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How to cite

CATTACIN, Sandro. Migration and Health. Ontological Security and Pluralist Inclusion. In: Migrants and Healthcare: Responses by European Regions. World Health Organization (Ed.). Copenhagen : World Health Organization, 2010. p. 1–19.

This publication URL: <https://archive-ouverte.unige.ch/unige:40302>

World Health Organization
Regional Office for Europe
Regions for Health Network



Migrants and Health Care:
Responses by European Regions
(MIGHRER)

Complete reference material

**II. Migration and Health -
Ontological Security and Pluralist Inclusion**

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This chapter is an attempt to analyse the relationship between Migration and Health from the point of view of migrants and their environment, as well as that of the health care providers embedded in a political and institutional framework.² Three main arguments are developed. Firstly, we describe the change in post-World War II Europe from the “healthy migrant effect” to the “unhealthy migrant effect”, which secondly coincided with the change from homogenous to heterogeneous societies and in particular from the acculturation perspective to the perspective of difference sensitivity in the provision of health services. Thirdly, we want to give some insights into the differentiation of institutional and political answers to these challenges on health and migration in Europe.

1. From the “healthy migrant effect” to the “unhealthy migrant effect”³

The danger of spreading infectious diseases and the need to preserve the health of the local population were already recognized when maritime commerce commenced (Ewald 1986). Throughout the 20th century, regulations within European countries were unilateral, defensive and nation-state based. In this framework, the question of the health of migrants has only been tackled as a problem of border control, focusing at that time on screening Tuberculosis (TB) among migrants. Particularly after World War II, the main goal was the selection of healthy workers for the Fordist industrialization of Europe. Migrants were accepted as a workforce for a limited period. The “Guest workers” were healthy, and policies concerning migration assumed that their stay in the host countries was of limited duration.

The political and scientific consciousness of migration as a continuing phenomenon, something 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, due to the economic crisis, migrants became an issue in developing unemployment policies. These changes shattered the image of migrants as young, healthy males, in work and present for just the short-term. Because most of the migrants of the 1960s through the 1980s were more threatened by unemployment and precariousness as they were low skilled and immigrants, host countries were led to formulate “integration policies” (Cattacin and Chimienti 2006). The field of “integration policies” began to be elaborated upon, and research was developed into settlement dynamics, consequences that migrants might have on the social security system and risks to harmony in a society with a high rate of immigration⁴.

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 this dawning of

² I would like to thank Milena Chimienti for her substantial contribution to this text and David Ingleby and Alison Ricketts for their constructive critics.

³ This introduction is partially based on Cattacin and Chimienti 2007.

⁴ This situation led to topics such as racism and discrimination on the political agenda see for the English case Schuster and Solomos (2004).



consciousness of migrants' settlement in the host country, the question of their inclusion 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 relevant elements concerning health, but instead were oriented towards schooling and professional training in most of European countries of destination (Mahnig 1998). In these fields, rapid inclusion was regarded as essential. Other aspects of everyday life - such as access to healthcare or quality of care - were not perceived to require 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 re-organization of migration flows led to differentiating migrants according to their knowledge and working skills, as well as according to their origins and legal status (OECD 2005). In particular, the world of asylum seekers of the 1980s and earlier was 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 needs⁵ as well as the economic crisis (which highlights that the labour market was no longer a way to integrate migrants), led to inclusion policies, most European countries developed measures of migrants' inclusion oriented 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, awareness of the specific needs of migrants and the necessity to prevent a broad spread of the epidemic led to precise measures. From this perspective, HIV/AIDS has been as important a motor for the transformation of migration flows as has political awareness of the need 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 measures funded as part of a broad approach based on health promotion may seem to be far away from the original scope of HIV/AIDS prevention⁶.

Another aspect is suggestive of the fact that health was in a way used as a tool for the inclusion of migrants. Interest in the health of migrants comes at a time when the politics of admission have become progressively more restrictive across the whole of Europe, which has caused an increase in 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 person, under certain circumstances, including where there is no possibility for the persons to be treated in their country of origin, is allowed to acquire an entry visa on humanitarian

⁵ Diversity among migrants in terms of age, sex, origins, possibility of employment and duration of stay in the host society brought the same plurality of health needs than the one within the general population of the host society.

⁶ For instance: community interpreters as well as documentation on health access were financed on HIV/AIDS funds.



grounds (Fassin 2001). In other words, the importance of health allows the state to reconsider the stay of people whose presence and integration are not favoured: in this case those who have entered the country without a valid work or residence permit, i.e. those whose presence in the country is perceived as provisional, or irregular, and by precarious consequences.

