

New times for migrants' health in Europe*

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ABSTRACT

Patterns of migration can change greatly over time, with the size and composition of migrant populations reflecting both, current and historical patterns of migration flows. The recent economic crisis has caused a decrease on migration flows towards the most affected areas, as well as cut offs in health interventions addressed to migrants.

The objective of this paper is to review available data about interventions on migrants' health in Europe, and to describe changes in migrant health policies across Europe after the economic crisis, that can have a negative effect in their health status.

Although migrants have the right to health care under legal settlements issued by the EU, there is no a standard European approach to offer health care to migrants, since; policies in each EU Member State are developed according to specific migrant experience, political climate, and attitudes towards migration.

Migrants use to face greater health problems and major health care access barriers, compared with their counterparts from the EU. Therefore, migrant health policies should focus in protects this vulnerable group, especially during economic hardship, taking into account economic and socio-demographic risk factors. There is an especial need for research in the cost-effectiveness of investing in the health care of the migrant population, demonstrating the benefit of such, even in the health of the European native population, and the need for constant intervention despite of resource constraints.

Keywords: Emigration and Immigration; Europe; Prisons; Communicable Diseases; Basic health services; Políticas Públicas de Salud; HIV; Tuberculosis.

NUEVOS TIEMPOS PARA LA SALUD DE EMIGRANTES EN EUROPA

RESUMEN

Los patrones de emigración pueden cambiar considerablemente con el paso del tiempo, y el tamaño y composición de la población de emigrantes pueden reflejar los patrones actuales e históricos de los flujos de emigración.

La reciente crisis económica ha provocado un decremento en flujos de emigración hacia las zonas más afectadas y reducciones en asistencia sanitaria para emigrantes. El objetivo de este estudio es revisar la información disponible sobre intervención sobre la salud de los emigrantes en Europa y describir los cambios en políticas de salud para los mismos en el continente después de la crisis económica que pueden repercutir de forma negativa en su estado de salud.

Aunque los emigrantes tienen el derecho de asistencia sanitaria bajo acuerdos legales emitidos por la UE, no existe una política común en Europa en cuanto a la provisión de asistencia sanitaria para emigrantes, ya que las políticas en cada estado miembro de la UE se han desarrollado según experiencias concretas relacionadas con los emigrantes, el clima político y las actitudes hacia la inmigración.

Los emigrantes suelen encontrarse con mayores problemas de salud y barreras considerables en la asistencia sanitaria en comparación a sus co-residentes de la UE. Por tanto las políticas de salud para emigrantes deben enfocarse en proteger a este grupo vulnerable, sobre todo durante tiempos de dificultad económica, teniendo en cuenta los factores de riesgo económicos y socio-demográficos. Existe una necesidad especial de investigación en la rentabilidad de la inversión en atención sanitaria de la población de emigrantes, demostrando los beneficios del mismo, incluyendo la salud de la población nativa europea, y la necesidad de una intervención constante a pesar de las restricciones de los recursos.

Palabras clave: Migración Internacional; Europa; Prisiones; Enfermedades Transmisibles, Servicios básicos de salud; Health Public Policy; VIH; Tuberculosis.

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INTRODUCTION

Migration has historically played a major role in shaping societies and influencing demographic changes. Patterns of migration flows can change greatly over time, with the size and composition of migrant populations reflecting both current and historical patterns of migration flows. The recent economic crisis has had an impact on migration flows in the European Union (EU), immigration levels have slowed while emigration has increased in some EU countries_ ENREF_1.

During 2011, there were an estimated 1.7 million immigrants to the EU from countries outside the EU. In addition, 2.3 million emigrants were reported to have left an EU-27 Member State, with 1.3 million people previously residing in an EU Member State migrated to another one². The United Kingdom (UK) reported the largest number of immigrants (566 044) in 2011, followed by Germany (489 422), Spain (457 649) and Italy (385 793); these four Member States together accounted for 60.3% of all immigrants to EU-27 Member States². Table 1 shows the immigration flow from 2009 to 2011 in the EU/EEA.

As a consequence of the economic crisis since 2008, migration flows changed, particularly in countries that experienced large inflows of labour migrants in the pre-crisis period¹. Among these countries, Spain reported the highest number of emigrants in 2011 (507 742), followed by the UK (350 703), Germany (249 045) and France (213 367). A total of 17 of the EU-27 Member States reported more immigration than emigration in 2011. In 10 countries (Bulgaria, the Czech Republic, Ireland, Greece, Spain, Poland, Romania and the three Baltic Member States) emigrants outnumbered immigrants².

Partly as a result of rising unemployment in male-dominated sectors, such as in construction, and continuing demand in more female-dominated sectors, such as care work, gender composition among migrants has also changed after the onset of the economic crisis. Female foreign workers increased their share of the local foreign workforce in some EU countries, such as Spain, Italy and Ireland¹.

While demographics is the baseline to understand the flows and trends of migrant populations between countries and regions, their health status along the different stages of the migration process constitutes the main interest in public health.

Health and health needs of migrants may differ from those of the general European population³⁻⁵. Upon arrival, migrants' health status might be better than the general host population due to "the healthy

migrant effect", but depending on the policies and practices of the host country, migrants may experience discrimination and drop in their socio-economic status post migration³. These changes might increase migrants' vulnerability, exposure risk to certain hazardous activities, ill health and reduced ability to protect or defend themselves⁶. Migrants from outside the EU are particularly affected by these challenges, which have been exacerbated following the economic crisis due to high rates of unemployment and job loss⁷. The situation of irregular immigrants (people who do not comply with country regulations of entry, stay or employment) is more precarious, because they tend to be excluded from social and health services, while often being exposed to high-risk working and living environments⁷⁻⁸.

