalist government.

The Netherlands. According to a study (see Foets 2004), which aimed at making an inventory of the intercultural interventions in Dutch healthcare (between 1995 and 2002), 130 initiatives have been identified. A minority, only 10%, has a permanent character. Only one quarter of the projects have been evaluated. Most interventions concern immigrants who came as a consequence of labour recruitment or decolonisation. The authors of this study noted that several organisations are developing very similar interventions, apparently without consultation. They concluded that the temporary character of many interventions in combination with the lack of evaluation implies that conclusions on the effectiveness of these interventions are difficult to make. As a consequence, the process of intercultural adaptation in the Netherlands can be considered as lacking engagement.

¹⁸ Migration and health is even less on the political agenda since the political change of the government (from left wing to right wing).

As a result of this restrictive policy, the budget for migration and health is nowadays very low: 150'000 euros per year (for dissemination and monitoring, which covers only one 40% occupation at the Ministry of Health)¹⁹. Since the change of policy, many projects are not financed anymore and have been stopped. The following activities are still being financed: some researches, monitoring, dissemination of information, network of peer educators (training paid by the state and activity paid on the local level).

Nowadays the Dutch state has two main activities in the field of migration and health: On the one side, clarifying through epidemiological data the health status of migrants (see Ingleby 2005); on the other side, the dissemination of information in the migrant community. A part of this informational strategy is the service of interpreters: anyone can use these services in the health care for free. This service works by telephone or face to face (for important problems) and exists since 20 years (it was created before the law on informed consent between doctors and patients, but that law gave it a legal basis). Information means also that some campaigns on the national level are being translated. But most of the projects that are translated are situated on the local level (migrant radio and TV channels).

If we summarize the current challenge in the Netherlands, we get a contrasting picture. In fact, few European countries can match this level of systematic attention to problems of migrant health, but there is currently a danger of seeing these initiatives stagnating. The 'Culture and Health' programme and the Action Plan both ended in 2004 and the present government has taken distance from the active policy on "interculturalisation", i.e. a policy of difference mainstreaming, announced by the previous Minister of Health in 2000. There are two reasons behind this decision:

a) "Interculturalisation" conflicts with the government's new approach to integration, in which the focus is placed on migrants to adapt to the host society and not vice versa;

¹⁹ Besides 8 millions euros are planned for interpreting services.

b) the central government's involvement is incompatible with the reduced role that the current administration envisages for itself in the health care, in which the responsibility for the quality and accessibility of care devolves on to service providers and individual consumers.

Specification of migration and health

Sweden. Due to the current Integration policies there is a divided responsibility officially interpreted as a non-stigmatising approach to migrants. The Ministry of Health and Social Affairs (*Socialdepartementet*) is responsible for the developments in health care. The National Board of Health and Welfare (*Socialstyrelsen, SoS*) is the government's central advisory and supervisory agency (follow up, evaluate, guidelines) in general and what they call immigrant and refugee issues.

SoS has an Epidemiological Centre. It focuses on vulnerable groups, including explicitly migrants, in terms of health, housing, segregation and integration. Analysis based on register data also implies the societal impact and efforts of institutions. The Public Health Institute (FHI) is also monitoring and evaluating the national public health policy and the current eleven goals for public health of which many have been bearing on diversity and integration (such as participation and influence, economical safety and equality, safe condition to grow up in).

Contrasting these state initiatives, we also find bottom-up movements in Sweden. Whereas health care has been more of a top down process, parallel to active professionals and researchers, elderly care was put at the agenda in late 1970s and 1980s by migrant organisations and researchers and health for undocumented by advocacy groups in the last years. There are so called "secret clinics" (more or less informal networks of medical doctors) targeted on undocumented migrants and rejected asylum seekers launched by health professionals and non-profit based (free of charge) in the three main cities²⁰. According to experts within the networks, there are no activities in other parts of the country, partly due to the fact that undocumented migrants are

²⁰ In Stockholm since 1995, in Gothenburg since 1998 and in Malmö since 2004, developed from a more loosely coupled network to a more stable organisation in term of a clinic.

mostly in the cities. This kind of network also operates in Stockholm, run by the Red Cross. The Red Cross is now trying to form a national network for all underground networks.

In the current Integration policy from 1998, the ‘multicultural’ strategy was revised due to critical reports on stigmatizing effects and regarding many aspects such as housing, education and health care situation for migrants and thus a failure. The new policy strengthened explicitly an inclusive approach in welfare issues. We find for example the right to ask for interpreters (including deaf) in contact with authorities and societal institutions regulated by the law of administration.