2. Health, Migration and Ontological Security

The consequences of this change in Europe can be summed up as the awareness that migrants' health can no longer be an exclusion motif at the border and that the selection process ensuring healthy migrants was vain, as migrants' reproduction in the host society caused specific health issues (Lechner and Mielck 1998). Addressing these health issues has been, since the 1990s, on the political agenda. While it is true to say that the healthy migrant still exists, he or she is no longer the only kind of migrant. We increasingly see the appearance of the unhealthy migrant in the world of asylum or illegality, and the health system has somehow to deal with this.

However identifying health determinants is complicated. They are strongly interrelated and difficulties have sometimes arisen in determining causality. What precisely causes persistent health variations and how they can be positively influenced is in fact not so easy to ascertain and current debates about health care reforms illustrate this very clearly. This difficulty is even greater when one considers the case of migrants as their situation increases the number of variables (Ingleby et al. 2005) related to duration of stay, history of migration (i.e. the difference between first, second and third generation), ethnic identity (Nazroo 1998) and the legal situation relating to their stay.

Going back a step and thinking about migrant experiences as a challenge to their ontological security (in the sense of Giddens, i.e. as a destabilisation of identity, material conditions and projectuality) permits clarification of what the public health literature tells us⁷. Hence, the point of view of migrants can be discussed from their personal perspective, differentiating their (a) personal history (b) relational experiences and (c) the confrontation of migrants' environment with the institutional and political environment.

- (a) Migration leads to a contextual change that generates uncertainty and insecurity for migrants (Obrist et al. 2007). Practices vary based on context and a demand that migrants make an effort to learn the rules of the new society. This learning process cannot be done from one day to another and requires research for information, situational experimentation and reflexivity (Chimienti 2008). The everyday challenge of migrants in a new context is to transform insecurity that prevents security that creates the possibility of projection. In this confrontation between the "old" and the "new" world, Sayad and Bourdieu see a central psychological burden with which each migrant has to deal (Sayad and Bourdieu 2003). Even if Sayad and Bourdieu go too far indicating that suffering is a structural component of the migration experience, they give us a first key to understanding a psychological burden that can have consequences

⁷ See for instance the review of Weiss 2003, Bischoff 2006 and Maggi 2003.



on health. However, the personal experience of migration can also be made worse by the professional and social aspects of inclusion in the new society.

- (b) The relational dimension of the process of the inclusion of migrants relates to the production of "otherness" in the new society, as it confronts differences and struggles to understand such differences (in the sense of Honneth 1992). The search for understanding relates to specific life experiences, cultural habits and the inclusion in a system of equal rights. This relational perspective includes health-related risks, inasmuch as the understanding of these differences is distorted by prejudices, misunderstandings and partial or lack of recognition of the access to concrete health services (Domenig 2007; Coker 2001).

Migration is, in this logic, a major challenge for health care providers. Having tried to deal with pluralistic indigenous demand since the 1970s, the quest for inclusion of differences is also aggravated by the diversity of migrant background and status. The main answer resulting from years of research and practical work on healthcare and migrants in the 1990s was Cultural Competent Care (CCC) (Bischoff 2006).

This programme focused on two levels. First, it focused on the health care providers and ensuring that they are able to integrate competencies in dealing with migrants. Second, it focused on the individual level with the idea that migrants have to be better informed about their rights, but also that they have to be seen as partners in the development of healthcare responses. This empowerment perspective was particularly important in order to show that that a new relationship has to be developed.

This ambitious programme failed when confronted with a complexity of the provision of medicine in a health system set up to provide medicine for the "middle classes" (patients of high performance, and high health literacy). The fundamental ambivalence appeared in the confrontation of this high performing medicine with the quest for a medicine for people on the margins (Cattacin 2007).

Access barriers appeared across Europe due to the fragile legal status of many migrants (asylum seekers waiting to be sent home or illegal workers without access rights to social security), the quality of provision of healthcare, and the high levels of mobility - all problems adherent to migrants. A known problem was also the continuing change of physicians and the rare use of psychiatric or psychological services (Watters 2001).