Table 1. Distribution of immigration in the EU-27, By country and year, 2009-2011.

	2009	2010	2011
Eu-27	2504.4	2871.6	2906.9
Belgium	:	131.2	144.7
Bulgaria	:	:	:
Czech Republic	75.6	48.3	27.1
Denmark	51.8	52.2	52.8
Germany	346.2	404.1	489.4
Estonia	3.9	2.8	3.7
Ireland	37.4	39.5	52.3
Greece	:	119.1	110.8
Spain	499.0	465.2	457.6
France	:	251.2	267.4
Croatia	:	:	8.5
Italy	442.9	458.9	385.8
Cyprus	11.7	20.2	23.0
Latvia (*)	2.7	2.4	7.3
Lithuania	6.5	5.2	15.7
Luxembourg	15.8	17.0	20.3
Hungary	27.9	:	:
Malta (*)	7.2	8.2	5.5
Netherlands	128.8	:	:
Austria	73.3	73.9	104.4
Poland	:	:	:
Portugal	32.3	27.6	19.7
Romania	:	:	:
Slovenia	30.3	15.4	14.1
Slovakia (*)	15.6	13.8	4.8
Finland	26.7	25.6	29.5
Sweden	102.3	98.8	96.5
United Kingdom	566.5	591.0	566.0

Figures are expressed in thousands.
 (*) 2011: break in series. Source: Eurostat².

Migration policies have received a lot of attention in the EU since 2007. During the Portuguese Presidency of the Council of the EU in 2007, the link between the health of migrants and that of all EU citizens was highlighted, and therefore, Member States were invited to integrate migrant health into national policies and to facilitate access to healthcare for migrants. After 2007, the UK, Italy, the Netherlands and Sweden have established national policies aimed at improving migrant health, and, prior to the economic crisis, Spain, Germany and Ireland were in the process of launching national plans to improve the access of migrants to the social welfare system⁹. The majority of policies relating to migrants in the EU countries aimed to control the importation of communicable diseases and to improve health care to asylum seekers and refugees, and most of them were not addressing health and access to health care of legal, long term migrants through any specific policy, beyond the normal access to health care according to their resident status⁹.

Since the economic crisis, many EU countries have had prolonged recessions, and consequent cuts to health expenditure along with changes to health policies that affected service delivery and population well-being, particularly for populations who are most vulnerable, such as migrants¹⁰.

The objective of this paper is to review the available data about interventions on migrants' health in Europe, and to describe changes in migrant health policies across Europe related to the economic crisis, that can affect the health status of those populations.

Data collection on health of migrants

Data on health of migrants are essential for monitoring and improving health and access to health services. However, countries in the European Union (EU) differ with regard to categorization and definitions of migrants; this is mainly due to different historical contexts, statistical traditions, administrative and political structures, welfare regimes and migration histories¹¹. The United Nations (UN) has defined a migrant as *any person who lives temporarily or permanently in a country where the individual was not born*¹², whereas Eurostat defines a migrant as *a person who establishes his/her usual place of residence in the destination country for 12 months or more*¹³. Despite these generic definitions to standardize the classification of migration, countries in the EU define migrants in different ways, such as; country of birth, citizenship, parental country of birth, duration of stay and rely on self-identification⁹. The lack of a standard migration definition makes data comparability across Europe a major challenge.

Data collection about migrants' health might hamper health monitoring in this group. Commonly used definitions of migrant status do not distinguish between sub-categories of migrants, and for instance, second and third generation migrants that face particular health problems are often excluded from national monitoring systems, ruling out this variation in migrant health in the data analysis¹¹. Another data limitation is that the focus on migrant's health has been mainly on communicable diseases, and research on social determinants of health while entitlements to health care, specific interventions, and accessibility and quality of care is still scarce¹¹. Finally, another common limitation in migrant health data collection is the unknown denominator (the size of the underlying population), due to the presence of undocumented migrants, the lack of notification to the public registers when leaving one country of residence, or even sometimes when this information is available, is not properly adjusted¹¹.

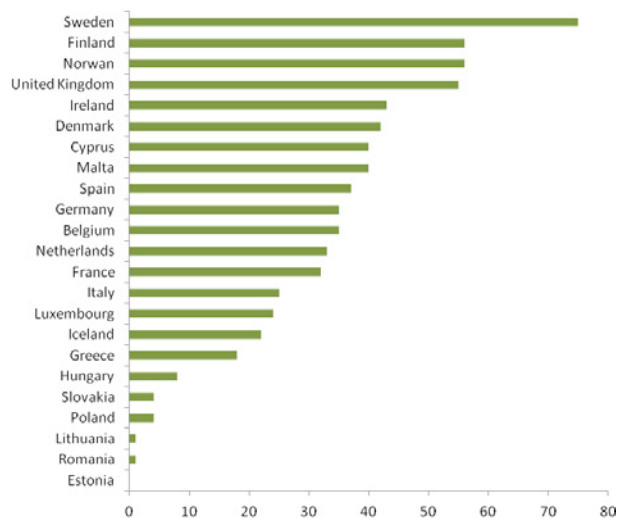
Situation of the most common infectious diseases in the area of migration and health

Migration has been discussed as a driver of infectious diseases in the EU. There is thought to be a large burden of infectious diseases among some migrant groups in the EU. This is due to several factors. First, many migrants come from countries with higher prevalence of infectious diseases¹⁴⁻¹⁵ than that of the hosting countries. Second, some migrants have a higher risk of acquiring infectious diseases due to poor working and living conditions, including overcrowding and insufficient housing^{14,16}. Third, the risk of HIV and sexually transmitted infectious may be higher due to higher prevalence of specific risk behaviours such as assortative sexual mixing with other migrants from high prevalence areas¹⁷⁻¹⁸. Finally, vaccine preventable diseases represent a disproportionate burden of disease, due to low coverage of vaccination programmes in children in some countries of origin or birth, which represent a source of outbreaks of childhood diseases that have been largely controlled in the EU¹⁹⁻²¹.

