Bringing the Migrant Health Discourse into Policy

2nd Research Exchange Workshop and Public Briefing

Asia-Europe Foundation (ASEF) / Yuchengco Center, De La Salle University
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Workshop Report

Organisers:
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BACKGROUND AND OBJECTIVES

ASEF Public Health Network

The Asia-Europe Foundation (ASEF) Public Health Network is a participatory platform which encourages public health dialogue in Asia and Europe. It provides space and opportunities for health and non-health sector representatives to share their knowledge and experience. This exchange facilitates partnerships between multi-level actors from governments, international organisations, corporations, academia, non-profit organisations and the media.

ASEF's initiative on health and migration

“Migration is a fact of life and governments face the challenge of integrating the health needs of migrants into national plans, policies and strategies” as reported by the World Health Organization (March 2010)1. Identification of migrants’ health-related needs and their reflection into policies and practices require research and data that provide evidence for migrants’ vulnerabilities. The Asia-Europe Foundation (ASEF) Public Health Network aims to address such migrant health issues by initiating joint research and a series of research exchange workshops through a multi-disciplinary and multi-sectoral approach. In 2011, the ASEF Public Health Network launched the 1st Joint Research on Regional Integration and Infectious Diseases. The research study by the Yuchengco Center (The Philippines) and Fondazione ISMU (Italy) on “Public Health Challenges in the Era of Migration: The Health Dimension of Southeast Asian Migration to Europe” (publication forthcoming in September 2013) presented accurate and useful data on the health status of Chinese and Filipino migrants in Europe and produced recommendations to integrate their needs into the policies of receiving communities.

In March 2012, the ASEF Public Health Network organised the 1st Research Exchange Workshop on “Social Determinants of Migrants’ Health across Asia and Europe”, in collaboration with Casa Asia in Barcelona, Spain2. The workshop provided researchers across Asia and Europe with an opportunity to better understand the health status of Asian migrants in Europe and to share the information and experience of multiple stakeholders in addressing migrants’ health issues. The workshop participants elaborated a list of recommendations and further research areas to strengthen bi-regional collaboration on health and migration.

Translating research evidence on migrant health into policy and practice

The research findings and outcomes of the workshop were considered highly useful and relevant for addressing and tackling issues on health and migration by not only academics but also other players such as international organisations (World Health Organization (WHO), International Organization for Migration (IOM), United Nations Development Programme (UNDP)), regional institution (European Commission), national authorities (Spanish National Public Health agency, National Board for the Placement and Protection of Indonesian Overseas Workers), and civil society organisations. The recommendations and conclusions of both the research study and workshop also drew out the implications of translating the evidence into public health policy and healthcare practice to obtain positive outcomes in health of migrants. Therefore, the ASEF Public Health Network aimed to invigorate policy dialogue at its second research exchange workshop, bringing together senior-level decision-makers, researchers as well as multiple stakeholders involved in migrant health issues.

Objectives

The 2\textsuperscript{nd} Research Exchange Workshop on “\textit{Bringing the Migrant Health Discourse into Policy}” specifically aimed to:

\begin{itemize}
  \item Address present challenges in migrant health policies based on the data generated from the ASEF Public Health Network’s research initiative on health and migration;
  \item Provide an avenue for debates on how to \textit{drive} changes in policy and practice in relation to migrant health and social integration; and
  \item Foster active co-operation between multi-sector players to achieve policy coherence on migration and health.
\end{itemize}
The Case of Poland as Receiving and Sending Country

The first two presentations on the first day of the workshop discussed the migration trends of Poland. Immigration size in Poland is still small but consistently growing, since its entry in the European Union (EU) in 2004. Meanwhile, the size of Polish emigration has already reached 20 million with its long history as a sending country that is both political and economic in nature. Ms Bogumila Jablecka of the Institute of Public Affairs (Instytut Spraw Publicznych) in Poland presented the situation of economic migrants from Ukraine and Vietnam to Poland and how Poland is dealing with corresponding healthcare issues. To discuss the case of Poland as a sending country, Dr Elzbieta Anna Czapka of Marie Curie-Sklodowska University shared the results of her research on the health of Polish labour immigrants in Norway.

Economic Migration to Poland: Case of Ukraine and Vietnam
Ms Bogumila Jablecka, Analyst, Migration Policy Programme, Institute of Public Affairs, Poland

Immigration to Poland is a marginal but steadily growing phenomenon, with 63,000 permanently residing foreigners (0.2% of the total permanent residents, and 0.3% of the Polish labour market). This number is rising yearly because of the need to employ foreign workers in some sectors, generally low-skilled, such as agriculture, commerce, construction, food services and household. This growing reliance on foreign workers in Poland results from high rates of Polish economic emigration, which led to labour shortages in some sectors (these flows intensified with Poland’s accession to the EU) as well as the shunning of some low-skilled jobs by nationals who have benefited from Poland’s economic development. Immigrants in Poland are mainly in the low-skilled sector. By country of origin, Ukraine (29,746) is the largest immigrant population accounting for nearly half of the total, while Vietnam (9,257) is among the top three as of 2011. These foreign workers are required to obtain a work permit, and while there have been some policy changes, which made it easier for immigrants to look for work in Poland, the issue of irregular employment remains a significant issue.

Figure 1 Immigrant Population by Country of Origin in Poland

Source: Polityka Migracyjna Polski (Polish Migration Policy), Ministry of Internal Affairs, 2012
Ukrainian immigrants. Poland is the main country of destination for Ukrainian migrants. The introduction of seasonal employment in 2006 made it quite easier to obtain a work permit visa, which is valid only for 6 months and issued through a statement from the employer registered in the country office. The legalisation of stay, however, does not translate to regularisation of work, which is one of the key dilemmas among Ukrainian immigrants. The assumption of seasonality made Polish authorities disregard mechanisms for establishing permanent residency. Many of the immigrants also prefer to work without regularisation, which means non-payment of taxes by both the immigrants and their employers. Furthermore, without control mechanism, the issuance of work permits in the black market in Ukraine remains unsolved due to the difficulties in cooperation with Ukraine authorities.

A recent policy development which is expected to impact positively on the health status of Ukrainian migrants to Poland, by making migrants’ insurance valid both in Ukraine and Poland, is the agreement on cooperation in the area of social security between Poland and Ukraine (18 May 2012). Lack of cooperation between sending and receiving countries in the field of migration and health is often cited as a factor in poor health status of migrants. This agreement therefore constitutes a good practice in the field of migrants’ health.

Vietnamese immigrants. There was a large influx of Vietnamese economic migrants in Poland in the late 1990s, though this group of migrants is cited to have no intention of staying permanently in Poland. What needs to be noted among these immigrants is the irregular migration trend. A new Abolition Act was introduced in 2011, offering irregular migrants in Poland an opportunity to legalise their stay. Vietnamese immigrants are expected to constitute the largest community to benefit from this measure (this was the case when the 2007 Abolition Act was introduced). The key challenges are the lack of cooperation with the sending country, and the exclusion of these immigrants from policy developments in Poland.

Challenges on access to healthcare. Ms Jabłecka noted that economic migrants are subjected to poor working and housing conditions which are major factors of high health risks. Aside from these social determinants, the problem with economic migrants is that even though those legally employed are covered by a monthly health premium purchased by employers, as legally required, health care services are not fully utilised. This is primarily due to a lack of information among migrants on how to access such services. Some are not aware that they are insured and are ignorant of the existing requirements and procedures to access services in hospitals and in consulting doctors. Another major concern is the fact that migrant workers tend not to consider health as a priority, due to potential loss of income when they skip work and other reasons that they consider more important than attending to their health. Irregular migrants who are not insured have few options which include being insured in their home country. However, due to the lack of control mechanisms, some of these insurance companies do not fulfil their obligation to provide coverage to their clients abroad. These immigrants then avoid visiting doctors and hospitals. There is postponement of health aid seeking behaviour that may result in threats to public health and high cost of emergency services.

Recommendations to address healthcare issues. In response to the issues in healthcare, Ms Jabłecka recommended developing the following: an adequate information system on migrants’ rights; a support mechanism for the enforcement of migrants’ rights in health care and labour market; a control mechanism in the area of illegal employment of migrants; and effective cooperation between Poland and sending countries in the area of economic migration.

The Health of Polish Labour Immigrants in Norway
Dr Elżbieta Anna Czapka, Researcher/Lecturer, Marie Curie-Skłodowska University, Poland

Since Poland joined the EU in 2004 and several job markets in Western Europe became accessible, a great number of Poles have emigrated in search of better work and higher income. Norway has become a popular destination for Polish migrants due to its demand for workforce. Data presented by Dr Czapka showed that

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Poles constitute the biggest foreign population group in Norway (along with in the United Kingdom (UK), Ireland, and the Netherlands). There were 67,339 registered Polish migrants in total in Norway (Statistics Norway, April 2012)\(^4\).

