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From control policies to health policies as a tool for inclusion

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The danger of spreading infectious diseases and the need to preserve the health of the local population was already recognized when maritime commerce had started off (Ewald 1986). Throughout the 20th century, regulations of European countries were unilateral, defensive and nation-state based. Within this framework, the question of the health of migrants was tackled only as problems of border control; focusing at that time on screening for tuberculosis among migrants. After World War II in particular, the main goal was to select healthy workers for the Fordist industrialization of Europe; migrants were accepted as a workforce for a limited period of time. The "Guestworkers" were healthy, and policies concerning migration were defined in view of the workers' temporary residence.

The political and scientific awareness of migration as a problem that is not particular or marginal in the host societies only began in the 1970s. On the one hand migrants settled and were joined by their relatives through family reunification. On the other hand, because most of the migrants of the 1960s and 1980s were more threatened by unemployment and precariousness during the economic crisis since they were low skilled and immigrants, host countries were lead to formulate "integration policies". These changes shattered the image of migrants as young and healthy males, as labour force and short-term inhabitants. As an effect, the field of "integration policies" was being elaborated, and research on settlement dynamics, on the consequences migrants might have on the social security system, and the perception of risks to any harmonious internal reproduction of a society with a high rate of immigration were developed (Hoffmann-Nowotny 1970; Wicker et al. 2003).

The political and scientific description of migrants started to become more realistic, indicating in particular the change from a mobile to a settled existence. Despite increasing awareness and acceptance of migrants' permanent settlement in the host country, the question of their integration was still regarded as a linear and one-way process. Popular concepts of assimilation or acculturation were more or less reduced to the idea that "time integrates" (Hoffmann-Nowotny 1985). First measures aimed at the inclusion of migrants did not include elements concerning health, but were instead geared towards school and professional training (Mahnig 1998). In these fields, rapid integration was regarded essential. Other aspects of everyday life – such as access to health-care or quality of care – were not perceived as needing specific policy measures. Indeed, it was assumed that these issues would be resolved automatically through the duration of stay.

The 1980s and, in particular, the 1990s completely changed the dynamics of migration and migration policy in Europe. The international reorganization of migration flows led to differentiate migrants according to their knowledge and working skills, as well as according to their origins and legal status (OECD 2005). In particular, issues around asylum seekers of the 1980s and earlier were transformed from a marginal and cyclical phenomenon to one of continuous flow (Efionayi-Mäder et al. 2001).

If the growing complexity of the composition of the migrant population and their needs as well as the economic crisis, has lead to integration policies, most European countries developed measures of migrants' inclusion orientated to health only since the middle of the 1980s or as late as the 1990s. With the arrival of HIV/Aids, previous, defensive health policies regarding migrants have become obsolete. At the same time, the awareness for the specific needs of migrants and the necessity to prevent a broad spread of the epidemic lead to specific measures sensitive to diversity. In this sense, HIV/Aids has been a motor just as important as both the transfor-

mation of migration flows and the political awareness for action in a context of increasing and differentiated migration. HIV/Aids prevention calls for innovative approaches, which include communitarian and street level measures. Some of the financed measures following a broad approach based on health promotion sometimes seemed to be far away from the original scope of HIV/Aids prevention.
Another aspect is suggestive of the fact that health was somehow used as a tool for migrants' inclusion. The interest in the health of migrant people comes at a time when the politics of admission have become progressively restrictive across Europe, which has increased the number of people migrating illegally, or into uncertain legal situations. In this frame it has become apparent that health and illness have taken on special significance: The sick body, under certain circumstances, and when there is no possibility for the persons to be treated in their country of origin, allows the acquisition of an entry visa on humanitarian grounds (Fassin 2001). In other words, the essential significance of health permits to reconsider the stay of people whose presence and integration are not favoured by the state: in this case those who have entered the country without a valid work or residence permit.

Difference as normality in the health system?
For some years, the multi-dimensional perspective on migration and health issues has lead to grasp these phenomena in a broad way and to regard them as societal dynamics of the differentiation of life worlds. This sensitivity to differentiate not only implies different cultural ways of living (Cattacin 2006), but also a differentiation of social rights affiliations, as exemplified by the discussion on health services for illegal workers. In order to give the proper answer to a specific problem, the challenge for our societies will be to deal with these differences and to grasp them as something normal.

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