HIV

HIV is an important health issue in the EU. Despite great variation in number of reported HIV cases in EU Member States, in 2011, 37% of HIV cases were diagnosed in migrants, as it is described in figure 1¹⁸. For countries in the Eastern part of the EU and some from Central Europe, these proportions are below 10%, whereas in most of the Northern countries, these proportions are over 40%. This pattern is consistent with migratory trends²².

Figure 1. Distribution of percentage of diagnosed HIV cases among migrants by country, EU/EEA countries, 2011.



Source: ECDC, technical report. Migrant health: Sexual transmission of HIV within migrant groups in the EU/EEA and implications for effective interventions¹⁸.

HIV surveillance conducted by ECDC and WHO Europe shows that, in 2012, approximately 40% of HIV cases in migrants, reported in the EU/EEA were related to men who have sex with men (MSM), 34% to heterosexual transmission and 6% to injecting drug use; less than 1% of cases reported were due to mother-to-child transmission²³. The type of HIV transmission among migrants differs between sub-groups, depending on the region of origin, for instance; heterosexual transmission was reported in 88% of HIV cases in migrants from Sub-Saharan Africa in 2012²³. Migrant MSM may be at particular risk of HIV acquisition and transmission post-migration, especially due to assortative sexual mixing^{18,24}. Infection acquired post-migration ranged from as low as 2% among Sub-Saharan Africans in Switzerland²⁵, to 62% among black Caribbean MSM in the UK²⁶, also a large proportion of HIV-positive Latin American MSM have been infected in Spain²⁷.

Table 2 shows examples of intervention and good practices in HIV related with migrants across the EU.

HIV testing has been one of the issues addressed by the EU to point out migrants as a vulnerable population for HIV. Testing policies for migrant population varies greatly across the EU Member States, as only 52% of the countries in the EU-27, with HIV policy documents recommend HIV testing for migrant population in 2011²⁸. As examples, HIV testing for migrants is recommended in Denmark, on the first contact with the health care system, while France and the UK recommend systematic screening for people

originating from regions of high HIV prevalence²⁸. However, as all the guidelines have highlighted, it is essential to link testing with care, support and treatment, ensuring proper treatment for those who test positive²⁹⁻³⁰. Nevertheless this might differ across different regions, especially for migrants with uncertain administrative status²⁸.

With the economic crisis, some countries across the EU, have implemented a reduction in their expenditure that might interfere with testing and treatment of HIV. For instance, in 2009 the UK removed HIV treatment from its emergency care list, hence abandoning free of charge treatment for all patients³¹. In Spain, during 2012 a new legislation was approved to deny healthcare to immigrants of uncertain administrative status, impacting negatively in HIV migrant's treatment and follow-up. As, it has been showed in one of the papers reviewed, where the authors described that the impact of such measures on the country's public health would increase mortality, morbidity and costs in the medium and long term³². And, in Greece since 2012, a policy of where mandatory HIV testing is carried out for some high risk groups, including undocumented migrants who are selling sex, is causing much controversy among Greek public health professionals³³_ENREF_3.

Tuberculosis

In the last 50 years, it has been described a decline in tuberculosis disease (TB) in most of the EU countries. However, this downward trend has been reduced by the re-emergence of TB among especially vulnerable population, such as migrants from countries with high TB prevalence of both infection and disease and less prevention and control strategies³⁴⁻³⁵. Moreover, drug-resistant TB among cases of foreign origin is commonly higher than among native EU citizens, especially among those from the Former Soviet Union³⁶.

In the EU in 2007, the mean percentage of foreign-born reported cases was 20 (range 0-82)³⁷. From the cases that reported country of origin, most of them were from Sub-Saharan Africa, Southeast Asia, specific areas of Latin America and former Eastern Europe³⁷. TB infection in migrants tends to occur at younger ages, and those infected are more likely to default on treatment and have a poor outcome³⁵. Poor socioeconomic conditions, social exclusion and limited access to health services appear to be far more important determinants of TB infection than purely country of origin or birth³⁸⁻³⁹. An important risk factor commonly described, it is being in a correctional

Table 2. Examples of intervention and good practices in HIV related with migrant across the EU.