**Migration trends and new challenges to healthcare.** In Norway, Polish men engage mainly in manual labour such as in the construction sector (for example 70% of Poles registered in Norway work as artisans) which exposes them to particular health risks. Women, on the other hand, are mostly employed as house cleaners, child minders or social care workers. They are often employed irregularly without being officially registered, and this leaves them with no access to social welfare benefits or healthcare services. In addition, Dr Czapka referred to the “new labour migration” trend that has significant influence on migrants’ health and the use of healthcare services in the country. This new trend is characterised by partial migration which only lasts for a relatively short period of time (in extreme situation even a few days). These migrants are usually not registered as residents of a Norwegian municipality and this could entail breaching legal regulation in the receiving country. In many cases, this also means no access to healthcare services. These factors would reveal how migration results in health deterioration. To illustrate further, Dr Czapka referred to the “healthy migrant effect” phenomenon, going abroad in good health, then shifting to the “exhausted migrant effect” as they become less healthy after a period of time in the receiving country. Taking such conditions into account, Dr Czapka shared the results of her research\(^5\) probing into the changes in Polish migrants’ health status, their usage of, and access to healthcare services, problems encountered, and how Polish migrants value their own health.

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**Health status and problems.** In general, Polish immigrants in Norway are satisfied with their health although more than a quarter stated that their health deteriorated. Problems are related to the physical nature of migrants’ job and the social isolation they experience, which seem to be the most alarming factors with regards to the social dimension of health. The most frequently declared emotional problems among migrants are overwhelming homesickness and mood swings that may be due to hard work and stress resulting from their separation from their families. The Poles show low levels of engagement in social activities and in organisations and associations in Norway. Among the reasons mentioned for isolation are: language and cultural barriers; lack of self-engagement; Norwegian’s negative attitude towards Poles; and unfair treatment and discrimination by Norwegians as well as by Poles themselves (e.g., claims that Norwegians always rank higher at work than Poles irrespective of their skills and ability for the job; Poles showing off that they are better, etc.). Food purchase was also an issue. While Norwegians reportedly spent 12% of their income on food, almost a quarter of the respondent migrants spend less than 10% (a significant number spend only between 2-5%) of their earnings on food, which affects the status of their health. Considering the high prices of food in Norway, migrants attempt to save money at the cost of buying less or spending less money on food.

**Immigrants’ use of and access to healthcare services.** As declared by Polish migrants, access to healthcare services was limited due to their incompetence in the use of the Norwegian language (39% do not speak Norwegian, 29% do not speak English, 12% speak neither English nor Norwegian) and insufficient access to information available about the health care system (59% of informants would like to get more facts about health care systems in Norway). The immigrants admitted to using healthcare services in Poland more frequently than in Norway (61% declared more frequent use). Based on the data presented during the workshop, only 41% of the surveyed immigrants declared using healthcare services in Norway. The migrants prefer going to doctors in Poland (43% visit a particular specialist back home) than Norway because of the ease in using their own language, relatively lower prices, familiarity and availability of information, accessibility, and trust that they have in doctors in Poland. Their future plans had a significant impact on the way they used the Norwegian health care system. People who intended to settle down in Norway were more likely to use the medical care available in Norway.

**Polish migrants’ hierarchy of values.** Families are prioritised by migrants over health needs. Health ranked 3rd in hierarchy of values, next to self-development (2nd) and family (1st). Approximately 90% of Polish migrant respondents are prepared to put their health at risk for the sake of their family. Seventy-three per cent would feel proud if they were to risk their health in order to earn money and support their family.

**Policy recommendations.** To conclude, Dr Czapka recommended addressing language barriers by offering migrants a partially subsidised Norwegian language courses. Other recommendations included exploring information channels frequently used by migrants (e.g., Polish Internet forums, church); reviewing the health information materials; assessment of health knowledge/literacy of migrants; and developing health information materials tailored to migrants.

**Discussion highlights**

**Health-related prevention services.** A participant from Austria asked the presenters about the healthcare services’ response to the “happy migrant effect”, which refers to the fact that migrants do not tend to complain regardless of the qualities of treatments or services they get; they try to be effective and healthy since their health is one of their main resources for employment. She inquired if there are preventive services which could respond better to the migrant’s needs in the receiving country.

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6 In a questionnaire survey filled by 107 Polish migrants in Norway, the latter assessed their health condition as very good (30 %) and good (49 %). Only 17 % declared that their health was satisfactory and 4 % defined it as bad or very bad. It was important to ask the immigrants whether their health had undergone changes since their arrival in Norway. It appeared that the health of 54 % had not changed. 20 % admitted that their health had improved and 26 % reported deterioration in their health (Czapka, NAKMI report 3/2010).

7 Norwegians tend to obtain higher or more prestigious positions (and consequently higher income) irrespective of skills and ability when compared to Poles

Ms Jabłecka affirmed the need to provide preventive services on a large scale. But she also brought up the need to address first the problem of lack of information, and make migrants aware of what they are entitled to and how they can use and access the relevant services. Dr Czapka mentioned that she had shared the same view and thus has been working with the Cancer Association for Prevention. She pointed out the importance of having a healthy lifestyle but expressed the difficulty in recommending healthy choices for migrants because of factors related to income. To save money, migrants’ choices and purchase of food are not sufficient to keep up with their health requirements.

A participant from Spain also echoed the importance to raise the need for prevention policies especially during an economic crisis. Citing as an example the economic conditions in Spain, she shared that its health system does not have enough resources to respond to and address all the healthcare needs of the population, especially the more vulnerable groups which include migrants. Spain’s policies and research objectives are to take into account the promotion of preventive services because she considers this as the best way to avoid further problems in the health system.

**Thematic focus.** A participant from Australia made a clarification on the groups of migrants that are included in the studies, stating that diverse groups of migrants have different implications for policy making. As both presenters confirmed that the scope and respondents of the studies are not diversified, he recommended that the organisers of the workshop be specific on the topics according to the different types of migrants, as this will help provide clear direction in terms of policy given how broad migration is.

**Collaboration between policy makers and researchers.** The need to establish collaboration between researchers and policy makers was also highlighted in response to a comment made by a participant from Hong Kong, on the need to reach a “meeting point” between researchers (bottom-up approach) and policy-makers (top-down approach) in order to have a comprehensive view of the issue. The participant added that such meetings can serve as an avenue wherein policy makers and concerned groups from various sectors including community representatives, grassroot organisations, public health institutions, academic institutions, and governmental agencies at different levels can consolidate interactions and have a healthy discussion on policies and perspectives associated with migrants considering their diversity. A participant from China highlighted that at the 2nd Project Workshop of the United Nations Research Institute for Social Development (UNRISD) and Sun Yat-Sen Centre for Migrant Health Policy ‘Migration and Health in China’ research project – a research project carried out in Guangzhou, China – which was held in July 2012, provincial government authorities also expressed the need for researchers to collaborate with government officials in the early stages of research design, rather than solely sharing results pertaining to migrant health. This could ensure that the research community responds to government needs and priorities.

**Policy for returning migrants.** A participant from Korea raised another important policy consideration for returning migrants. In Korea, returning migrants encounter family issues such as being emotionally distant, and migrants need corresponding help for this. Dr Czapka confirmed that there are psychological centres where they can seek help but Poland does not have special policies for return migrants despite a relevant programme drafted in 2008. She also added that, due to more favourable economic conditions in Norway, return migration in Poland was not as high as expected. This led to the loss of political momentum for the implementation of programmes for returning migrants in Poland.

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10 Due to significant outflow of skilled employees from Poland, the issue of their return has been a subject of social debate since 2006. In 2008 specific actions were taken to estimate the scale of return migration. It was anticipated that world recession and worsening economic situation in Eastern European countries would generate intense return migration to Poland. Since 2006, different programmes facilitating migrants’ return have started (2006 – Closer to work, closer to Poland; 2007 – National Programme for Co-operation with Polish Community Abroad, Return Home). In 2008 an inter-department governmental Working Group for Return Migration was established. It drafted a programme: Do you have a Plan to return?, which produced a printed guidebook “A Returner. Navigation for Returning Migrants” and a website: www.powroty.gov.pl. The interest in the programmes was not as high as it had been expected, as return migration did not develop into a mass phenomenon.
Promoting Equity in Healthcare for Migrants and Other Vulnerable Groups: The Case of Italy

Dr Antonio Chiarenza, Co-ordinator of the WHO-HPH Task Force on Migrant-Friendly and Culturally Competent Healthcare (MFCCH), AUSL of Reggio Emilia, Italy

Migrant population and migration trends. Italy has become a place of immigration for over four decades with a growing population of migrants. In 2011, the number of legal foreign residents reached 5 million making Italy the third country in the EU with the highest presence of immigrants. Migrants in Italy represent 8.2% of the total population, which is above the European average of 6.6%. The increase from 2011 is little in the sense that the number of permits delivered was less than of those that were not renewed (230,000 vs. 263,000) because of the economic crisis. Estimated number of irregular migrants increased to 500,000. Refugees were about 60,000 mainly from Eastern Europe and North Africa and there were about 37,000 asylum seekers. The highest density of migrants (63% of the total) is in Northern Italy which is the richest part of the country. Nationalities of the migrants vary, both from the EU and non-EU countries. Top regions of origin are Europe wherein 50% of the migrants came from, followed by Africa at 22% and Asia at 19%.

Migration trends in Italy are characterised by precariousness and diversification. Migrants face precarious state when they lose their jobs which means losing their regular status and their full access to healthcare. The other element is diversification. Origins of migrants are highly diversified; there are a lot of different nationalities which can make integration of migrant communities weak. Migrants are diverse between them and among the same group because of their status, gender, different levels of living conditions and legal entitlements.