Furthermore, the new policy states that cultural and ethnic diversity should be mirrored in different societal arenas such as care. According to this policy, the universalistic oriented mainstream institutions should have competence to encounter particular needs, as opposed to particularistic approaches and rhetorically changed the term of ‘immigrant policy’ to ‘integration policy’ as a marker of the general political significance. The universalistic approach implies the focusing on needs as opposed to immigrant hood. Needs due to migration are only targeted the first two years. In the debate, the tendency has been to develop a way from a minority oriented towards a more ‘civic assimilationistic’ strategy.

In this logic, the Board of Integration and Board of Migration launched in 2004 a National Agreement on Health promotion for new migrants (asylum-seekers, refugees and other newcomers) with the point of departure that health is a determinant for successful introduction (2 years). The partners are, among others, the Swedish Migration Board, the National Board of Health and Welfare, the Public Health Institute, the Institute for Psychosocial Medicine²¹, *Karolinska institutet*, the Swedish Association of

²¹ The National Swedish Institute for Psychosocial Medicine (IPM) conducts multidisciplinary and longitudinal research on *Migration and Health* and coordinates researchers’ networks in cooperation with Karolinska institutet since 1993. IPM is an independent governmental institute founded in 1981 by the Swedish Government and Parliament. The Institute reports directly to the Swedish Ministry of Social Affairs and aims at developing, evaluating and disseminating knowledge about psychosocial risk situations, risk groups and risk reactions and ‘success factors’. IPM specially emphasizes the psychosocial consequences of

Local Authorities, the National Agency for School Improvement and the National Agency for Education.

The Public Health Institute is carrying out a study on “Discrimination and Health” (2004-6), since discrimination is recognised as a health determinant²² but there is a lack of indicators and measure. It is also not clear how common is the practice of discrimination based on ethnicity, “race”, religion, sexuality, gender or handicap. The first report was published 2005 and showed correlations between experienced discrimination and indicators on health and identified need of research.

The current challenges that Sweden faces are identified by the state and by civil society organisations. The authorities underline the growing social stratification of health in term of gender, class and ethnicity. Concerning migration, they want to face the work-related unhealthy conditions common in migrant groups and to manage elder care for migrants, but also to find a strategy to manage care seeking behaviour of migrants, seen as too cost intensive.

Civil society groups – and some academics – see other challenges. There is an ongoing evaluation conducted by UN Special Rapporteur on the right to the highest attainable standard of health, Paul Hunt. His report will be published in the spring 2007 and submitted to the United Nations Commission on Human Rights. He published a preliminary reflection in which he is strongly critical especially about the fact that Swedish law and practice regarding the health services available to asylum seekers and undocumented people do not match the international human rights law. Furthermore, that there is a weak domestic understanding of the right to health. The report will also recommend that Sweden’s record for collecting good quality health data has to be further enhanced by more systematically collecting data that are disaggregated on grounds such as gender, socio-economical status, and ethnicity. This critical observation implies that

stress (including posts-traumatic stress) and unemployment. The activities include applied research in addition to education and training, consulting, documentation and information and have also a clinical approach.

²² The law against Discrimination was sharpened in year 2003 and health care and social service institutions were included in the formulations. Since then there have been 79 reports regarding health care to the Ombudsman.

monitoring is underdeveloped in terms of ethnicity, a point also made by researchers as a major challenge.

Critics also concern the “institutional racism” and the lack of reflexivity among staff. Activists underline that the universalistic oriented care and services can function in an exclusionary way.

United Kingdom. The strategy of the UK was to mainstream differences through systematic equity policies concerning not only the access to health but also the employment policies. It is certainly a successful policy in the field of migration and health. Law changes, clear policy orientations, differentiated epidemiological data and classifications for monitoring, systematic and professional organisation of activities, synergetic collaboration with local authorities and with other departments (employment, education) are effective signs of success. But also the continuously increasing number of women, black and minority communities in executive director positions and the reduced barriers to health care access are positively monitored.

It is nevertheless difficult to judge the effect on health state because it is only possible to measure the direct impact of the measures and there is still a wider gap in health inequalities. Life styles and demography have changed which had widened the health inequalities even though a good job had been done. Challenges do exist and they seem to concern especially the implementation level, as it was pointed out by our interview partners who underline that many services are not prepared to change their shape and embed that the diversity is part of the mainstream, of the daily way of thinking.

Main challenges

The challenges depend on what has been already done. In Austria and Germany, the interviewed people (both from authorities and research) agreed to say that a lot remains to do because of the lack of policy and because the migrants’ health is not on the political agenda. These countries have to highlight the importance of this topic in order to get money.