Area of activity	Examples	Good practice features
Prevention	Germany: The FluG (Flucht and Gesundheit) project offers a range of HIV prevention interventions as part of a wider action to address the health issues of newly arrived migrants. There is cooperation with Red Cross and involves migrants as peer educators.	Interventions developed and implemented by and with migrant communities, with cooperation between different organisations.
Treatment, care and support	Norway: AKSEPT uses peers to provide psychosocial support for migrants living with HIV.	Interventions developed and implemented by and with migrant communities.
	Germany: The Afrikaherz project provides support on health issues for migrants in addition to HIV-related support.	Comprehensive approach to health and social needs.
	Portugal: The living with HIV/AIDS project provides home care, treatment, psychosocial, rehabilitation and legal support for migrants living with HIV and their families. It aims to promote social integration of migrants infected or affected by HIV and their communities, working with multidisciplinary teams.	Meets basic needs of migrants living with HIV and their families and provides links clinical and care services.
Policy	UK: The African HIV Policy Network (AHPN), an alliance of African, has tackled the issue of deportation of migrants with HIV, mainly the undocumented, and has highlighted the discrepancy between UK policy on access to HIV treatment for all and the policy on deportation of undocumented migrants to countries where treatment is not readily available ⁶⁰ .	Alliances of community-based organisations representing migrants.
	France: Réseau d'Associations Africaines et Caribéennes brings together 34 migrant and HIV NGOs to promote the HIV needs of migrant communities at national level.	Advocacy based on sound policy research and analysis.
	UK: The All-Party Parliamentary Group on AIDS (APPG) brings together MPs from all political parties who are concerned about HIV. In 2003, the APPG published a comprehensive policy related with HIV and migrants health.	Alliances and links between individuals and organisations with shared interests.
Research	Netherlands: The Positive Living Under Stigma (PLUS) project conducts quantitative and qualitative research on stigma related to HIV and migration and links research outcomes with the development of interventions.	Support from municipal health services, NGOs and community organisations.
	Belgium and Netherlands: The International Centre for Reproductive Health conducted research on refugee sexual health needs and sexual violence towards refugees to raise awareness and develop a prevention tool.	Use of research to shape the design of interventions.
Networking	Belgium: community leaders are working together on the HIVSAM project, which aims to improve the sexual health of African migrants through developing culturally appropriate interventions for sexual health promotion, building capacity for self-support for African migrants living with HIV, and reducing HIV-related stigma.	Alliances of community-based organisations representing migrants.
	Sweden: The African women's network AKN unites several organisations and aims to improve the sexual health of African women and girls. The network carries out advocacy initiatives and organises meetings for network members.	

Source: ECDC, technical report. Migrant health: Access to HIV prevention, treatment and care for migrant population in EU/EEA countries⁶¹.

facility, as the overall rate of TB among migrant inmates of penitentiary institutions is as 15 times higher, than in the general populations in countries from the EU³⁶.

Screening for TB is the main intervention performed to control this disease among new entrants in the EU countries. In 2003, a study described that just 13 countries from the EU had a screening programme, three conducted screening at the port of entry and nine at other centres after arrival⁴⁰. However, TB screening programmes are currently subject of debate⁴¹⁻⁴², due to its small public health impact and high costs. Current chest radiograph and sputum culture screening programmes in migrants have been demonstrated not to be cost-effective⁴³. Whereas, tuberculin skin testing or chest radiographs for latent infection, have showed a higher impact and cost-effectiveness when they have been used under coercive measures⁴³. The only measure that appears to be more cost-efficient and less intrusive is contact tracing, particularly within common socio-demographic groups^{37,43}. Also, studies do not indicate differences in effectiveness between the three main strategies of screening; screening at port of entry; screening just after arrival in reception/holding centres; or screening in the community following arrival in the EU countries³⁷. Therefore, there is a need for improved data related with; assessment and improvement of cost-effectiveness. Screening should be a component of a wider approach, rather than a stand-alone intervention in the EU^{34,37}.

With the economic crisis, European data do not show at present an effect on TB⁴⁴, as TB is a slow disease (incubation period from two to eight weeks), so it may take time to see a significant increase in the number of cases. It's even possible to see initially a decrease in the number of TB cases, because healthcare systems in some new EU countries may experience difficulties in diagnosing and reporting TB⁴⁵. However, in Europe, TB notifications are higher where national incomes are lower and/or income inequalities are higher⁴⁵⁻⁴⁶. If one or both two factors are present, then TB rates may rise. Outside the EU, economic crisis has demonstrated to have an impact on TB, especially if it is associated with shortcuts of TB social and health services and TB dispensaries, leading to collapse centrally controlled programmes and to a negative impact on the detection and management of TB in the community with magnifying rates of progression to active disease, and case fatality rates⁴⁷. Likewise, financial crisis can broaden the size of groups with a high risk for TB, for instance due to increase unemployment, which favours criminal behaviour, and therefore an enlargement of prison population⁴⁵.

Vaccinated preventable diseases

Coverage of childhood vaccination programmes varies across the EU. In the recent years a decline in coverage rates have been observed in some Member States, for instance; Austria and Denmark that have witnessed a decline in coverage for diphtheria, tetanus and pertussis⁴⁸. Coverage rates in some countries have also declined as some parents choose not to vaccinate their children due to different reasons²⁰. As a result of those changes, it has been observed an increase in measles outbreaks, due to the growth of susceptible children irrespective of their origin or country of birth²¹.

There are little data available on vaccination coverage in migrant children in the EU, as most countries do not collect coverage data, or if they do, it is under especial situations. For instance, in Germany, the vaccination status of migrant children and adolescents depends on the type of the vaccination, country of origin, age and duration of residence⁴⁹. However, some studies indicate that the vaccination rate is lower among migrants or foreign born residents than among the local population⁵⁰. Assessment of countries migration status profile and vaccination access of migrant population is a challenge mainly in migrants with an irregular administrative status. Experience from some countries in the EU indicates that, there are challenges in reaching migrants with routine vaccination services, because they are unaware of these services, or due to health care access barriers⁵⁰. A successful intervention that reduces these challenges and increases vaccination coverage in migrant groups, has been described for MMR vaccine at local level in different EU countries, by using key individuals from the migrant communities to reach susceptible individuals and increase awareness among community⁵⁰.