Undocumented migrants’ entitlements to access healthcare services. Undocumented migrants (UDMs) do not have the right to register with the Italian National Health System (NHS) – or Servizio Sanitario Nazionale – but they have the right to access health care services for urgent and essential medical care both including continual treatment. They receive a temporary code – the regional Straniero Temporaneamente Presente (STP) code – recognised across the nation. Applicants who do not possess sufficient economic means are treated free of charge (no moderating fee required). Access to healthcare must not entail any form of reporting to authorities. Dr Chiarenza shared his experience in healthcare provision for UDMs in Reggio Emilia where a dedicated service was set up for them by the local health unit, in partnership with the Non-Governmental Organisation (NGO) Caritas. The service is called “Centro per la Salute della Famiglia Straniera (CSFS)” and provides for general medicine, internal medicine, general surgery, tuberculosis (TB) surgery, obstetrics and gynecology, pediatrics, dental care, psychiatry and social support. In 2010, the CSFS provided care for more than 3,000 UDMs. It ensures connections with other services of the Local Health Authority and the Hospital Trust for specialist care, psychiatric and psychological care, vaccinations and surgery. It runs projects with the Local Authority: Dental care project with the dental school, Care of sex workers and Roma.

UDMs can have their health needs met through three entry points: dedicated services for UDMs, the NGO/Caritas clinic, and the city hospital. This is a way of opening the healthcare system to them. The organisation is sensitive to migrants’ needs by offering interpretative services and training for staff on cultural competence. These migrant-friendly services create conditions for the integration of irregular migrants in the health system.

Inequalities in health status, access and quality of healthcare. The “healthy migrant effect” disappears over time (“exhausted migrant effect”). Some migrants would arrive healthy but become ill after a few years due to poor living, working, and social conditions (poor housing, marginalisation, social exclusion, etc.), resulting in major health problems pertaining to occupational health safety, depression, diabetes, and cancer among others. Poor living conditions and exposure to risk factors are more prevalent among migrants than the rest of the population. Even if services are available, the following barriers prevail, causing inequalities in access and quality of healthcare: legal and financial barriers, language and communication barriers, low level of migrant patients’ knowledge and information on the availability of and access to health services, and low level of health staff’s competence on migrants’ needs. There are also organisational and service delivery barriers which means that services offered to migrants are not suited to their needs.

Information on the World Health Organization (WHO) and International Network of Health Promoting Hospitals (HPH) Task Force on Migrant-Friendly and Culturally Competent Healthcare (MFCCH) can be found on Azienda Unità Sanitaria Locale (AUSL) di Reggio Emilia website at www.ausl.re.it

Developing equity standards for migrants in healthcare. In response to those healthcare issues and barriers, the WHO-HPH Task Force on Migrant Friendly and Culturally Competent Healthcare (MFCCH) established the “Project to Develop Standards for Equity in Healthcare for Migrants and Other Vulnerable Groups”, which produced the “Preliminary Standards for Pilot Testing in Healthcare Organizations”. The project’s objective is the development of a comprehensive framework for measuring and monitoring the capacity of healthcare organisations to improve access to appropriate and effective services, and health promotion and preventive care for migrants and other vulnerable groups. Dr Chiarenza noted that it is a self-assessment tool that contains standards to measure and monitor equity in healthcare, which are not fixed parameters but can be considered as criteria to analyse performance and situation. Upon producing the preliminary standards, the pilot test was conducted in 12 countries and involved the healthcare organisations which will be asked to use the tool eventually. The idea was to involve them in the process of constructing the standards.

The conceptual model of the projects was based on the notion of “cultural competence”, probing whether it is the most effective way to address disparities in health. Dr Chiarenza noted, based on the WHO-HPH Task Force’s review, that there are some pitfalls in the concept of cultural competence when put into practice. Being culturally competent does not guarantee understanding individual needs. They also considered the changing context of cultural competence with the new migration trends in Europe, which made evident that cultural differences and identities of different ethnic groups are not sufficient to express individual needs. Not only are there many different groups that need to be taken into account, but also the differences within these groups may be even greater than the differences between one group and another. What we notice is that, this new migration has brought with it an increased level of differentiation of diversity and not just in terms of involving more ethnicities and countries of origin, but also with respect to a multiplication of significant variables that affect inclusion or exclusion processes. To understand and more fully address the complex nature of contemporary migration-driven diversity, Vertovec suggests we take into account the dynamic interplay of a number of variables including, not only ethnicity and country of origin, but also differential legal or socio-economic status, age, gender, degree of entitlement and inclusion, and migration history.

The standards then proposed an alternative approach at both individual and organisational levels, based on the ideas of: 1) encouraging staff to focus on the uniqueness of the individual, recognising and valuing differences; and 2) ensuring equity of treatment for all as the major strategy to reduce disparity in health care. Taking these ideas into account, five main standards were developed: equity in policy; equitable access and utilisation; equitable quality of care; improvement of user and community involvement; and promoting equity outside the organisation.

The first standard, equity in policy, aims to define how the organisation should develop policies, governance and performance monitoring systems, which promote equity. The goal of the second standard is to encourage health organisations to address barriers, which prevent people from accessing and benefiting from health care services. The aim of the third standard is that the organisation provides high quality, person-centred care for all, always acknowledging the unique characteristics of the individual and acting on these to improve individual health and well-being. The fourth standard aims to ensure equitable opportunity for service users and citizens to participate in service planning, delivery and evaluation. The fifth standard, promoting equity, wants to promote an understanding with the organisation as part of the wider system, which means that the principles of equity have to be promoted through advocacy activities also outside the organisation in order to influence other sectors of society.

Dr Chiarenza also shared briefly the results of the pilot test. The aim of the pilot–test was to evaluate comprehension, importance and applicability of the standards and to assess the level of compliance with standards in pilot-organisations. The overall evaluation of the standards was positive. However certain measurable elements proved to be somewhat problematic, in particular those pertaining to the fourth standard.

on user involvement, and to some extent the third standard on equitable quality of care and the fifth standard on promoting equity outside the organisation. The current level of compliance with the standards was low in a number of organisations, in particular compliance with equity policy implementation, user involvement and promoting equity in the wider system.

With regard to clarity, improvement has been suggested to wording and structure, as well as the need for explanation of controversial terms. For example, changes in the terminology, the emphasis used, the order and internal coherence of measurable elements. Concerning relevance, a need for some revision of the proposed measurable elements was highlighted. It was suggested that new issues be introduced, such as equity policy for staff recruitment and careers, informed consent, health literacy, as well as inclusion of family members, when person-centred care is addressed. Comments on the applicability of the standards provide important indications for effective implementation of the tool in healthcare organisations, with regards to national legislation, health systems organisation and socio-political contexts. Concerns have been raised on possible conflict with local norms and values, existing processes and resource restraints. For example, lack of favourable legislation or limitations imposed by existing legislation, as in the case of collecting user data; and the clash with existing assessment systems or influential health reforms and the political climate.

Based on the results of the pilot test, Dr Chiarenza stated that the WHO-HPH Task Force is going to improve the standards. As suggested by the people involved in the group, there is a need to develop implementation guidelines for the standards, as this would help and encourage organisations to use this tool. Most importantly, the WHO-HPH Task Force will undertake the implementation test in the healthcare organisations involved, in order to strengthen the evidence of standards. It also aims to define a strategy that will make the tool available to all healthcare organisations.

Discussion highlights

**Building the capacity of healthcare providers.** A participant from Spain brought up a question on how a programme that is developed at the local level can be effectively adapted at a global level. She shared that the local health organisation where she works tried to adapt programmes for migrants of different origins but found it very difficult to make the programmes work. Dr Chiarenza addressed this by emphasising capacity building of healthcare providers to improve their relationship with the migrants. This can be done by listening openly to the patient and learning from the patients rather than assuming to know what the patient needs. The actual knowledge of the healthcare providers comes from their direct experience with patients and the idea is to move that forward from cultural competence. In practice, the key to capacity building of healthcare providers should involve focusing on the uniqueness of the individuals.

**Resource allocation decisions.** A participant from Hong Kong raised a question on the process of making decisions in terms of allocating resources which ensures equality. Dr Chiarenza referred to the need to include this issue in the agenda of the management of the healthcare organisation and get their understanding and support in improving the services for the migrants’ groups. Convincing the top management requires presentation of quality evidence and data. The participation of healthcare organisations in producing the data comparing socio-demographic indicators related to access is critical to the process. Talking to different groups of migrants themselves will increase participation of potential users and will enable healthcare organisations to set priorities.

**Cultural competence vs. cross-cultural training.** A participant from Australia commented on the differentiation between cultural competence and cross-cultural training. He referred to cultural competence as a policy issue that is beyond the individual and mentioned that it is about institutional, societal, and structural change; while cross-cultural training applies to the service delivery issue that Dr Chiarenza pointed out in his presentation. Dr Chiarenza responded that he meant both things and stressed that when it comes to implementation and practice, it becomes something different to what is stated at the theoretical level. He added that cultural competence is still important but healthcare providers should include other aspects of the individual.
Rural to urban migration. China has experienced unprecedented material improvements during the past 30 years through a structural transformation involving a process of industrialisation and urbanisation. The share of agriculture in Gross Domestic Product (GDP) declined from 43% in 1979 to less than 10% in 2010. Over the same period, increasing population is crowding the cities from the rural areas and those living in the urban areas increased from 19 to 47%. China then is considered to be home to the world’s largest “floating population”, which encompasses individuals who temporarily live in an area which is different from the place of their household registration, with rural-to-urban migrants accounting for the majority of this population. The number of migrants has reached hundreds of millions, a product of China’s urban-rural dual economic structure. Migrant workers, who are registered as permanent residents in the rural areas but work in the urban areas, make up the majority or 80% of the total migrant population (221 million by 2010). These migrants are bearing the costs of the great social and economic transitions. They are mainly engaged in the manufacturing, construction, and services industries without enough labour and social protection.