Switzerland and the United Kingdom are on the opposite side. In the UK, as there is a policy and law obliging the structures to tackle discrimination, the main challenge seen by the interviewed people is to implement the law.

Some structures are usually reluctant to change and the risk is that they promote alibi measures. In Switzerland, the major problem consists in the development of the program on migration and health as a timely limited project within the administration, without a real change concerning the structural founding of laws against discriminations.

In France, the interviewed researchers and authorities agree to say that the main challenge will be to widen the intervention in the field of migration and health from the HIV/Aids topics to other topics. We see that this country began very recently to show specific groups of migrants (North and West Africans) in the health campaign, but the tendency is still to hide the migrants’ issue treating this part of the society as if they were potentially in the same situation as the French population.

The biggest discrepancy among the interviewed people about the challenges has been found in the Netherlands and Sweden. In the Netherlands this can probably be explained by the recent change in the policy, which became more restrictive and the cut of the budget in the field of migration and health. In Sweden it is rather the lack of awareness of migration issues and the assimilationist approach of the authority that stops further changes.

3. Health and migration: the dynamics of a policy development

The analysis indicates that the existence of difference sensitivity in a universalistic system and the development of a policy based on the “fact of pluralism” (Rawls 1993) – the difference sensitivity as a result of an equity oriented modernization – are fertile conditions for introducing measures in the field of “health and migration”, like the case of the UK has pointed out. It’s nevertheless a risky model because it is based on the assumption that ideas can be implemented only hierarchically (top down). In this case the risk is a boycott of the decision from decentralised administration. The inclusion of difference as a solution for the disenclousure of communities is also controversial. The openness of the universalistic systems is certainly a good basis against discriminations, but forgets in fact the high dynamic of migration and ethnic communitarisation processes. The (Marshallian) static view of society interpreted as a continuous inclusion towards a middle class society of all disadvantaged groups, contrasts with the normality of an extreme mobile society, less distinct by class than by lifeworlds. Concretely

that means that the measures of inclusion on the one hand should be promoted as soon as migrants enter the host country. On the other hand they should be more flexible as the migrants' stay in the host country might be short term.

Switzerland is also a clearly intricate case, but structurally advantaged regarding the introduction of difference sensitivity. Communitarian solutions are accepted and based on the idea of empowerment and promoting self-help (Fibbi and Cattacin 2002). Because the culture influences behaviours, policies have to be close to the communities and their reproductive logic. The introduction of equity in the health system is in this context easier because a communitarian difference orientation already exists. The problem in this country is, as we have described it earlier, to accept policy changes permitting to introduce a general orientation (and legal basis) putting forward the idea of equity and non-discrimination. The main disadvantage of the communitarian model is the limited institutionalization of policy choices. Like the struggle for equal rights for women indicated, the system adapts only slowly from the legislative point of view and subsidiary solutions, which are fragile and based on weak legal instruments are privileged (Cattacin and Vitali 1997). The solution path in Switzerland is the sectoralization of policies (for each question a specific policy), which hinders systematically the introduction of similar policy orientations in other fields (Bütschi and Cattacin 1994) and prevent the horizontal diffusion of innovation (Cattacin 1996a).

This short discussion indicates already that the search for an ideal model in the field of health and migration cannot be done out of one concrete reality, but has to cope with different histories and values.

A “new model”, if we nevertheless want to try to describe it, would be necessarily based on a combination of the UK and the Swiss experiences. It has certainly to stress what we can call “difference sensitivity”,²³ introducing a systematic – structural – empathy for differences in systems

²³ Or at least “migration mainstreaming”.

(like described in the Migrant Friendly Hospitals-project²⁴). This means adapting the health system from the management (including difference sensitivity in the decision making through the incorporation of “advocacy”-positions) to the quality control, giving power to differences and through this, changing from a paternalistic inclusion to an active participation and an autonomy in project development. This means also to normalise difference sensitivity in the training of health care providers – and migrants, to introduce “transnationalism” in organisations with a concrete employment policy based on the analysis of the social and human capital of candidates. In this concern, we can learn from the gender mainstreaming measures; we would even say that we have to radicalize this approach with its transformation into a more open logic of difference mainstreaming. This is the strength of the universalistic model.

But the new model of “difference sensitivity” has also to work in a multidimensional way against exclusion tendencies, without privileging only the universalistic approach, at the risk of forgetting differences, migrant dynamics and communitarian acceptance of the chosen inclusion tactic. This relativization of universalism can be done by introducing elements of pragmatism, judging useful to have partial rights for instance for the undocumented migrants. Pragmatism also means putting forward group and situation related projects, based on the idea that only a specific adaptation of a measure permits to get in contact with a complex reality.