The financial crisis might impact vaccine preventable diseases in migrants, as during these times this group is at risk of becoming conduits of epidemics due to: decreased vaccination coverage and augmented of disproportional infectious disease burden, compared with the general population in Europe. Also, because with the economic crisis, immunization programmes targeting migrant population, are the most frequently preventive programs that might be affected. As a result, Hepatitis B vaccination programmes have suffered financial reductions within some EU countries⁵¹.

Sexual and reproductive health in migrants in Europe

Compared to general EU population, the sexual and reproductive health (SRH) in migrants differs

greatly. Migrant women are less screened for cervical and breast cancer, have less access to family planning and contraception and lower uptake of gynaecological healthcare, are more at risk of unintended pregnancies, pay fewer and later antenatal care visits, have poorer pregnancy outcomes (more induced abortions and complications), and have higher infant and maternal mortality rates^{3,52-53}. Whereas, both migrant women and men are more at risk of sexually transmitted infections (STI), and sexual violence³.

There is a scarcity of specific European legal and policy provisions related to SRH interventions in migrants. Therefore, migrants have to overcome multiple barriers to access SRH services, as in most of the EU countries the legal status remains the major determinant in accessing SRH⁵². As for undocumented migrants, current legislation in the EU does not guarantee access to SRH care and tends to become more restrictive^{3,54}. Couple with this, migrants often lack knowledge about the health system and available SRH services in the host country^{3,52}, and health care providers often lack skills in culturally competent communication and are unaware of migrants' entitlements to SRH services and support available³. This has been endured with the austerity measures during the economic crisis. As an example of this, Greece has reduced funding for NGOs that initially provided free health care for undocumented migrants in term of SHR⁵⁵.

Migrants' occupational health in Europe

Migrants tend to do jobs in higher risk occupational sectors, therefore migrant male and female non-manual workers are more exposed than non-migrants to adverse psychosocial conditions and to some adverse employment arrangements⁵⁶. Also due to language barriers, migrants may be unfamiliar with safe use of equipment and often receive inadequate training, supervision and protection⁵⁶. Occupational accidents due to lack of legal contracts and acceptance of hard working conditions are a bigger healthcare burden for migrants than for the autochthonous population¹⁷.

In general, during the economic crisis the employment situation of migrant workers, especially of nationals of non-EU countries, has deteriorated more rapidly than that of the native¹⁰. The increase of unemployment rates for foreign workers compare to those for native workers between 2008 to 2009 was most marked in Estonia, Spain, Portugal, Latvia, Ireland, France and Austria¹. Rate of unemployment from 2008 to 2009, among migrant from EU countries was 2.8%, whereas, for non-EU migrants was 5%¹.

Non-EU migrants were more affected by worsening working conditions; this can be explained by the high concentration of non-EU migrants workers in sectors highly cyclical, such as construction, retail and hospitality¹. Furthermore, the long duration of unemployment has been associated with an increased risk of mortality in this group in the EU, due to more unhealthy behaviours which may lead to psychological and behavioural disorders and increase of psychosomatic diseases and suicides⁵⁷.

Prior to the economic crisis, migrants were less likely than local population to be welfare recipients in countries like Spain, Italy and Ireland. However, this pattern has changed as more migrants are registering for unemployment benefits, despite that some studies in Germany and Ireland described that non-EU migrants are more reluctant to claim unemployment benefits due to their administrative status¹.

Changes in migrants' health care policies after the economic crisis

Many of the EU countries adjusted but not substantially changed their migration policies during the economic crisis. Again, policy adjustments varied from country to country and across regions in the EU, as migration policies are far from uniform among EU Member States.

Despite the economic crisis, migrants face different barriers to access health care in the EU. Particularly, legal regulations have tended to restrict the access to health services for undocumented migrants. In 2010, undocumented migrants did not have access to emergency care in nine of the EU-27 countries, and primary and secondary care access to health services in just the Netherlands, France, Italy, Portugal and Spain⁸. However, in 2012 Spain changed its policy, and the access to care to undocumented migrants was significantly reduced³². Apart of legal restrictions, migrants also might be affected by other barriers, such as; the use of fees, which can be seen as a general formal barrier, creating inequity in access for many migrant groups due to their generally lower socioeconomic status compared to non-migrants⁵⁸. Among the informal access barriers, it has been described; administrative obstacles to get health insurance; language barriers; unfamiliarity with rights entitlements; gaps in health literacy; social exclusion, and direct and indirect discrimination⁸. Finally, being a recently arrived migrant might inhibit access to care, in particular for those migrants who have not received any introduction to the health system of their new host country⁵⁸.

Different changes after the economic crisis have been introduced in country policies at different levels of migrant health care. In the past, interpretation services were hired to reduce migrants' barriers to access health systems. With the financial hardship, countries such as the Netherlands and the UK have stopped paying for those services⁵⁹. The tendency to cut services might target at minority populations, but this might affect other parts of the health system, as these measures can be more costly in the longer term. Without translation services, patients who do not speak the language of the host country well, therefore, are more likely to access health care at emergency departments or in the late stages of the disease¹⁰.

Other shortcuts in migrant health services have been also observed, in Scotland with mental health services for asylum seekers, in Ireland for several agencies that supported migrant rights, and in England where non-urgent secondary care services are no longer for free for asylum seekers, whose applications have been refused⁵⁹.