Regulations and access to healthcare. With the movement to urban areas in search of employment, the major concern is the difficulty in getting access to welfare services including healthcare services. This was brought about by the local government’s policy on social exclusion; migrant workers still remain at the bottom of the society with the government’s lack of provision of basic labour benefits and social protection. One of the policies contributing to this is the household registration system, or hukou system, which is the basis for public healthcare and financial allocations. Public healthcare services are provided based on household registration, and local governments shoulder the responsibility for public health services with financial allocations from their regional governments. Thus, migrants who do not possess local household registration identities are rejected by the public health system and face great difficulty in accessing public health services and medical insurance. Consequently, migrants, who undertake the most tiring and dangerous work are deprived of adequate labour and social protections, become one of the society’s most vulnerable groups and victims of a wide range of social problems. Health risks for migrants are higher than those of local inhabitants.

Different public health concerns over different migration stages. Resources are lacking for those migrants whose registered residencies are not in the cities where they currently live, as a result of the allocation of public health services that is based on local residency. This leads to substantial deficiency in family planning services and disease control for the migrant population. The wide discrepancy in public health services is also due to different migration trends in different periods. Prof. Ling identified the different stages of public health in China.

The initial stage of migration during the 1980s involved migrant population’s movement to the urban areas and this became a serious problem for family planning in the receiving areas. Prof. Ling cited that because of the family planning policy in China, migrants moved to urban places if they wanted more children. While they moved to the cities, infectious diseases relapsed. The major problems at this point were the poor quality of healthcare provided to pregnant and puerperal women, as well as the re-emergence of malaria, a previously well-controlled disease, caused by the flotation of migrants.

The second stage was during the 1990s when migrant population grew rapidly and became a high risk population for infectious disease outbreaks because of inadequate living conditions, lack of health information, and low levels of immunisation. Maternal and child-rearing problems were also significant. For example, TB...
was one of the major problems of this period, characterised by high incidence and low diagnosis rates for migrant populations. From 1993-2001, the newly diagnosed migrant patients accounted for 68.8% of all cases in Shenzhen City, China.16

By the 21st century, there have been further complications of migrant issues, wherein sexually transmitted diseases (STDs) and Human Immunodeficiency Virus infection/Acquired Immunodeficiency Syndrome (HIV/AIDS) became part of the major concerns. Furthermore, there are threats of new-found infectious diseases, and serious issues of injuries and occupational diseases. The outbreak of Severe Acute Respiratory Syndrome (SARS) drew broad attention towards public health policy. Mental and psychological health problems also began to emerge as evident in the 2010 Foxconn suicides event17, which became the symbol of the health problems that migrants face.

**Health service demand, provision, and utilisation among migrants.** The disease pattern includes infectious diseases, HIV/AIDS, STDs, industrial injuries, and occupational diseases. Aside from pre-natal health issues, among others, psychological problems of migrants are also crucial issues to be addressed. The Foxconn mass suicides show the importance of migrants’ psychological health in the labour intensive industries. The provision of public health services for migrants is severely undersupplied, caused by lack of or insufficient resources from the local governments. Generally, medical and health services provided to them were usually inferior to local people. Most of the services are not free and the migrants have to pay for these out of their low income.

The conditions aforementioned resulted in low utilisation of health services, which is also due to poor accessibility because of the following factors: 1) cost – a major concern due to economic difficulties and low income of migrants, lack of medical insurance coverage, and high proportion of cost borne by the individuals; 2) time – most migrants workers have long working hours and there is also a long waiting time at the clinic; and 3) distance – lack of community medical services institutes, geographic inconvenience, and transportation charges make it difficult for them to see a doctor.

**Recommendations and policy implications.** Prof. Ling outlined several recommendations which include the promotion of the coverage of basic medical insurance and building a scientific and unified service platform for the transference and continuation of medical insurance as migrants move from one location to another. This policy recommendation hopes to address the high mobility of migrant workers who relocate from one area to another, broaden the scope of medical services, and eliminate the economic burden of clinical care for them. An equally important recommendation is the incorporation of migrants’ health issues into health policies and programmes related to local population. Prof. Ling noted that the government has a lot of challenges to overcome because of the existing *hukou* system significantly affecting the access to healthcare. Health policies should be formulated based on the specific needs of the migrants affected by existing local regulations.

**Discussion highlights**

**Reviewing and adapting proven solutions for healthcare.** A participant from Spain highlighted that all the problems identified related to migrants’ diseases and to access healthcare services in China are very similar to other migrant health problems that prevail globally. Thus, she recommended using the solutions that have worked in other countries to respond to similar problems and adapt them to different contexts. She added that investing on research to explore and review those initiatives and strategies is necessary. Prof. Ling then stated that she is aware of experience from other countries and noted that the situation is different for every country. She also mentioned that a relevant information system is needed to be able to work together with policy makers and researchers from other countries and know more about the situation of migrants in various

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countries. A participant from Australia added that reviewing country initiatives and strategies may be viewed as a systematic approach, provided that there is evidence that what has worked in the past can be adapted to China’s context.

Immigration Health Policy in Korea
Professor Youngtae Cho, Department of Health Sciences and Services, School of Public Health, Seoul National University, Korea.

Migration groups in Korea. Migration in Korea can be characterised by three major groups: marriage migrants, migrant workers, and international students. Korea, which used to be a sending country, had had a negative net migration rate until 2006 when the system changed to open the labour market to foreign workers who are needed mainly in the manufacturing and in the agricultural industries in Korea. This development has led to the influx of migrant workers seeking better living conditions. The large number of marriage migrants coming to Korea, mostly from China and Vietnam, has been growing since the early 2000s as a result of the lack of brides in rural areas. As the Korean economy grew, Korean universities also started accepting a lot of foreign students from a number of countries worldwide. Korea has become attractive to international students due to its consistent investment in the development of the country’s education sector. In 2011, a total of almost 1.4 million foreigners were living in Korea.

Korea’s health policy. In Korea, the basic philosophies with regard to how foreigners should be treated pertain to multiculturalism and the concept of inclusion. The approach in migrant health is based on the human rights perspective, thus, Korea does not have discriminatory health policies or services for migrants, according to Prof. Cho. Any migrant holding an appropriate visa (such as a student visa, working visa, or marriage visa) can stay in the country for more than three months and become eligible to participate in the National Health Insurance System. However, he added that while the size of the migrant population is increasing in Korea, there are no specific arrangements or regulations related to the health of migrants. Prof. Cho noted that his research is part of a project supported by the Center for Disease Control and Prevention in Korea, with the objective to understand what kind of health care or health management system exists in the country.

Medical requirements and insurance coverage. Marriage migrants, applying for a Korean visa would require medical examination. Prof. Cho shared that the medical results, however, may not be accurate. In Vietnam, where most of the marriage migrants come from, a medical exam that costs as low as US$10 involves a meeting with a physician who would only ask useful and appropriate questions without requiring the migrants to undergo actual medical tests. For that reason, the medical clearance which is just based on the migrants’ answers may not be reliable. Moreover the Korean Consulate does not check on the medical clearance’s accuracy. Once married to the Korean husbands, marriage migrants automatically become members of the Korean National Health Insurance. This status changes in case of divorce if the marriage lasted only for less than two years. Migrants also face the threat of deportation. If the marriage lasted for more than two years, marriage migrants become permanent residents, according to Prof. Cho.

For migrant workers, at the pre-arrival level, full medical examination is required by the local government of the migrant’s sending country and by the Ministry of Employment and Labour of Korea. Within 90 days after arrival, migrant workers are still required to submit medical certificates issued by doctors in Korea. As labour migrants become part of the health insurance system, contributions are shared equally between the employee and employer (each pays 50% of the contribution) on the same basis as nationals. This entitles them to the same coverage as Korean nationals. Korean Chinese migrant workers, on the other hand, are not required to undergo medical examination conducted by a doctor, but only to submit a self-reported health form. They

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19 According to “International Marriage by Nationality of Foreign Wife Married to Korean Husband” by Statistics Korea (April 2011), Vietnamese wives married to Korean husbands were the largest group (7,636 out of 22,265 constituting 34.3% of the total number).
21 Korean Chinese migrants, according to Professor Cho, are Koreans who have Chinese nationality mainly because their fathers or grandfathers were forced to move to Chinese territory during the period of the Japanese colonisation.
only need to be checked and declare “I’m very clean.” To apply for the certificate of alien registration, which migrant workers usually have to do within 90 days upon arrival, they must submit to a medical examination conducted by a physician in Korea. Since a large number of Korean Chinese in Korea work illegally in small businesses, they are not often covered under the employment insurance. They can also get medical treatment using the Korean National Health Insurance. Medical insurance is provided by the employer. If one is self-employed and does not have an employer, then coverage can be obtained through local community medical insurance and the level of coverage would be the same but with a lower premium. Nevertheless, Korean Chinese migrants are usually not covered by medical insurance; those without employers who need to pay on their own are not willing to do so. This group of migrants poses a burden to Korea’s health system as a result of not taking a proper medical examination, legal status, and employment insurance.

For international students, however, no medical examination is required during the immigration process. Most universities do not require any type of health insurance for international students during their registration either. This could eventually be a threat because these students may end up staying in Korea without those proper health assessments, either during the stay of the students or post-graduation.