Migration and ethnic difference are normal in Europe. We have arrived at the end of the assimilative policy model, but also of that of the communitarian policy model; we hope that our study will indicate new ways to consider pragmatically the combination of measures in a logic of multidimensional change of the health system.

Lessons for Switzerland

In the analysed European Countries, there exist practices. Switzerland can learn from these practices, from failure and success story. But

²⁴ For detailed information about research instruments and outcomes see the final project report by Krajic et al. 2005 at <http://www.mfh-eu.net/public/home.htm>.

Switzerland has to find, as we have tried to demonstrate, a proper way to act in the field of migration and health. Importing such practices is simply impossible, because they have to find an own way to be settled in a history and in a model of welfare.

Nevertheless some indications are possible, and this on different levels:

On the *political level*, we noticed that the general reference system is relevant for the establishment of a policy in the field of migration and health. As Germany and Austria indicate, stabilising a policy field demands a strong political legitimacy on the national level. Otherwise, the fragility will preclude innovation and the diffusion of good practices. One time established, the orientation of the policy will be difficult to change completely, like the Netherlands indicate us. In this country, the decisions taken in the field of migration and health in the last years – after the populist drift of the general policy in the field of migration – have influenced only partially the development of concrete activities. Projects are no more subsidized, but structural decisions are established. The state still finances for instance with 8 million Euro interpreting services all around the country. In other words: political ideologies influences more the policy field at beginning of it's development, but less on time a policy field is established. The explanation of this statement lies in the fact of the structural conservatism of organisations, which can legitimize themselves through recognized procedures (Luhmann 1969).

The relation between the general framework in the health system and in the regulation of migration to the field of migration and health has not only an ideological, but also a territorial dimension. In countries with decentralised health systems, compatibility of orientations at different levels (local, regional and national levels) has the effect to reinforce each other orientation. This compatibility has to be constructed through voluntary policies of persuasion, of promotion of innovation and of coordination.

Switzerland acknowledged the necessity to convince highest political and administrative level of the usefulness of a strategy in the field of migration and health. Nevertheless the Swiss strategy is still facing many challenges. On one hand, Switzerland has to maintain this orientation in order to insure the sustainability of the actions in this field and the diffusion at the regional level. This national policy might only be reduced when the field is organisationally stabilized in the federalist system, i.e. on all regional levels. Otherwise, the field might have a development, but on a

fragile basis. As the compatibility between national and territorial level discussed above is not yet accomplished, the future Swiss strategy has, on the other hand, to manage to reinforce the follow up at the regional level.

On the *legal level*, decreeing a law includes four main advantages: it assures a long term policy, it legitimates and forces to propose measures, it standardizes actions and it punishes who circumvents the law. We can see from the French case (but also from Spain and Italy), that the provision of minimal health services for migrants solves problems related in particular to undocumented migrants. Health care organisations can easily include this perspective, if financing and legitimacy is guaranteed. These laws are sectorial and especially focused on the access level. France, for instance, has decreed a law guaranteeing a state health financial assistance for undocumented migrants. The Netherlands has established a law of informed consent between doctors and patients which gives legal basis for interpreting services. Even though these laws stabilize and legitimate specific initiatives for migrants as well as in certain way recognition of differences, this legitimacy is very limited and might create a stigmatization of “privileged” groups.

For established migrants and ethnic communities, there is a need for antidiscrimination laws, which are actively implemented. The UK does not differentiate its citizens, but in the same time takes into account their differences. This sensitivity to difference becomes possible through antidiscrimination laws. The obvious advantage of such a broad legal framework is on the one hand, the obligation to all organizations to promote antidiscrimination measures. On the other hand, this model decreases the risk to stigmatise a group.

In contrast, Austria and Germany lack of sensitivity to difference on the legal level. These two countries did not promote a law, which could legitimate initiatives in the field of migration and health creating a fragile legitimacy for initiatives in this field.

Switzerland can firstly learn from these cases that a legal basis against discrimination could open organisations to difference sensitivity. Secondly, Switzerland can deduce from the French case, that the access to basic services in health care organizations, like hospitals, has to find another financial basis than insurances, otherwise these organizations enter in a structural dilemma (between the objective to care only people who are insured and the objective to care everybody needs). For insurance based

systems, that could be reached for instance by a special fund for people outside the system.

On the *organisational level*, the success and failures of the seven countries studied give information about orientation of the strategy, way to finance initiatives in this field, and finally models of relation between national and regional levels facilitating the implementation of local policies and projects in this field. The examples of these countries show that these three aspects of the organisation (orientation towards difference and health policy, finance and relation between national and regional levels) are very often linked. In other words from the type of the health policy and difference orientation, one can assume the sort of financing and spreading out of the initiatives.