CONCLUSION

In spite of the limited scope of the present review, this paper provides an overview of migrant health in Europe and some recent changes related to the economic crisis. Different authors have highlighted the need to standardize data collection practices related with migrants health in Europe, as the information available differs greatly across countries. Therefore it is difficult to compare it between countries, and to make evidence based policies and programmes when essential data is lacking.

Although migrants, including the undocumented, have the right to health care under legal settlements issued by the EU, there is no standard European approach to offer health care to those populations, since; policies in each EU Member State are related with migrant experience, political climate and attitudes towards migration. During recent years, the EU has raised its concern related with migration, adopting diverse health approaches in different diseases. These policies however might have been constrained greatly with the economic hardship and so public health interventions proven to be effective such as free vaccination. As mentioned in the article even the access to health care services have disappeared recently.

Migrants face greater health problems and major health care access barriers, compared with their counterparts from the EU, therefore, migrant health policies should be focused in protect this vulnerable group especially during economic hardship, taking

in to account economic and socio-demographic risk factors. Nevertheless, to avoid adverse reactions from non-migrant vulnerable groups and from some sectors of the general population, those policies addressed to migrants need to be developed within the context of general measures and interventions for the general population. Not only the health sector, but also the education, housing and social services have often been accused of implementing positive discrimination measures for migrants while autochthones have no access equal benefits.

Finally, as stated in many scientific papers, there is a special need for research in the cost-effectiveness of investing in the health care of the migrant population, demonstrating the benefit of such, even in the health of the European native population, and the need for constant intervention despite of resource constraints.

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BIBLIOGRAPHIC REFERENCES

1. Koehler L, Aghazarm SJ. Migration and the economic crisis in the European Union: Implications for Policy. Brussels: International Organization for Migration; 2010.
2. Eurostat [Internet]. *Luxembourg*: Eurostat; c1998-2013 [updated March 2013; cited 2013 Dic 12]. Migration and migrant population statistics; [about 2 screens]. Available from: http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Migration_and_migrant_population_statistics#Further_Eurostat_information
3. Keygnaert I, Guieu A, Ooms G, Vettenburg N, Temmerman M, Roelens K. Sexual and reproductive health of migrants: Does the EU care? Health Policy. Forthcoming 2013.
4. Bhopal R. Chronic diseases in Europe's migrant and ethnic minorities: challenges, solutions and a vision. *Eur J Public Health*. 2009; 19(2): 140-3.
5. Woodward A, Howard N, Wolffers I. Health and access to care for undocumented migrants living in the European Union: a scoping review. Health Policy Plan. Forthcoming 2013.
6. Ingleby D. Ethnicity, Migration and the 'Social Determinants of Health' Agenda. *Psychosocial Intervention*. 2012; 21(3): 331-41.

7. Koser K, Laczko F. World Migration Report 2010. The Future of Migration, building capacities for change [Internet]. Geneva: International Organization for Migration; 2010 [cited 2013 dic 28]. Available from: http://publications.iom.int/bookstore/free/WMR_2010_ENGLISH.pdf
8. Rechel B, Mladovsky P, Ingleby D, Mackenbach JP, McKee M. Migration and health in an increasingly diverse Europe. *Lancet*. 2013 Apr 6; 381(9873): 1235-45.
9. Mladovsky P. A framework for analysing migrant health policies in Europe. *Health Policy*. 2009; 93(1): 55-63.
10. Karanikolos M, Mladovsky P, Cylus J, Thomson S, Basu S, Stuckler D, et al. Financial crisis, austerity, and health in Europe. *Lancet*. 2013 Apr 13; 381(9874): 1323-31.
11. Rechel B, Mladovsky P, Deville W. Monitoring migrant health in Europe: a narrative review of data collection practices. *Health Policy*. 2012 Apr; 105(1): 10-6.
12. Mrki S, Chen H, Rose M, editors. Principles and recommendations for a vital statistics system 2013 [Internet]. Geneva: United Nations; 2013 [cited 2013 dec 12]. Available from: http://unstats.un.org/unsd/demographic/standmeth/principles/unedited_M19Rev3en.pdf
13. Eurostat [Internet]. *Luxembourg*: Eurostat; c1998-2013 [updated March 2013; cited 2013 Dic 12]. migrants in Europe. A statistical portrait of the first and second generation 2011; [about 2 screens]. Available from: http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-31-10-539/EN/KS-31-10-539-EN.PDF
14. Baussano I, Mercadante S, Pareek M, Lalvani A, Bugiani M. High rates of Mycobacterium tuberculosis among socially marginalized immigrants in low-incidence area, 1991-2010, Italy. *Emerg Infect Dis*. 2013; 19(9).
15. Hamers F, Downs A. The changing face of the HIV epidemic in western Europe: what are the implications for public health policies? *The Lancet*. 2004; 364(9428): 83-94.
16. Vives A, Vanroelen C, Amable M, Ferrer M, Moncada S, Llorens C, et al. Employment precariousness in Spain: prevalence, social distribution, and population-attributable risk percent of poor mental health. *Int J Health Serv*. 2011; 41(4): 625-46.
17. Nagy R. Migrants and healthcare within the European Union. *Int Rev Soc Res*. 2011 (1): 61-72.
18. European Centre for Disease Prevention and Control. Migrant health. Sexual transmission of HIV within migrant groups in the EU/EEA and implications for effective interventions [Internet]. Stockholm: European Centre for Disease Prevention and Control; 2013 [cited 2013 Dec 12]. Available from: <http://www.ecdc.europa.eu/en/publications/Publications/Migrant-health-sexual-transmission.pdf>
19. Coughlan S, Connell J, Cohen B, Jin L, Hall WW. Suboptimal measles-mumps-rubella vaccination coverage facilitates an imported measles outbreak in Ireland. *Clin Infect Dis*. 2002 Jul 1; 35(1): 84-6.
20. Ringler M, Gobel G, Most J, Weithaler K. Fully vaccinated children are rare: immunization coverage and seroprevalence in Austrian school children. *Eur J Epidemiol*. 2003; 18(2): 161-70.
21. Zandotti C, Jeantet D, Lambert F, Waku-Kouomou D, Wild F, Freymuth F, et al. Re-emergence of measles among young adults in Marseilles, France. *Eur J Epidemiol*. 2004; 19(9): 891-3.
22. European Centre for Disease Prevention and Control. Epidemiology of HIV and AIDS in migrant communities and ethnic minorities in EU/EEA countries [Internet]. Stockholm: ECDC; 2010 [cited 2013 Dec 12]. Available from: http://www.ecdc.europa.eu/en/publications/publications/0907_ter_migrant_health_hiv_epidemiology_review.pdf
23. European Centre for Disease Prevention and Control. HIV/AIDS surveillance in Europe 2012 [Internet]. Stockholm: ECDC; 2012 [cited 2013 Dec 12]. Available from: <http://www.ecdc.europa.eu/en/publications/Publications/hiv-aids-surveillance-report-2012-20131127.pdf>
24. Barlow D, Daker-White G, Band B. Assortative sexual mixing in a heterosexual clinic population—a limiting factor in HIV spread? *AIDS*. 1997 Jul; 11(8): 1039-44.
25. Staehelin C, Egloff N, Rickenbach M, Kopp C, Furrer H. Migrants from sub-Saharan Africa in the Swiss HIV Cohort Study: a single center study of epidemiologic migration-specific and clinical features. *AIDS Patient Care STDS*. 2004 Nov; 18(11): 665-75.
26. Burns FM, Arthur G, Johnson AM, Nazroo J, Fenton KA. United Kingdom acquisition of HIV infection in African residents in London: more than previously thought. *AIDS*. 2009 Jan 14; 23(2): 262-6.
27. Caro-Murillo A, Gutierrez F, Manuel-Ramos J, Sobrino P, Miro J, Lopez-Cortes LF, et al. HIV infection in immigrants in Spain: Epidemiological characteristics and clinical presentation in the CoRIS Cohort (2004-2006). *Enferm Infecc Microbiol Clin*. 2009 Aug-Sep; 27(7): 380-8.