**Problems on migrants’ access to healthcare and corresponding policy reactions.** The first problem on access to healthcare identified by Prof. Cho is the lack of systematic policy structure that can enhance co-ordination between related ministries and local governments. There are three ministries related to migrants in Korea (Ministry of Employment and Labour, Ministry of Justice, and Ministry of Health and Welfare) and there is no policy dialogue among these three ministries. Prof. Cho suggested that there should be an Inter-Ministerial Migrant Health Council that could orchestrate segmented policies. Lack of an information dissemination system was also an issue. Information from the government does not reach individual migrants, which results in unawareness of their eligibility for health insurance and availability of free community medical clinics. Thus, establishing an information delivery system from the government to individual migrants is recommended. Migrants are also facing challenges pertaining to cultural and language issues. The Korean government uses a system of translation instead of a cultural competence system. Language and culture supporting systems should be developed.

Problems with access to National Health Insurance abound, particularly with regards to the non-mandatory health insurance provision by employers. There are no penalties against employers who do not provide it. Migrants would usually choose to receive their full salary instead of having the employers pay for their premium at the migrants’ own expense. Furthermore, those who are young and healthy do not see the need for insurance. Migrants also perceive the monthly premium to be costly. Thus, they do not even get community insurance even if they have the option to do so. Lastly, Prof. Cho cited the “laissez-faire approach” too often adopted by the government. There are no regulations specifically for migrants, and the government just implements policies designed for the local population to migrant populations. Interventions to ensure an effective health insurance access for migrants should be in place. Prof. Cho also pointed out that there should be government interference to ensure that migrants maintain their good health, emphasising that little political attention combined with a lack of regulations is not always desirable.

In addition, Prof. Cho brought up the need for research on the health and quality of life of the second generation, that of individuals born in multicultural families (which have at least one family member of foreign origin). This generation is increasing dramatically (recent statistics reveal that two out of ten newly-born infants in 2011 were born from a mother of foreign origin in Korea), which requires to consider the impact of their health needs on the Korean health system. Prof. Cho argued that a reliable data accumulation process is also critical to construct a culturally competent health care system for foreign population in Korea.

**Discussion highlights**

**Role of ministries.** A participant from Australia followed up on the recommendation regarding the ministries’ co-ordination mechanisms for migrants’ issues in Korea, and asked how a synergy could be created among them. Prof. Cho admitted that it is not going to be easy and mentioned that it could be brought up with the change of administration after the presidential election to be held soon. Dialogue with relevant stakeholders at all levels and across sectors, who can support the idea, is crucial. Another approach is by convincing the
Ministry of Health and Welfare to take the lead instead of the Ministry of Justice that is currently doing it in relation to their issuance of visa. The issues are obviously more than just securing a visa, therefore, the lead responsibility to address the migrants’ needs should be with the Ministry of Health and Welfare.

Factors affecting the rise in marriage migration. A participant from the Philippines posed a question on why there is a rise in marriage migration and whether it has something to do with the sex ratio in Korea. She cited the consequence of the one-child policy in China and the preference for male children; at some point, when the males reached the marriageable age, there were not enough brides.

Prof. Cho confirmed that Korea’s situation is very different from China’s and the sex ratio is not an issue at the moment. Nevertheless, he added that they encountered problems with sex ratio and birth disruption in the 1990s, and this influenced marriage migration then. Foreign brides used to come to the rural areas where most of the grooms were, but by 2010 they also started going to the urban areas because of the low fertility issues, which are often linked to higher education levels among women, a higher proportion of women working or the lack of living space in urban areas. Marriage rate has gone down, particularly among those who are young and educated. As most of them delay or disregard marriage, the demand for marriage migrants has increased. The increase in celibacy in Korea is another factor.

Welfare and protection for children of marriage migrants. A participant from China requested to expound on the marriage migrants’ eligibility for medical insurance and other access to healthcare. She also raised a question on what happens to the children after the breakdown of marriages that can lead to deportation of a migrant. According to Prof. Cho, those who do not work are insured through their working husbands. They are covered by the community insurance in absence of the husband’s employment insurance. On concerns about the children or the second generation, if the parents get divorced, their children can stay in Korea. In some cases, the mother brings her children to their home country, Vietnam. Interestingly, there is one community in Vietnam where mothers, who used to be marriage migrants, settle in (instead of going back to their hometown) and a number of second generation children from former international marriages in other countries also choose to integrate the community. Prof. Cho suggested that relevant interventions or programmes should be in place to support these returning migrants who are jobless. Most of them are likely to go back again to Korea for marriage and leave their children in Vietnam.

Monoculturalism vs. multiculturalism issues in Korea. A participant from Singapore made a comment on Korea’s foundations which are multiculturalism and social inclusion, as mentioned in Prof. Cho’s presentation. In contrast, she acknowledged that Korea could be viewed by foreign communities as one of the most discriminatory countries because of monocultural hegemony in Korean society and the myth that has been carried on over centuries that Korea is the one indigenous people. She asked Prof. Cho to share any recommendation from his research or his opinion on how to make the country multicultural in practice.

Prof. Cho expressed his agreement that migrants often feel that Koreans discriminate them much more than in any other country and that this is partly due to Koreans’ strong national identity. He mentioned though that there are some changes, at least for the government considering the policy of inclusion, but not for the society as a whole. Indeed, although the government has shown political will by introducing multicultural policies, working towards more inclusion, such will is not necessarily translated and visible at society level. This relates to the difficulties encountered in policy implementation. Prof. Cho added that he does not know if this is something Korea has to change but he suggested the need for the government to invite more people to Korea and work with the civil society who can really influence and raise awareness on what needs to be changed. On the other hand, a participant from Hong Kong claimed that monoculturalism in Korea is not as apparent as it used to be. He cited the increasing number of migrants brought about by economic factors regardless of the cultural issue. He shared that one of the flip sides of multiculturalism is that people recognise that, as long as you are a good citizen, you will be accepted in the society.
A public briefing on “Facing the Public Health Challenges: Southeast Asian Migrants in Europe” was organised to present the outcome of the ASEF Public Health Network’s first joint research, “Public Health Challenges in the Era of Migration: The Health Dimension of Southeast Asian Migration to Europe,” conducted by the Yuchengco Center in the Philippines and the Fondazione ISMU in Italy. The main focus of the research was the health issues encountered by Chinese and Filipino migrants living in Italy and Spain.

Mr Junichi Nitta, Second Secretary of the Embassy of Japan in the Philippines, gave the welcome remarks, citing the objectives in the establishment of ASEF to promote greater mutual understanding between Asia and Europe through intellectual, cultural and people-to-people exchanges. One of the initiatives implemented through ASEF is the “ASEF Public Health Network” which acts as a platform fostering Asia-Europe co-operation in the field of public health, gathering stakeholders such as international organisations, regional institutions, NGOs, private sector entities, and academic institutions. Joint research initiatives in health and migration are conducted through the Network. Mr Nitta emphasised the timeliness of this topic, reaffirming that public health issues are increasingly globalised and need to be tackled collaboratively.

The Health Dimension of Chinese and Filipino Migration to Spain
Dr Trinidad Osteria, President, Yuchengco Center, The Philippines

Dr Trinidad Osteria presented her key findings on the health issues of Filipino and Chinese migrants in Spain. The research objective was to come up with meaningful recommendations for the incorporation of Asian migrants’ health concerns in European public health policies and programmes, through reviews of current regional and national policy prescriptions as well as the delineation and analysis of the perspectives of the migrants, health service providers and key informants that would affect health service utilisation.

Language: major barrier to healthcare. Among the concerns related to the utilisation of healthcare services, language barrier is cited to be the most serious obstacle to quality health service provision. Colloquial knowledge of the Spanish language among Filipino and Chinese migrants is not sufficient to understand and address the migrants’ health needs in the clinic. Clinical mediators have to translate not only words but also the meaning and the context of statements to both patients and health providers. In order to do this, considerable knowledge of the patient’s socio-cultural and health context is necessary as well as the basics of illness diagnosis and management. Another concern on the utilisation of healthcare services is the migrants’ reluctance to utilise health facilities as they fear the stigma attached to particular illnesses (such as TB, HIV/AIDS, and mental health problems) and discrimination by their community. They are unaware that the confidentiality of medical interactions is ensured by law. Moreover, because of employment constraints, problems related to health consultation arise when migrants encounter difficulties in taking time off from work during clinic hours. And the situation is aggravated by long waiting time in clinics. Distance between the clinic and residence/workplace may cause inconvenience since travel is time-consuming and consultation detracts from their income generation which is mainly based on hourly duty.

Socio-cultural issues. Differences in mindsets between providers and patients cause problems when illness and its management are explained by providers from the biomedical perspective. The patient may regard this as incomprehensible. Besides, migrant patients have their own expectations in health service provision based on their previous consultations in their own home countries to the point of calling the professionals

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“incompetent” when these are not met. Hearsays on management and treatment of illnesses prevail. Furthermore, the tendency to seek remedies from traditional systems among the Chinese and self-medication in the case of some Filipinos delays timely consultation, constraining appropriate management (e.g., hospitalisation, fluid intake, therapy, consultation, and appropriate rest and medicine intake for cardiovascular and circulatory problems).

**Spain’s response to needs of migrants.** Spain attempts to meet migrants’ needs through the following: increased access to and adaptation of health services to migrants’ needs; health promotion through distribution of pamphlets and leaflets in immigrant languages; migrants’ health needs assessment; personnel training in cultural competencies; the production of guidelines to healthcare workers in management of immigrant patients; and cultural mediator training courses which also need to be monitored.