- (c) Migrants repeat the same habits in a new setting as in their region of origin. These habits include religious practices, traditional forms of consumption and ways of dealing with health matters. In addition, there are some specific health issues related to different groups of migrants (diffusion of specific somatic figures, biological differences) that demand a varying range of responses from the health system. The challenge for a health system confronted with such specificities is to learn how to respond to such requirements from specific groups. For the migrants, the question is not only to understand how to communicate the differences, but also how the health system in a new setting differs from the known one. It is in some ways a necessity to develop health literacy from two sides: from the health system's and the migrants' ones.



Attempts were made to classify factors that explain the inequalities in health determinants, whether individual, social, economic or environmental factors that influence health outcome, as well as the way macro-political factors lead to inequalities in health. A long tradition of public health literature highlights the relationship between health risk factors and the socio-economic position at an individual level, lending itself in a straightforward way to empirical analysis. A more conceptual model focuses on underlying structural factors, the role of which has been more difficult to measure (Asthana and Halliday 2006: 45). Among the different models that were developed since the 1980s, some are referred to as social models (Black et al. 1980 and Acheson 1998). In Whitehead and Dahlgren (1991) the determinants of health are illustrated as layers of influence.⁸ Bartley (2004) and Asthana and Halliday (2006:28) mention different reasons for health inequalities that cannot be directly influenced by migrants or health care providers.⁹ Wilkinson and Marmot (2003) discuss such factors having an influence on the health outcome in terms of the health implications of economic and social policies, in particular those concerning the social gradient, early life, social exclusion, workplace and unemployment, social support, addiction, food and transport.

In comparison studies on health of the native-born and migrants, the differences in such studies are often explained by socio-economic factors (Nazroo 2001) or legal status (Chimienti and Achermann 2006; Wolf 2008). For example, we know that:

- migrants and ethnic minorities on average are more likely to experience poor health compared to the rest of the population;
- ill-health in ethnic minorities starts at a younger age than the rest of the population;
- there are increased rates of long-term illness or disability and worse health reported for several ethnic groups;
- they have higher rates of cardiovascular diseases than the rest of the population (Ingleby et al. 2005).

In such ethnic differences, genetics play only a small role. This means that personal factors play a smaller role in differences than social or structural factors. However, there are a number of diseases, which could be defined as ethnically specific (Pearce et al. 2004). For example, Tay Sachs disease is associated with people of Jewish descent; Glucose 6 Phosphate Dehydrogenase deficiency is associated with people from the Mediterranean; Cystic Fibrosis affects mostly white Europeans and some South Asians and Sickle Cell Diseases affect mostly

⁸ The layers include (from outside): the general socio-economic, cultural and environmental conditions influencing the living and working conditions; social and community networks as well as individual lifestyle factors; age, sex and constitutional factors of individuals.

⁹ Such as individual income, beliefs, norms and values influencing health behaviour, status, control, social support at work or at home and the balance between effort and reward, events and processes starting before birth and during childhood, political processes and distribution of power affecting the provision of services as well as the quality of physical environment and social relationships.



African, Caribbean and Asians (Pearce et al. 2004). With time (both over the duration of the stay and during the following generation) these differences, with change in lifestyles, may disappear.

The difficulty in isolating risk factors complicates prevention and even treatment, and so there is a need to act in a holistic and dynamic way. In concrete terms, health systems should be flexible enough to go beyond sectoral priorities (i.e. to find a *modus vivendi* between for instance migration and employment and health policies), to take into account both individual and structural factors, and to include the time perspective in relation to birth rates and ageing patterns of migrants and their duration of stay in the host society.

3. Difference as normal in the health system? Institutional answers¹⁰

Let us consider now how institutions really react to these challenges. For some years, many local, regional, national and international commissions have been searching for viable solutions for dealing with patterns of new migration. The response of the health systems differs from country to country across Europe but with a common framework - the first initiatives were adapted in the context of a competent health care system and not solely dictated by cultural differences. 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 especially true when new policies are developed. A first distinction can be made in relation to the insurance scheme in the health system, which can be divided into more universalistic systems (i.e. ones favouring universal access - access for all, with tax based financing and open access to health care services) or more 'categorical' systems (i.e. ones where individuals are allocated to a category or status, based around separate insurance schemes and a means-tested access to health). As Ferrera points out, the two systems are often mixed today, but the initial decision on how the system works is always influencing and structuring future developments (Ferrera 1993). The second distinction is related to the general value systems framing the management of diversity. We can distinguish systems that are based on a communitarian approach of diversity (sensitive towards diversity) and systems that are based on the republican approach ("blind" towards diversity). Table 1 indicates where the major immigration countries are placed in relation to this logic. This differentiation already permits an analysis of the major institutional responses in Europe relating to migration and health, which we call liberal universalism (a), liberal selectivity (b), socialist universalism (c) and socialist selectivity (d).