28. Alvarez-Del Arco D, Monge S, Caro-Murillo A, Ramirez-Rubio O, Azcoaga-Lorenzo A, Belza M, et al. HIV testing policies for migrants and ethnic minorities in EU/EFTA Member States. *Eur J Public Health*. Forthcoming 2013.
29. European Centre for Disease Prevention and Control. HIV testing: increasing uptake and effectiveness in the European Union [Internet]. Stockholm: ECDC; 2010 [cited 2013 Dec 12]. Available from: http://ecdc.europa.eu/en/publications/Publications/101129_GUI_HIV_testing.pdf
30. WHO. Scaling up HIV testing and counseling in the WHO European Region as an essential component of efforts to achieve universal access to HIV prevention, treatment, care and support 2012 [Internet]. Copenhagen: WHO; 2010 [cited 2013 Dec 18]. Available from: http://www.euro.who.int/__data/assets/pdf_file/0007/85489/E93715.pdf
31. The European Observatory – Médecins du Monde Access to health care for undocumented migrants in 11 European countries [Internet]. Paris: Médecins du Monde European; 2009 [cited 2013 Dec 15]. Available from: http://www.epi-south.org/doc/r_documents/Rapport_UK_final_couv.pdf
32. Perez-Molina JA, Pulido-Ortega F. Assessment of the impact of the new health legislation on illegal immigrants in Spain: the case of human immunodeficiency virus infection. *Enferm Infecc Microbiol Clin*. 2012 Oct; 30(8): 472-8.
33. The Lancet editorial group. HIV testing in Greece: repeating past mistakes. *Lancet*. 2013 Jul 13; 382(9887): 102.
34. Falzon D, Ait-Belghiti F. What is tuberculosis surveillance in the European Union telling us? *Clin Infect Dis*. 2007 May 15; 44(10): 1261-7.
35. Falzon D, van Cauteren D. Demographic features and trends in tuberculosis cases in the European Region, 1995-2005. *Euro Surveill*. 2008 Mar 18; 13(12).
36. Veen J, Migliori GB, Raviglione M, Rieder HL, Dara M, Falzon D, et al. Harmonisation of TB control in the WHO European region: the history of the Wolfheze Workshops. *Eur Respir J*. 2011 April 1, 2011; 37(4): 950-9.
37. Klinkenberg E, Manissero D, Semenza JC, Verver S. Migrant tuberculosis screening in the EU/EEA: yield, coverage and limitations. *Eur Respir J*. 2009 November 1, 2009; 34(5): 1180-9.
38. T.B. A, Pell C, Bueno-Cavanillas A, Guillen-Solvas J, Pool R, Roura M. Tuberculosis in migrant populations. A systematic review of the qualitative literature. *PLoS One*. 2013; 8(12): e82440.
39. Gagliotti C, Resi D, Moro ML. Delay in the treatment of pulmonary TB in a changing demographic scenario. *Int J Tuberc Lung Dis*. 2006 Mar; 10(3): 305-9.
40. Coker RJ, Bell A, Pitman R, Hayward A, Watson J. Screening programmes for tuberculosis in new entrants across Europe. *Int J Tuberc Lung Dis*. 2004 Aug; 8(8): 1022-6.
41. Dahle UR, Sandven P, Heldal E, Caugant DA. Continued low rates of transmission of Mycobacterium tuberculosis in Norway. *J Clin Microbiol*. 2003 Jul; 41(7): 2968-73.
42. Laifer G, Widmer AF, Simcock M, Bassetti S, Trampuz A, Frei R, et al. TB in a low-incidence country: differences between new immigrants, foreign-born residents and native residents. *Am J Med*. 2007 Apr; 120(4): 350-6.
43. Dasgupta K, Menzies D. Cost-effectiveness of tuberculosis control strategies among immigrants and refugees. *Eur Respir J*. 2005 June 1; 25(6): 1107-16.
44. European Centre for Disease Prevention and Control/WHO Regional Office for Europe. Tuberculosis surveillance and monitoring in Europe 2012 [Internet]. Stockholm: ECDC; 2012 [cited 2013 Dec 15]. Available from: <http://www.ecdc.europa.eu/en/publications/Publications/1203-Annual-TB-Report.pdf>
45. van der Werf M, Giesecke J, Sprenger M. Can the economic crisis have an impact on tuberculosis in the EU/EEA? *Euro Surveill*. 2012; 17(12).
46. Suk JE, Manissero D, Buscher G, Semenza JC. Wealth inequality and tuberculosis elimination in Europe. *Emerg Infect Dis*. 2009 Nov; 15(11): 1812-4.
47. Arinaminpathy N, Dye C. Health in financial crises: economic recession and tuberculosis in Central and Eastern Europe. *J R Soc Interface*. 2010 Nov 6; 7(52): 1559-69.
48. Vaccine European New Integrated Collaboration Effort. Vaccination coverage assessment in EU/EEA, 2011 [Internet]. Stockholm: ECDC; 2011 [cited 2014 09/01]. Available from: http://venice.cineca.org/Final_Vaccination_Coverage_Assesment_Survey_2011_1.pdf
49. European Centre for Disease Prevention and Control. Background note to the 'ECDC Report on migration and infectious diseases in the EU' [Internet]. Stockholm: ECDC; 2009 [cited 2013 Nov 12]. Available from: http://www.ecdc.europa.eu/en/publications/publications/0907_ter_migrant_health_background_note.pdf