**Conclusion.** Dr Osteria cited three issues in utilisation of services that should be considered in the incorporation of Asian migrants’ health concerns in European public health policies and programmes: 1) quality of services with emphasis on interpersonal dimension through compassion (a value reflected in provider’s concern toward the client’s illness), personality (the distinctive aura of authority, competence, and knowledge that the provider exudes), respect (patients expect reciprocal respect from the provider by not scolding them or showing dissatisfaction over the patients’ narration of their health complaints or suffering), and familismo (collective loyalty to the family in making decisions related to health); 2) medical pluralism widely practised within Chinese and Filipino communities (migrants tend to use traditional medical practices before turning to mainstream national health services), reconciling both traditional and modern medicine systems; and 3) transnationalism versus integration, which is an issue raised given the circular movement of both the Chinese and Filipinos between the country of origin and destination. Dr Osteria, to further explain the issue of transnationalism and integration, cited that there is a tendency for migrants to go back to the country of origin to seek medical care instead of integrating themselves in Spain by learning the language and availing of other advancement opportunities, as well as making use of public health facilities. Integration matters for long-term migration scenarios. Migrants integrate when they take roles inside organisations (such as businesses, universities, health centres, and local administration) and fulfil the social expectations linked with these roles as workers, students, and patients.

**The Health Dimension of Chinese and Filipino Migration to Italy**

Dr Daniela Carrillo, Researcher, Health and Welfare Sector, Fondazione ISMU, Italy

For the case of Italy, Dr Daniela Carrillo presented Fondazione ISMU’s research findings. Introduction consisted of citing the trend in health policies for foreigners, which is formally inclusive, referring to the availability of free access to healthcare. The multilevel type of governance includes the regions, provinces, and the communes. Decentralised systems of governance (like in Italy) mean that, even if the right to access National Health System is guaranteed at national level, effective levels of access will differ in different regions, as national provisions will be implemented by sub-national actors who retain some independence. In theory, the main goal is moving from emergency services to diversity management services.

**Qualitative findings.** The qualitative findings reflected the unique features of each migrant community as well as their common traits, use of health services, and main obstacles to access relevant services. The study shows that Filipinos have a relatively good knowledge of the health system in Italy. The main sources of information are personal networks and the Internet. It was also noted that, when compared to the Chinese, Filipinos refer more to government information. The Chinese community is less acquainted with the Western medical system. They are strongly rooted in their traditional beliefs and practices, and they are reluctant to undergo practices that they do not understand.

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23 Medical pluralism is an approach recognised in many Asian countries and has been adopted as a component of public health programmes within the Asian region. Patients utilize their traditional medical system, simultaneously or sequentially with Western medical practices. Migrant populations with developed health systems in their home country utilise multi-level, pluralistic healing systems. They are likely to initially seek out health facilities and practices that are familiar, appropriate, affordable, and effective to them. (Osteria, Carrillo, Sarli, (2012). *The Health Dimension of Southeast Asian Migration to Europe* (Abridged Report). ASEF Public Health Network)
The research also found that many Filipinos are more aware of the services offered. But among the common traits of Chinese and Filipino communities is the very low frequency of use of these services except for emergency care. The main obstacles to access to healthcare are the linguistic barriers and the poor knowledge of the health services and bureaucratic procedures required for their use. Misunderstandings and mistrust occur between health providers and their patients. Technical competence of health providers is questioned because of ineffective communication. And as a result of the long process or waiting time in the health service, negative perceptions arise and migrants find it difficult to identify a trustworthy professional that guide them through diagnostic and appropriate therapy.

**Conclusion.** As a conclusion, Dr Carrillo emphasised the importance of further research to strengthen evidence. Researchers should conduct more quantitative analysis, and at the same time adopt more qualitative techniques and elaborate different strategies for both migrant communities to discuss migrants’ health problems. For the improvement of health services, health organisations should develop outreach activities in the communities to disseminate information on the health system and other relevant subjects. They should work and start programmes with consulates, churches, and related associations to better reach the Filipino and Chinese communities. Health organisations should also involve the second-generation of migrants in preventive services and projects, and use peer-to-peer strategies. Otherwise, as Dr Carrillo expressed, it is quite difficult to speak to adolescents and minors using mainstream strategies. For example, the second-generation of migrants will not refer to the same places or individuals to obtain information on health services as first-generation migrants would. In this regard, using peer-to-peer communication is an innovative strategy to reach this population segment. Finally, active participation of migrants in relevant public meetings and mixed working groups should be enhanced to discuss healthcare issues.

**Panel discussion**

Brief presentations were followed by the discussion of the research findings. The discussants provided their perspectives on the research findings shared by Dr Osteria and Dr Carrillo. The first two discussants presented from an academic perspective and the other two discussants shared their perspective as policymaker and healthcare provider respectively.

**Utilisation of health services by Chinese migrants.** Professor Li Ling (Director of the Center for Migrant Policy and currently a professor in the school of Public Health in Sun Yat-Sen University) made a brief comparison of the utilisation of health services between the internal migrants in China and external migrants from China to Europe. Health services’ utilisation among both groups is lower than for local population. For the internal migrants in China, the influencing factors associated with health services utilisation include the high prices of health services, time constraints, stigmatisation and discrimination, undersupply and uneven allocation of health services, as well as lack of medical insurance. For the external migrants in Europe, health beliefs and health-seeking behaviour, linguistic barriers, stigma and anxiety, time constraints, and social-cultural barriers are the main determinants. She added the use of traditional Chinese medicine as a prevailing tendency among migrants.

The policy implications for the internal migrants in China include promoting coverage of basic medical insurance, and building a scientific and unified service platform for the transfer and continuation of medical insurance when migrants move from one location to another (as the access to healthcare services in China is based on a resident’s registration policy). That means that, regardless of one’s residency, a migrant should be entitled to insurance. Equally important is the promotion of health education for migrants to increase awareness on relevant information and to change behaviours that can be detrimental to their own health. For external migrants in European countries, incorporation of Asian migrants’ issues into European health policies and programmes should be considered.

**Good relationships as key to good health.** Prof. Jose Maria Arcadio Malbarosa from the Political Science Department of De La Salle University, Manila, shared his experience as a migrant in Madrid, Spain, where he had pursued his advanced studies. Prof. Malbarosa stated that the problem with the Spanish public health system and the medical profession in general is that they are not trained to deal with patients in general. From
his perspective, healing actually entails a holistic recovery. He cited the Filipino perspective of connecting healing to good relationship (e.g., loyalty to doctors). Health is deeply rooted in relationships and in everything that Filipinos value, and in the community and society. He added that migrants from the Philippines practice and understand the benefits of medical pluralism.

Responding to Migrant’s Needs in Spain: the Case of Catalonia. Dr Tona Lizana, a medical doctor and surgeon, heading the Migration and International Projects Division of the Public Health Agency of Catalonia Government, discussed the policies that the Catalan government developed to improve access to health care for migrant population. The Immigrant Health Plan was introduced back in 2001 as an increasing number of migrants were creating a number of healthcare demands that medical professionals or service providers were not prepared to handle. In the course of the study assessing migrants’ needs, the Health Ministry of Catalonia saw the need to develop three plans: 1) a Professional Training Plan which includes development of protocols, guidelines, and support materials for the healthcare professionals; 2) a Reception Plan which is prepared for migrants to explain them how to access healthcare services, what to do when they are ill, etc.; and 3) an Intercultural Mediation Plan which aims to define the profiles and competencies of mediators and the situation of mediation in Catalonia including the involved intercultural model, and to identify the needs of mediators. It also has the function of sourcing financial support and overseeing implementation as well as evaluation.

From 2008 to 2012, implementation of the Intercultural Mediation Plan accomplished corresponding results. The Immigrant Health Plan of the Catalan Government with the support of the “la Caixa Foundation” was able to train intercultural mediators and create a co-ordination team to do fieldwork where there was no presence of mediators. A dissemination plan was also implemented through brochures and signs at hospitals and other health centres with information on the availability of mediators. The project is evaluated through an IT system.

More information (available in Spanish only) can be retrieved from [http://www20.gencat.cat/portal/site/canalsalut/menuitem.f33b7c6193cf4b0c48af8968b0ce1a0/?vgnextoid=44a0e899fbd210VgnVCM1000008d0f0d0ce1e0aCRD&vgnextfmt=default](http://www20.gencat.cat/portal/site/canalsalut/menuitem.f33b7c6193cf4b0c48af8968b0ce1a0/?vgnextoid=44a0e899fbd210VgnVCM1000008d0f0d0ce1e0aCRD&vgnextfmt=default)

where mediators can log their activities and patients’ information such as age, nationality, and their need for mediators. A major concern recently growing is the sustainability of this project under the economic crisis that is forcing the government to cut budgets, mainly on health and education. Spain used to have a universal system that covered all health needs of the population, but the laws have changed after the crisis. Those who do not pay taxes will really have poor access to healthcare.