¹⁰ This chapter is partially based on Cattacin et al. 2007.



Table 1. Health structures and value system of differences

Health structure Value system regarding diversity	Tax-based (Universalistic approach)	Insurance-based ("Categorical" approach)
Sensitive towards diversity (Communitarian)	Liberal universalism	Liberal selectivity
"Blind" towards diversity (Republican)	Socialist universalism	Socialist selectivity

(a) What we call *liberal universalism* seems to be best prepared to include migrants in the health system, because of its openness and its structural sensitivity towards diversity. The United Kingdom (UK), as a former colonial power can be taken as an example of this logic: first because the UK is oriented towards diversity in the sense of liberal acceptance of black and minority ethnic differences (due to its past), nowadays demonstrated by the plurality in terms of origin and ethnicity of its population (about 8 % of the UK population in 2000 considered themselves as having origins outside the UK or as being of a foreign nationality and the majority of them are ex-colonials and labour migrants from Pakistan, Somalia, India and Nigeria (ONS 2004) and second because the UK has, in theory, egalitarian access to health care. However, this egalitarian approach is based on the logic of minimal appropriate services, corresponding to the liberal ideal of health for all, but only for basic services. In concrete terms, this universalistic health care system means that no-one will be denied life-saving, urgent care and most people are entitled to primary health care. This is helped by the fact that the UK National Health Service (NHS) is financed at 80% by taxes.

Nevertheless, since the neo-conservative political change in the 1980s, private health insurance services have grown. Most private health care providers are focused on treatment rather than primary care. In 1997, 11% of the population was already covered by a private supplementary health care insurance (Robinson and Dixon 1999).

Undocumented migrants do have the right to private (non-NHS) health insurance and service provision - but many will be unable to pay for it. They do not have entitlements to free secondary health care through the NHS (except for certain diseases and for life-saving treatment). They may be able to access free primary care through the general practitioner (GP) but it is the GP who has discretion as to whether they are registered¹¹. Before April 2004 they also had free access to specialists, which is no longer 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 free care for undocumented migrants. The UK also offers, in exceptional cases, an authorisation for three years for acute medical troubles, authorisation that can theoretically be renewed.

¹¹ With general practitioners, it depends on the individual doctor whether he or she takes someone on as his or her patient.



There are two main types of protection:

- humanitarian protection for a maximum of three years if the person risks being killed or tortured in his or her country of origin;
- 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 residence. It is interesting to note that seropositive people cannot get this authorisation.

The main actor in the field of migrants health access promotion is the Department of Equality and Human rights. It has a long history: started as a women's unit looking at employment, then an equality unit looking the employment, it then became an equality unit looking at employment and service delivery. Finally, the unit works on equality and human rights and looks at employment and service professions. 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 under-represented in several positions in the health services (only 25% of the executive directors were women and today that figure is 43%). The claim of ethnic recognition started from black and other ethnic 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 at both national and local level), guides and help for the 28 local authorities and co-ordinates 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 the year 2000 a new legislation was decided upon 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 produce an action plan that identifies what they would do to tackle discrimination and inequalities. That is now a legal requirement but the local organisations can choose the way they wish 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 or 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 this Act (as amended) and to impose specific duties to ensure compliance and better performance. The Act gives to the Equality and Human Rights Commission (the



former Commission for Racial Equality) power to enforce specific duties to promote racial equality and to influence codes of practice to provide guidance to public authorities on how to fulfil their general and specific duties to promote racial equality.

The general duty means that, in performing their functions public authorities must have due regard to the need to promote racial 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 receives around 5.3 millions euros per year in order to implement this policy which covers 17 jobs, guidelines, and some innovative projects at national level.

Whereas the policy tried to improve the inclusion of UK residents whatever their gender, age, ethnicity or ability is, entitlements to free NHS services changed. They are based on length of (legal) residency, amongst other criteria, in England, and not the migrant status or ethnicity. As a result, undocumented migrants and asylum seekers failed since 2004 from accessing free secondary health services, such as treatment in hospitals for HIV, amid concerns about the spread of so-called 'health tourism'- people travelling to country to receive treatment. A case won in April 2008 by an undocumented migrant against the NHS changed once more the law until the NHS makes appeal, showing how much the current policy is versatile. This decision has actually been again revoked.