As Austria and Germany follow a categorical health policy and show difference blindness, the initiatives in the field of migration and health are based on projects that aim mostly at decreasing barrier of access. Without a national policy and without a specific budget in the field of migration and health, the financing of these initiatives is very precarious and sporadic. It comes more from the regional level, the EU, or from civil society organisations. In this case reducing the budget means to cut some projects. The case of the Netherlands shows that when the policy becomes more restrictive, the finance focuses on few specific projects (in this case interpreting service and diffusion of information both financed by the ministry of health) or like in France on one topic (HIV), which has as potential side effect to reinforce the stigmatisation of some migrants groups instead to promote equality of chance. As another limit of this kind of orientation, we can mention the difficulty of collaboration between national and regional level as well as the lack of learning process from each other experiences.

Sweden and the UK, with their universal health system are examples how a structural foundation can influence the organisational level. Sweden has implemented a citizen oriented policy without difference sensitivity. The idea is republican, in the sense that inclusion is possible through egalitarian policies. For resident migrants, the consequence is that they have only few services with specialised activities. For undocumented migrants, the system is simply closed. Initiatives are then more developed in parallel structures within the state health system and characterised by a lack of legitimacy. As many actors have a responsibility within their mainstream

activities, the financing regarding health and migration initiatives becomes invisible covered by the general expenditure.

This integrated financing can be useful if the universalistic system is difference oriented, like in the UK. Migration and health is not a budget line, but inserted in the general expenditure for adequate health services for all people living in the country. In contrast to Sweden, this policy allows to generalize the difference orientation on many dimensions, like gender, disabled people or migrants. In particular through employment strategies, the UK introduces inside the organisation (the National Health System) decisional and coordinating activities in which stakeholder differences are represented. The consequence on the services side is a strong legitimacy of the measures taken and – through the presence of difference between the employees – a high empathy between service givers and service takers. This kind of orientation represents besides an advantage in order to increase the collaboration between national and regional levels.

Switzerland has to learn from this universalistic approach, that beside specific projects, empowerment of people representing the pluralist society through cooptation in decisional bodies has consequences on the whole organisational dynamic. Only this inclusive strategy can change the actual, more paternalistic model of services for different people to a model of services coming from people representing differences. This orientation permits also to reduce stigmatising elements in the service delivery. From the financing point of view, Sweden and the UK indicate that integrated budgets allow to spread initiatives through the label of another group or in name of promotion of equity, adopting an universal orientation. Because regions or organisation which are less convinced to promote migration and health could do it through the label of another group or in name of the promotion of equity, this kind of orientation might allow to promote in Switzerland the dissemination of initiatives at the local level. In addition, integrated budgets blend out the specificity of some services for migrants. Costs are no more visible on one group but supported from the whole social welfare which decreases the risk of massive reduction of budget. Budget cuts are in other words supported by all services.

If Switzerland can still learn from other countries, its current developments in the field migration and health are also inspiring other countries that are less aware of this question. Furthermore its policy is confirmed by the recent recommendations of the Council of Europe. Nevertheless, the main challenge is related to the fragility of the legal foundation of the policy, which can easily politically be questioned.

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- Nazroo, James Y. (2001), *Ethnicity, class and health*. London: Policy Studies Institute.
- Richie J & al. (1981). *Access to primary health care*. London: HMSO.
- Robinson Ray & Dixon, A. (1999). *Health Care Systems in Transition: United Kingdom*. European Observatory on Health Care Systems.

Townsend P. & N. Davidson (1982) *Inequalities in Health (The Black Report)*. Harmondsworth: Penguin.

Appendix 1 – List of persons interviewed

	Austria
Karoline Kandel	Kaiser Franz Josef Spital
Claudia Habl	Österreichisches Bundesinstitut für Gesundheitswesen (ÖBIG)
Esra Kilaf	Municipal department for integration and diversity in Vienna
Robert Schloegel	Austrian Ministry of Health : Bundesministerium für Gesundheit und Frauen
Ursula Trummer	Institut für Interventionale Soziologie und Ludwig Boltzmann-Institut für Medizin- und Gesundheitssoziologie
	Germany
Theda Borde	Alice Salomon Fachhochschule Berlin
Jeffrey Buttler	Bezirksamt Mitte von Berlin Abteilung Gesundheit und Soziales
Dorothea Grieger	Plan- und Leitstelle für Gesundheit Bundesregierung für Migration, Flüchtlinge und Integration Arbeitskreis Migration und öffentliche Gesundheit c/o Beauftragte der Bundesregierung für Ausländerfragen
	France
Catherine Chardin	Direction générale de la santé
Felicia Heidenreich	Hôpital Avicennes, Service de Psychopathologie
Elhadji Mamadou M'Baye	Université Grenoble, Doctorant
Elodie Stanojevich	Institut national de prévention et d'éducation pour la santé
	The Netherlands
David Ingleby	University of Utrecht, Ercomer
Loes Singels	Ministry of Health
	Sweden
Danuta Biterman,	The Board of Health and Welfare, EpC