Dr Lizana, in conclusion, raised the issue in obtaining financial support to develop and sustain the programmes especially in the midst of the economic crisis. Dr Lizana cited the need to figure out the options in the current health system, as it pertains to the services that can or cannot be retained from what the public health centres used to provide. To be more cost-effective, there is a strong need for these public health centres to work at the community level in terms of raising further awareness on the importance of health consciousness and health improvement among the migrant communities, especially in the absence of free healthcare services the government used to provide. Private-public partnership can also be considered as a coping strategy to support the costs incurred by the health system in Spain. An example that can be cited is the case of “la Caixa Foundation”, a financial institution in Spain which has a private foundation that funded the implementation of the Intercultural Mediation Plan of the Public Health Agency of Catalan Government initially for 4 years (2008-2012) and recently granted an extension of 24 months. The emphasis is on the migrant communities, public health agency, and concerned private organisations, to work together in improving the services given the challenges brought about by the current economic conditions.

Foreigners orientation desk in Milan, Italy. Ms Valentina Nigrotti, a social worker at Sacco Hospital Social Services in Milan, started her presentation with the migration background in Milan. According to Piano di Sviluppo del Welfare-Comune di Milano, there were 217,324 total resident immigrants as of January 2011 and Filipinos (31,000) were the largest group, followed by those from Egypt (26,000), China (17,000), Peru (16,000) and Ecuador (13,000). The Sacco Hospital, which has been in operation since 1931 and considered to be among the principal institutions in Milan with national reference centre for various diseases and specialty treatments, opened the Foreigners’ Orientation Desk in 2011. It is a one-stop-shop for foreigners, which was created mainly to provide orientation on the hospital services and relevant information, promote access to healthcare services for migrants, and establish transcultural services to bridge the gap in information and understanding of migrants’ needs between the Hospital and the territory it serves. It has seven social workers (four social workers assigned within the hospital and three more working in the field) and five linguistic and cultural mediators who work 32 hours/month on a shifting basis. The Foreigners Orientation Desk provides translation and interpretation services for mediation during clinical interviews, and for information materials. The mediators are also present in relevant departments dealing with obstetrics and gynaecology or infectious diseases for example. Ms Nigrotti showed the 2011 statistics on the utilisation of hospital services among migrants, particularly by Filipinos and Chinese. Consistent with previous evidence from ASEF research presentations, utilisation among Filipino migrants is very low and in fact there is a huge disparity, in terms of emergency and outpatient visits and hospitalisation records, compared with the Chinese migrants (Filipinos had 217 emergency ward and outpatient visits and 39 hospitalisations while Chinese had 1,597 emergency ward and outpatient visits and 150 hospitalisations).

The critical issues and difficulties cited concerned the capacity of healthcare workers (which should be strengthened at organisational level) to make the role of linguistic and cultural mediators relevant. The healthcare situation for migrants is not only about simple language translation, but what is critical is the understanding and transferring of, and appropriate use of the knowledge of different cultures. Future funds are also a concern with the looming economic difficulties and budget cuts. Ms Nigrotti suggested 1) tapping the private sector for the funding aspect of quality healthcare service provision for migrants, and 2) strengthening the activity of linguistic-cultural mediation for all hospital departments (in terms of augmenting the number of mediators, diversifying origins of mediators and strengthening their role).

« La Caixa Foundation » on “La Caixa” website http://obrasocial.lacaixa.es/ambitos/home/convivenciaentreculturas_es.html
Questions and reactions from the audience: highlights

Key policy direction. A participant from the Philippines asked the research team, especially in terms of co-ordination of policies between countries of origin and countries of destination, which key policy directions and recommendations exist at the national and local levels to improve migrants’ access to health services.

Dr Osteria referred to the policy prescriptions from the World Health Organization (WHO) on how co-operation will be forged between sending and receiving countries especially now that the epidemiological gap between sending and receiving countries has narrowed down and most of the sending countries are now giving attention to chronic non-communicable diseases. The current need in health management goes beyond control of infectious and tropical diseases. Sending countries in Asia can learn from the experience of developed countries in terms of prevention and management of non-communicable diseases which involved lifestyle changes, dietary modifications, and other factors, especially now that the ageing population in most Asian countries is increasing, combined with both low fertility and mortality rates, putting a strain on health care systems. Looking at the statistics of morbidity and mortality patterns, in both receiving and sending countries, the study found some similarities in terms of diabetes, cardiovascular infections, and other chronic conditions. Thus, these non-communicable diseases constitute an area that needs to be looked into.

Dr Osteria also noted in her presentation during the workshop the four areas of WHO policy prescriptions. One of which is on a mechanism for co-ordination and co-operation between sending and receiving countries like shared policies, promotion of bilateral and multilateral co-operation on disease surveillance, monitoring and reporting, strengthening of health systems in developing countries particularly in illnesses that are being confronted by them, promotion of migrants’ health in the agenda of international organisations like the WHO, exchange of information and materials as well as good practices related to migrants’ health, and involvement of non-EU countries in EU funded projects on migration. Other areas include 1) the incorporation of social provisions in service delivery through increased accessibility to culturally-sensitive health services, involvement of migrant communities in promotion that includes progression, program planning and delivery of services, and the availability of high-quality translation and interpretation services; 2) enhancement of providers’ competence and these are the appropriate training of health professionals in dealing with migrants’ health issues; and 3) monitoring and surveillance of health programmes on migrants.

Dr Daniela Carrillo stressed the role of consulates and migrant communities in the receiving countries, citing the importance of making an initiative work by getting the ideas and insights from migrants themselves as active participants. She called for institutions that represent migrant groups to be more responsible. She cited the consul of Ecuador in Milan as an example, who has been influential in organising several meetings wherein migrants can directly propose topics to discuss and directly address their questions to the health system management in Italy. Another point highlighted was the importance of cultural mediators in identifying and understanding the needs and differences among migrant communities. Their presence can be very effective in getting relevant information from the migrants, especially information that is critical to the safeguarding of their health but is not typically disclosed.

**Employment of cultural mediators.** A participant from the Philippines inquired on the practice of the employment of cultural mediators in hospitals other than Sacco. Ms Nigrotti revealed that other hospitals only manage to use the help of cultural mediators should the need arise. The programme is not mainstreamed and the establishment of one depends on the needs of hospitals. Dr Lizana shared that, in Catalonia, many hospitals used to get mediators from the consular offices. But as the number of migrants increased, hospitals were increasingly in need of mediators, which pushed the government to draft and implement a plan responding to hospitals' needs, which in turn relieved hospitals from the cost of paying for mediators out of their budget.

**Methodology and respondents of the study.** Another participant from the Philippines inquired about the research's account for undocumented migrants. An additional question was raised on whether the methodology used in Dr Osteria's research was random sampling and if the respondents included domestic workers. Dr Osteria noted that the respondents of the study were all documented migrants because the take off point of the research was the family reunification law, where legal status is given to these migrants. On the sampling issue, it was supposed to be non-probabilistic and not representative because the intention was to look in-depth into the health services utilisation and the reasons for non-access to services. Aside from doing the interviews, a lot of ground work was conducted in terms of analysing the health policies of both sending and receiving countries, the health problems, the epidemiological studies, the WHO regional mandates for what we call Western Pacific\(^\text{29}\) (region to which China and the Philippines belong), and the WHO Geneva policies related to migration as well as other issues. She added that there is no effort to come up with a representative sample given the very large population. Instead, the modal feature (identification of common features) of the migrants in Spain was considered. The large majority of migrant women sampled are domestic workers, while the men who were included as respondents are restaurant workers and shopkeepers. This represents the modal characteristic as eminent in the study. Dr Osteria cited that adding more respondents would not really add value and affect the results, especially when the survey was conducted and as responses were converging. The same responses are obtained, only with slight deviations.

In the case of Italy, aside from regular migrants, Dr Carrillo added that the respondents in Italy also include irregular migrants as the research aimed to consider their point of view as well. Inquiry from another member of the audience was made about the services provided for migrants in Italy. Dr Carrillo answered that Italy has several NGOs and outpatient clinics for irregular migrants and the results show that Chinese and Filipinos do not turn to them as much as other communities do (e.g., those coming from North Africa, Sub-Saharan regions, Pakistan, and Bangladesh among others) mainly because of linguistic barriers as well as poor knowledge of the health services and bureaucratic procedures required for their use. Differences between communities in terms of access to NGOs can also be explained by community structures and how communities respond to the health needs of their members; but also the command of a third language to communicate with NGOs/health services; or the unequal distribution of NGOs supporting migrants on the territory.

\(^{29}\) WHO Western Pacific Regional Office. [http://www.wpro.who.int/en/](http://www.wpro.who.int/en/)
ASEF’s objective to promote migrants’ health

In her closing remarks, Ms Sunkyoungh Lee, Project Manager of the ASEF Public Health Network, emphasised one primary objective of any ASEF initiative — furthering mutual understanding between Asia and Europe — and the importance of data to enhance this process. These led to the ASEF Public Health Network’s research initiative on health and migration. Ms Lee also mentioned the need to overcome the cultural differences between Asia and Europe as pointed out by Dr Antonio Chiarenza from Italy, citing that listening to personal or individual needs is more important than only counting on the cultural perceptions and differences. She concluded by saying that, given the data and information acquired from research and discussion, we have no more excuses to say that we do not know what to do; we all have to do our part regardless of the sectors we belong to.
On the second day of the workshop, Session 3 was held under the heading “The Impact of Migration Policy on Migrants’ Access to Healthcare” which included the outcomes of the ASEF-commissioned research on the nature and magnitude of the cost of exclusion of documented and undocumented migrants from healthcare. The preliminary results of the studies of Austria, Italy, Singapore and Hong Kong were presented.