50. European Centre for Disease Prevention and Control. Review of outbreaks and barriers to MMR vaccination coverage among hard-to-reach populations in Europe 2012 [Internet]. Stockholm: ECDC; 2013 [cited 2013 Dec 10]. Available from: <http://www.ecdc.europa.eu/en/publications/publications/mmr-vaccination-hard-to-reach-population-review-2013.pdf>
51. Rechel B, Suhrcke M, Tsovala S, Suk JE, Desai M, McKee M, et al. Economic crisis and communicable disease control in Europe: a scoping study among national experts. *Health Policy*. 2011 Dec; 103(2-3): 168-75.
52. Norredam M, Mygind A, Krasnik A. Access to health care for asylum seekers in the European Union-a comparative study of country policies. *Eur J Public Health*. 2006 Jun; 16(3): 286-90.
53. Reime B, Janssen PA, Farris L, Borde T, Hellmers C, Myezwa H, et al. Maternal near-miss among women with a migrant background in Germany. *Acta Obstet Gynecol Scand*. 2012 Jul; 91(7): 824-9.
54. Mladovsky P, Rechel B, Ingleby D, McKee M. Responding to diversity: An exploratory study of migrant health policies in Europe. *Health Policy*. 2012; 105(1): 1-9.
55. Kentikelenis A, Karanikolos M, Papanicolas I, Basu S, McKee M, Stuckler D. Health effects of financial crisis: omens of a Greek tragedy. *Lancet*. 2011 Oct 22; 378(9801): 1457-8.
56. Ronda Perez E, Benavides FG, Levecque K, Love JG, Felt E, Van Rossem R. Differences in working conditions and employment arrangements among migrant and non-migrant workers in Europe. *Ethn Health*. 2012; 17(6): 563-77.
57. Schuring M, Burdorf L, Kunst A, Mackenbach J. The effects of ill health on entering and maintaining paid employment: evidence in European countries. *J Epidemiol Community Health*. 2007 Jul; 61(7): 597-604.
58. Rechel B, Deville W, Mladovsky P, Rijks B, Petrova-Benedict R, editors. *Migration and health in the European Union*. Berkshire: McGraw-Hill; 2011 [cited 2013 Dec 17]. Available from: http://www.euro.who.int/__data/assets/pdf_file/0019/161560/e96458.pdf
59. O'Donnell C, Burns N, Dowrick C, Lionis C, MacFarlane A. Health-care access for migrants in Europe. *The Lancet*. 2013; 382(9890): 393.
60. Fakoya I, Reynolds R, Caswell G, Shiripinda I. Barriers to HIV testing for migrant black Africans in Western Europe. *HIV Med*. 2008; 9(s2): 23-5.
61. European Centre for Disease Prevention and Control. Access to HIV prevention, treatment and care for migrant populations in EU/EEA countries [Internet]. Stockholm: ECDC; 2009 [cited 2013 Dec 16]. Available from: http://ecdc.europa.eu/en/publications/publications/0907_ter_migrant_health_hiv_access_to_treatment.pdf