- (b) The second category, that we call *liberal selectivity* can be represented by Switzerland, by the Netherlands and in part by Germany. This group includes 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, but have to devise special measures for people (like undocumented migrants) who are outside the regular insurance system (and not only the health system) because of the need to identify their social position (their categorical affiliation). These systems are obliged to create parallel structures for specific needs outside the normal insurance schemes. There structures are largely recognized as complementary to the system and generally subsidized by the State. To keep it brief, we will discuss in concrete terms only the Dutch case.

The Netherlands represents *par excellence* this type because of its particular openness related to its history of religious pluralism (the pillarized system; Kriesi 1990) and its colonial background and its fee-based insurance system for health. Recently (in January 2006), the Netherlands introduced obligatory insurance for residents. For the poorest a possibility to get reimbursement exists, but it involves an administrative process of registration and means testing. Since then, health care has been structured according to the type of insurance (it means that some treatments are no longer covered by the basic health insurance).



For asylum-seekers there is a gate-keeping model. In centres where they have to stay, a nurse is required to 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 1 1998. This new law states 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 (GP) or hospitals, and it is the GP responsible that decides if they can be treated. In the case of an acute illness their expulsion is delayed but there is no possible regularisation.

If we analyze the first initiatives, we 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 community in deprived neighbourhoods with nurses and peer educators (Ingleby 2005).

The GP plays a central role in 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'. The provision of health care in the Netherlands is characterised by a high degree of professionalism. 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 consciousness that important problems exist in this area is fairly widespread. However, a small but highly active group of concerned professionals has been drawing 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 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 the year 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 most vigorously for improvements. A four-year Action Plan for intercultural mental health was approved, which was to be supervised by the co-ordinating agency for mental health services (GGZ Nederland). At the same time an 'inter-cultural mental health centre of expertise' called MIKADO was set up, with financing guaranteed until 2007.



However, opposition to cultural pluralism has been increasing. In the Netherlands this started in the early 1990s, although it did not become a major political theme until the end of that decade: "9/11" and the assassination of Pim Fortuyn in 2002 contributed to a hardening of public attitudes and a renunciation of multiculturalism by the government (Ingleby 2005).

- (c) The third category we call *socialist universalism*, here represented by Sweden, which works on the basis of openness to residents, but because of the high level of social security and the high homogeneity of the population (for Sweden in a comparative view: Lijphart 1984), socialist universalism distinguishes strongly between insiders and outsiders (Olsson 1993). In this context, inclusion of difference is organised by parallel systems outside state institutions (NGOs), lacking state legitimisation.

The Swedish health system is based on a universally-oriented provision, and financing of health services is a public sector responsibility. Responsibility rests primarily with the County Councils (in 21 geographic areas). Patient fees range from 10 to 30 Euros. Personal expense has a high-cost ceiling (of 90 Euros) and entitlement 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 health and dental care social insurance but have a special entitlement on the level of County Councils. They have access only to emergency treatment and care that cannot wait according to responsible experts. Children are treated free of charge. The County Councils (Regional Authorities) are funded 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 are eligible for emergency and immediate health and dental care. In the case of non-emergency (such as births) fee-for-service (without public subsidy) is supposed to be applied. There is a great inconsistency within the health care system and different interpretations apply in different regions. Consequently practitioners are forced to act as gatekeepers. Undocumented migrants are in general dependent on civil society associations and individual health care professionals engaged in their deprived access to care. In the 2006 Social Report from the Board of Health and Welfare these circumstances are acknowledged and discussed.

The first developments in the field of migration and health took place in the 1960s. Migrants were identified as a welfare target group and officially acknowledged in an 'Survey of Immigrants' in 1968 in general socio-economic terms as "getting satisfactory social and cultural services" and equality with the majority of the population in terms of living conditions and health care, education and social services. The responsibility lay explicitly



with the general authorities and institutions within the welfare system, not with special provision. This process can be understood as a result of a trade union movement standpoint since the mid-1950s against the guest worker model as a political strategy.

In 1975 a new Immigrant Policy was brought into effect expressing a 'multicultural' strategy regarding immigrants and minorities. The focus was on equality in terms of access to cultural goods (language, education, culture) aimed at maintaining linguistic and cultural identity linked to inclusion in the overall society. Issues of health were not explicitly addressed but were implied in general welfare solutions.