Sandra Dolietis	Redcross, Stockholm
Anita Doratzio	Humanitas
	United Kingdom
Hali Jan Haider	Director of Equality and Diversity, Bradford
Surinder Sharma	Department of Health, Director of Equality and Human Rights
	Europa
Nadège Drouot & Nathalie Simonnot	Médecin du Monde

Appendix 2 – List of documents

Austria

Documents

Amsterdam report für Ibi	2004
Gesundheitswesen in oesterreich	2005
Health care system in transition_EU	2001
Projektbericht MFH	2005
Quant und Qual Analyse der nicht Krankenversicherte	2003

Web side

Relevante Links Wien

<https://www.wien.gv.at/index/zuwanderer.htm>

<https://www.wien.gv.at/who/berichte/index.htm>

<https://www.wien.gv.at/who/downloads.htm>

<http://www.frauengesundheit-wien.at> (Frauengesundheitsbeauftragte der Stadt Wien, Fonds Soziales Wien, Wiener Programm für Frauengesundheit; ao. Univ.-Prof. Dr. Beate Wimmer-Puchinger, 1030 Wien, Guglgasse 7-9, Tel +431-4000 DW 66 771, beate.wimmer-puchinger@fsw.at)

Aktivitäten/Projektberichte des Bundesministeriums fuer Gesundheit

<http://www.bmgf.gv.at/cms/site/>

NGOs working in the field Migration/Health

ZEBRA is an independent, private and non-governmental organization offering counselling and care services to foreigners (migrants and refugees) in Styria since 1986 <http://www.zebra.or.at/> (English, French)

Autonomes Integrationszentrum MAIZ ist eine Organisation von und für Migrantinnen und entstand aus der Notwendigkeit von Veränderungen hinsichtlich der Lebens- und Arbeitssituation von Migrantinnen in Österreich und im Sinne einer Stärkung von politischer und kultureller Partizipation. <http://www.maiz.at/>

Verein OMEGA ist eine nichtstaatliche, politisch unabhängige und nicht auf Gewinn orientierte Organisation (Verein) mit Aktivitäten zu Betreuung von Flüchtlingen, Internationalen Projekten. <http://www.omega-graz.at/home.html>

Information, Rat und Hilfe

- MA 17 Abteilung für Integrations- und Diversitätsangelegenheiten Friedrich-Schmidt-Platz 3/ 3.Stock, 1080 Wien, Tel: 01-400081510, e-mail: post@m17.magwien.gv.at (keine Beratung)

- LEFÖ (Arbeitsmarktpolitische) Beratung, Bildung und Begleitung von Migrantinnen aus Lateinamerika Kettenbrückengasse 15/2/4, 1050 Wien, Tel: 01-5811881, e-mail: office@lefoe.at
- Miteinander lernen - Birlikte ögrenelim, Beratungs-, Bildungs- und Psychotherapiezentrum für Frauen, Kinder und Familien Koppstraße 38/8, 1160 Wien, Tel: 01-4931608, e-mail: mitein.lernen@nexta.at
- Orient Express Beratungs-, Bildungs- und Kulturinitiative Frauenservicestelle Hillerstraße 6/3-5, 1020 Wien, Tel: 01-7289725, e-mail: office@orientexpress-wien.com
Kurszentrum: Wehlstraße 178, 1020 Wien (Schwerpunkt: Frauen aus der Türkei und aus arabischen Ländern)
- Peregrina Bildungs-, Beratungs- und Therapiezentrum für Immigrantinnen Währinger Straße 59/6/1, 1090 Wien, Tel: 01-4083352 und 01-4086119, e-mail: beratung.peregrina@aon.at
- Verein Pyramidops Frauentreff für Migrantinnen Volkertplatz 1, 1020 Wien, Tel: 01-9425330, e-mail: pyramidops@chello.at
- Hotline für Jugendliche ohne Papiere Caritas der Erzdiözese Wien
Tel: 01-3109808 (Mo 10 - 12 Uhr + 13 - 17 Uhr, Di + Do + Fr 8 - 12 Uhr), e-mail: gabriele.sommer@caritas-wien.at
- Tangram Multikulturelles Netzwerk für Mädchen Neustiftgasse 89-91, 1070 Wien, Tel: 01-5248873, e-mail: office@tangram-mkn.at
- Interface Unterstützung für neu zugewanderte Kinder und Jugendliche (12 - 19 Jahre)
Kenyongasse 15, 1070 Wien, Tel: 01-5245015, e-mail: info@interface.or.at
- Caritas-Migrationszentrum (allgemeine Beratung) Lienfeldergasse 75 - 79, 1160 Wien, Tel: 01-3109808, e-mail: mig.zentrum@caritas-wien.at
- Kostenlose Beratung zu den Themen Ausländerbeschäftigung, Fremden- und Staatsbürgerschaftsrecht: Helping Hands Taubstummengasse 7-9/4, Stock, 1040 Wien, Tel: 01-3108880-10, e-mail: info@helphand.org
- Familienberatungsstelle
Wurmsergasse 36, 1150 Wien, Tel: 01-9857603
- Familienberatungsstelle - Außenstelle Integrationshaus Engerthstraße 161 - 163/3, 1020 Wien, Tel: 01-2169729
- Familienberatung für MigrantInnenfamilien Gerichtsgasse 6/Zi 178 (Gericht), 1210 Wien, Tel: 01-27770-249 (Di 9 - 12 Uhr)