- (d) The fourth case, which we call *socialist selectivity*, indicates a combination of a 'categorical' system - with all the difficulties that hinder entry into an affiliation scheme without a resident permit - and difference-blindness. Migrants - or people with a migrant background - also experience, in these cases, difficulties in finding appropriate care - difference-sensitive care. The pressure on migrants and minorities to assimilate to a model of normality 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 the capacity to read and intervene in a pluralistic society. Adaptations in these systems challenge not only the logic of the health system, but also the general model of welfare provision. They are highly controversial. France, with its republican tradition, is a good example to use in describing this situation.

The French social security system for all regular residents covers 70% of their needs. In fact, as a categorical system, employed people get insurance ("mutuelle") in order to be insured. Today, this system has also integrated universalistic elements. In fact, unemployed people enter into an insurance scheme through a complementary financing system (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 had access, since the year 2000, to the "assistance médicale d'Etat (AME)", which provides 100% insurance cover, but two reforms in 2002 and 2003 limited access to those who were in France for less than 3 months. Health care professionals do not have a duty to report an undocumented migrant to the authorities because the law stipulates that they have the right to health care regardless of their residence status in France. They can also get a provisional permit to stay if their illness is acute and they cannot be treated in their country of origin.

Responsibility for the development of a strategy in the field of migration and health lies with the Department for the Direction of Population and Migrations, which deals with the interface between the General Directorate of Public Health and the Directorate of Public Liberties and Judiciary Affairs (in the Ministry of Internal Affairs) on questions relating to health. Some initiatives of outreach work are also taken at the regional level (Departments), but under the auspices of acting in the field of marginalized people.



In contrast to the selective model, France has taken the question of migration and health 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 since 1998 has taken into account for the first time the question of health with the possibility of getting a provisional permit of stay and work for people with acute illnesses and without the possibility of being cared for in their country of origin. This “republican” model adopts a policy of blindness towards difference as a strategy of inclusion.

4. Conclusions

This rather simple typology - combining structure and referential¹² - nevertheless permits one to understand why the measures taken in different countries to act in the field of migration and health are so different. It also allows recognition of the different measures taken in the light of similar challenges coming from migrant health issues.

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) -difference-sensitivity as a result of an equity-oriented modernization - are fertile conditions for introducing measures in the field of “health and migration”, as the case of the UK has illustrated. It is nevertheless a risky model because it is based on the premise that ideas can be implemented hierarchically and that the inclusion of difference is also a solution for the “dis-enclosure” of communities. The openness of universalistic systems is certainly a good basis against discrimination, but in reality overlooks the highly dynamic nature of migration and ethnic communitarisation processes. The (Marshallian) static view of society interpreted as a continuous inclusion towards a middle class society for all disadvantaged groups, contrasts with the normality of an extreme mobile society, less determined by class than by the world of everyday life. In practical terms that means that the measures of inclusion on the one hand should be promoted as soon as migrants enter the host country, while on the other hand they should be more flexible as migrants’ stay in the host country might be short term.

This short discussion indicates already that the search for an ideal model in the field of health and migration cannot be based on a static 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 Dutch experiences. It certainly has to put forward what we can call *difference sensitivity* (or “migration mainstreaming”), introducing a systematic - structural -

¹² 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 (Esping-Andersen 1990); see also: Cattacin 1996.



empathy for differences in systems (as described in the Migrant Friendly Hospitals-project¹³). This means shifting the focus of the health system from the management (including difference sensitivity in the decision-making process through the incorporation of “advocacy” positions) to quality control, giving power to differences and through this, changing from paternalistic inclusion to active participation and projectuality. This also means normalising difference sensitivity in the training of health care providers - and migrants, to introduce “trans-nationalists” in organisations with a concrete employment policy based on the analysis of the social and human capital of candidates. In this context, we can learn from the gender mainstreaming measures; we would even say that we have to radicalize this approach transforming it into a more open logic of difference mainstreaming. This is the strength of the universalistic model.

However, the new model of “difference sensitivity” also has to work in a multidimensional way against exclusion tendencies, so that there is no privileging only of the universalistic approach, with 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 as useful having partial rights, for instance, for the undocumented migrants. Pragmatism means also putting forward group and situation related projects, based on the idea that only a specific adaptation of a measure permits entry into contact with a complex reality.

Migration and ethnic difference represents normality in Europe. We have arrived at the end of the assimilative policy model, but also of the communitarian policy model. Our argument, we hope, indicates ways to think pragmatically about how to combine measures with the grain of multidimensional changes to the health system.

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¹³ For detailed information about research instruments and outcomes see the final project report by Krajic et al. 2005.
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