- FIBEL Frauen-Initiative Bikulturelle Ehen und Lebensgemeinschaften Heinestraße 43/Gassenlokal, 1020 Wien, Tel: 01-2127664, e-mail: fibel@verein-fibel.at
- CBIF - Centrum für Binationale und Interkulturelle Paare und Familien Information, Beratung, Krisenintervention und Psychotherapie Märzstraße 43/2/11, 1150 Wien, Tel: 01-9820394 (Mi 16 - 18 Uhr), e-mail: cbif@utanet.at
- Afrikanische Frauen Organisation
afrikanisc.frauenorganisation@chello.at
Türkenstraße 3, 1090 Wien, Tel: 01-3192693, Montag 13 - 17 Uhr, Mittwoch 9 - 17 Uhr, Freitag nur nach Vereinbarung. Telefonische und persönliche Beratung und Begleitung in Deutsch, Türkisch, Arabisch und Englisch.
Gesundheit:
- AMBER Kostenlose medizinische Betreuung und Beratung Diakonie Österreich Große Neugasse 42, 1040 Wien, Tel: 01-5870656, e-mail: amber@diakonie.at
- Informationen über niedergelassene zweisprachige ÄrztInnen, Ärztekammer für Wien Servicestelle für ausländische PatientInnen Weihburggasse 10 - 12, 1010 Wien, Tel: 01-51501-1213, e-mail: rupperecht@aekwien.or.at
- Frauengesundheitszentrum F.E.M. Süd im Kaiser Franz Josef-Spital Kundratstraße 3, 1100 Wien, Tel: 01-60191-5201
- Gesundheits- und Sozialzentrum für den 1., 2. und 20. Bezirk Vorgartenstraße 129 - 143, 1020 Wien, Tel: 01-21106-02806, e-mail: gsz1.2.20@fsw.at
- Gesundheits- und Sozialzentrum für den 4., 5. und 10. Bezirk Gudrunstraße 145-149, 1100 Wien, Tel: 01-60534-10800, e-mail: gsz4.5.10@fsw.at
- Gesundheits- und Sozialzentrum für den 12., 13. und 23. Bezirk Arndtstraße 67, 1120 Wien, Tel: 01-81134-12800, e-mail: gsz12.13.23@fsw.at
- Gesundheits- und Sozialzentrum, Fonds Soziales Wien 6.,7.,14.,15.Bezirk - Beratung am Eck (speziell für SeniorInnen) Reindorfasse 22, 1150 Wien, Tel: 01-8913415850, e-mail: gsz6.7.14.15@fsw.at
- Beratungszeiten: Mo 9 - 12 Uhr + 13 - 15 Uhr (Muttersprachliche Beratung in Serbisch, Kroatisch, Bosnisch und Türkisch) Dr. Ursula Karl-Trummer Ludwig Boltzmann Institut für Medizin- und Gesundheitssoziologie am Institut fuer Soziologie der Universitaet Wien, WHO-Kooperationszentrum für Gesundheitsförderung in Krankenhaus und GesundheitswesenRooseveltplatz 2, 1090 Wien.

France

Documents

Politique française de lutte contre l'infection VIH 2000

BEH veille_sanitaire_inégalités	2005
Alexia SAVIGNONI, Florence LOT, Josiane PILLONEL, Anne LAPORTE (1999). Situation du sida dans la population étrangère domiciliée en France depuis le début de l'épidémie jusqu'en 1998. Paris : Institut de Veille Sanitaire	
CRISP sida	2006
La santé en France	2002
Prise en charge médico-psycho-sociale	2005
Programme VIH et Migrants	2004-2006
Programme VIH et Migrants	2005-2008

Web site

http://www.sante.gouv.fr/	(Ministère de la santé)
http://www.inpes.sante.fr/	(Institut national de prévention et d'éducation)
http://www.lecrips.net/reseau.htm	(Centre Régional d'Information et de Prévention du Sida)
http://www.invs.sante.fr/	(Institution national de veille sanitaire)
http://www.inserm.fr/fr/	(Institut national de la santé et de la recherche médicale)
http://www.gisti.org/	(Groupe d'information et de soutien des immigrés)

Germany

Documents

Gesunde_Integration.Fachtagung	2003.
Gesundheitsbericht	1998
Handbuch zum interkulturellen Arbeit im Gesundheitsamt	2000
Health care systems in transition_EU doc résumé	2004.
Integration Bundesländer (Hessen, Mecklenburg, Niedersachsen, Schleswig-Holstein)	
Positionspapier des bundesweiten Arbeitskreises Migration und öffentliche Gesundheit	
Gesundheit	2005
Telsurvey	2004

Netherlands

Documents

Brief allochtonen gezondheid	2004
The new health insurance	2006

Web site

http://www.minvws.nl/en/	(Ministry of health, welfare and sport)
<u>National Institute of Public Health and the Environment (RIVM)</u>	

Sweden

Documents (legislation)

Law on Anti Discrimination	(2003:397)
Law on Health Care	(1982:763)
Law on Dental Care	(1985:125)

Web sites Governmental level

http://www.sos.se	The National Board of Health and Welfare
http://www.fhi.se	The Public Health Institute
http://www.migrationsverket.se	The Board of Migration
http://www.integrationsverket.se	The Board of Intergration
http://www.do.se	Discrimination Ombudsman

Websites Organisations and Institutes

http://www.redcross.se	Redcross
http://www.farr.se	Refugees groups and asylum committees' national council
http://www.enigma.se/hmr/	HMR - Swedish organisation for Health and Human Rights
http://www.psykosocialmedicin.se	National Swedish Institute for Psychosocial Medicine
http://www.arbetslivsinstitutet.se	The National Institute for Working Life
http://www.sll.se/w_tkc/59332.cs	Transcultural Centre
http://www.fmc.nu/	Refeggee Medical Centre in Rissne
http://www.lio.se/default.aspx?id=14302	Refeggee Medical Centre in Norrköping

Switzerland

Federal office of public health, migration and health:
<http://www.bag.admin.ch/themen/gesundheitspolitik/00394/00395/index.html>

United Kingdom

Documents

Race amendment 2000_Sarah_Corlett	2003
RACE EQUALITY SCHEME	2002-2005

RACE EQUALITY SCHEME 2005-2008
 Tackling Health Inequalities_Programme for Action 2003
 Tackling Health Inequalities_Status report on the programm for Action 2005.
 Adressing diversity_leadership challenge Kevin Barton 2003
 Entitlement Asylum seekers.
 Equality and diversity national strategy in health
 Equality priority for Action
 Ethnic inequalities in health James Nazroo 2003
 Ethnic_Health_Intelligence Report 2003
 Ethnicity and Health Report 2005
 Health survey_minority ethnic groups 2004
 Healthwatch 2005
 Infant mortality 2004
 Life expectancy 2004
 Providing health Intelligence for London Bobbie Jacobson 2003
 Action Point race equality

Web site

<http://www.dh.gov.uk/Home/fs/en> (Department of Health)
<http://www.statistics.gov.uk/> (National statistics)
<http://www.ic.nhs.uk/> (National and Social Care Information Center)

Europe

Documents

Health inequalities_a challenge for EU
 Health care in transition_EU 2004
 Carte santé 2004

Web site

<http://wikihost.org/wikis/euro/> (European Survey on Migration and Health initiated by IMISCOE-IOM – work in progress)
<http://www.health-inequalities.org/> (Information on the EU project)
<http://www.picum.org/> (Information on undocumented migrants)
<http://www.migrationinformation.org/> (Information about migrants' flows)
<http://epp.eurostat.cec.eu.int/> (Data)
<http://www.iser.essex.ac.uk/epag/dataset.php> (European European Panel Analysis Group (EPAG))