Costs of Exclusion of (Un)documented Migrants from Healthcare: Comparative Policy Analysis of Austria and Italy
Dr Ursula Karl-Trummer, Executive Director, Center for Health and Migration, Austria

Premise on the cost of exclusion vs. inclusion. Dr Ursula Karl-Trummer based her discussion on the access to healthcare being acknowledged as a basic human right and a prerequisite for healthy societies and economic growth, citing that societies where people are not in good health have problems to compete globally. Dealing with ageing societies, Europe has become increasingly reliant on the foreign workforce to fill labour shortages, and it is therefore important to give such migrants appropriate access to healthcare. Migrants, however, face difficulties in accessing healthcare services. Regular migrants have in-principle access to the health care systems, but in many cases, the cultural competence of healthcare organisations is still low and language barriers frequently arise. Irregular or undocumented migrants, who do not hold official work contracts are affected by the lack of regulations which could give them minimum social security and they are excluded from regular healthcare facilities even if they participate in the labour market. Cost has been the main consideration or argument for exclusion, especially for undocumented migrants. It is argued that irregular migrants, who are unable to pay taxes or cannot afford insurance fees, do not contribute to the regular system. Consequently, this poses a question on why the receiving country should then provide services in return. But it is also argued that exclusion itself is costly, and this is what the study aims to determine.

Basic regulations and costs of exclusion. In most European countries (20 out of 27 EU member states), undocumented migrants are denied access to basic or primary healthcare until their condition becomes an emergency that has to be treated with high costs. Regular migrants also have the high risk to be the subject of maltreatment or treatment errors, due to miscommunication without interpretation services. Exclusion can be costly and expensive on several dimensions detailed below, which suggest that cost of exclusion may be higher than the costs of (partial) inclusion: 1) economic cost — people are driven to enter the system as “forced emergencies” where medical treatment is very expensive; 2) humanitarian cost — exclusion undermines human rights regulations and equity policies; and 3) social cost — inequity in health weakens communities, as societies with more equal distribution of incomes have better health, fewer social problems such as violence and drug abuse, among others, and are more cohesive than ones in which the gap between the rich and poor is greater.

Figure 2 European Landscape on Access to Health Regulations for Undocumented Migrants

The above illustration, which was presented by Dr Karl-Trummer, shows the countries in Europe (27 member EU member states, Norway and Switzerland) with full, partial, and no access to healthcare for undocumented migrants. Using a public health frame of reference, “no access” countries are those that do not provide any health services, except for emergencies. The landscape is based on findings from a previous European project directed by Dr Karl-Trummer, “Health care in NowHereland” and integrates the most recent changes in regulations in two European member states (Spain and Sweden). The colours which mark the respective countries can be read like traffic light labelling: red means no access, yellow means partial access, and green means full access.

Demographic role of migration. Austria is a small country with a population of about 8.4 million, 11.5% of which has foreign citizenship. Its net migration rate of 4.6% is the only demographic drive of Austria’s population growth. Thus, without positive migration rate, Austria would shrink and this trend will not change anytime soon. The Asian population residing in Austria has consistently increased for the last 10 years with a total of about 69,000 in 2012.

Migration policies in Austria. Migration policies in the country were introduced in the 1960s in reaction to economic growth. Austria needed “guest workers”, and the term was very much oriented towards the Swiss idea of having people temporarily come to the country as substitute to the needed workforce and then go back to the country of origin again. This was regulated by labour market demands and health screening was required.

Austria has an insurance-based health system with compulsory health insurance that is linked to employment; its coverage is close to universal (99.3% in 2011). Yet, there is an estimate of about 60,000 official residents who are not covered by any kind of insurance scheme (this arises from situations such as changes of status, for example when a women previously registered under her husband's health insurance gets divorced or when a person is eligible for insurance coverage from social funds but does not apply). Migrants with undocumented residing status are not included in official numbers and need further considerations. It is difficult to assess the actual number as these migrants are in hiding.

Austria’s policies on access to healthcare for regular migrants. In terms of regulation, migrants are treated equally and have equal rights once they are integrated into employment and insurance schemes. It is defined by law that any individual with regular status and insurance coverage should be treated equally. In practice, however, studies show that migrants are at higher risk of getting insufficient/inappropriate treatment, mainly because of health care organisations’ low level of sensitivity to diversity, cultural background of migrants as well as other socio-economic determinants. It can be attributed to a low cultural sensitivity, which is still a marginal issue in the Austrian healthcare system. For example, there is no implementation on the broader bases of translation services or interpretation services in healthcare institutions.

Austria’s policy for undocumented migrants and role of NGOs. There are no specific regulations in place and the access to services is either through emergency or on a fee for service basis. As for other uninsured people, in principle services are only available when paid out of pocket. Nevertheless, the Austrian Federal Hospitals Act obliges hospitals to provide first aid in case of emergencies. The only access to (routine) medical care for the poor and the uninsured is through emergency. It was noted that Austria’s policy towards undocumented migrants is in a state of “functional ignorance”. The issue of healthcare for undocumented migrants is not on the agenda of public sector units, which ignore the problem and there has been no discussion to change this. Functional ignorance on the part of the Austrian government may endure because NGOs at least partly make up (mainly in larger cities such as Vienna and Graz) for what the system lacks in terms of service provision through “informal solidarity”, meaning the integration of undocumented migrants into service provision by labelling them as another vulnerable group (e.g., homeless people or uninsured people). The NGOs provide services free of charge for marginalised people, often by working with volunteer healthcare professionals.

The case of Italy: providing partial acceptance to undocumented migrants. The case of Italy was highlighted in the presentation, citing its very impressive system of partial acceptance towards undocumented migrants and provision of the necessary services regardless of their status. Italy has legislation on healthcare for foreign nationals who are not registered with the National Healthcare System. Provided are access to emergency/urgency care, prenatal and maternity care, vaccinations, preventive medicine programmes, and prevention/diagnosis/treatment of infectious diseases among others. There are two central administrative instruments that are dedicated to these services and provide continuity of care: the Straniero Temporaneamente Presente (STP — foreign national temporarily-present) and the Dichiarazione di Indigenza (DI — self-declaration of indigence). It has to be noted that the implementation of these regulations differs regionally to a large extent. A specifically interesting and successful Italian practice is to be found in Reggio Emilia, wherein there is co-operation between dedicated public services and NGO efforts, and STP is used for co-ordination and documentation of health status of undocumented foreign nationals and services provided.

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The role of informal solidarity through NGOs in continuity and provision of services. At the end of her presentation, Dr Karl-Trummer highlighted the role of NGOs. Comparing Italy and Austria, the system towards undocumented migrants are different with Italy having a system of partial acceptance and Austria being characterised by a state of functional ignorance. There is, however, a common logic pertaining to the structural compensation from NGOs, based on informal solidarity that plays a decisive role in continuity and provision of services that government does not and/or cannot provide.

Health of Migrants in Singapore
Dr Kai Hong Phua, Associate Professor of Health and Social Policy at the Lee Kuan Yew School of Public Policy, National University of Singapore, Singapore

Dr Phua shared that in the course of their study on the social cost of migration, which he considers to be mainly the loss of productivity as a result of poor health of migrants, attention shall be directed to economic costs and benefits in the Asian context. Dr Phua then gave an overview of migration trends in Southeast Asia (particularly within the Association of Southeast Asian Nations (ASEAN)) and Singapore, related policies, and issues that would illustrate and explain the overall situation of migrants’ health.

Overview of migration trends in Southeast Asia and Singapore. There is growing intra-regional migration due to the rapid economic development of some Asian countries. This is especially true for those that have reached first-world status like Singapore and which have become more attractive to migrant workers. In 2010, there were 4 million migrants within ASEAN, one third of total ASEAN migration (12.8 million as per World Bank data). Migration trends within ASEAN are characterised by its temporary nature, low skilled flows, and high rate of irregular migration. The gap between restrictive immigration policies and high labour market demand has resulted in large flows of irregular migrants (estimates of 1.5 to 2 million irregular migrants) in the region. These migrants are exposed to health risks at all stages of migration (origin, transit, destination, return), which are compounded by the role played by the complex migration industry (agencies, employers, etc.). The reluctance of governments in the ASEAN region to deal with migration flows, which are left to be managed by private actors such as recruitment agencies, and the temporary nature of migration, are both factors which impact on the health of migrant workers. Singapore is considered to be one of the main receiving countries in Asia and one of the most affluent. Yet, it has a similar migration environment as the region. The immigration policies in Singapore are partly characterised by the use of quotas, levies, and security bonds, and recruitment occurs mainly through private agencies.

Profile and size of migration in Singapore. Migrant workers in the country mainly work in construction, manufacturing, domestic work, and services and about 931,200 workers were semi- or low-skilled as of 2012. The total foreign workforce is close to 40% (about 1.23 million) of Singapore’s total workforce. Work Permit holders (who are the subject of the Singapore part of the research) are the largest group (75% of the total foreign workers) and others are Employment Pass and Special Pass holders. Dr Phua noted that documented migrants are still the majority in Singapore because of its strict enforcement of immigration laws. However, documented, low-skilled, or unskilled workers are in a special category of work permit holders whose stay should only be within one to two years in Singapore. But many of these workers would come back under a different name and passport. They are low-wage migrant workers involved in low- or semi-skilled manual jobs, including women employed as live-in domestic workers. Documented foreign domestic workers (FDWs) were 208,400 or 16% of the total foreign workforce, while those in construction were 277,600 or 23% of the total. Work Permit holders are usually employed in sectors “shunned” by Singaporeans (dirty, dangerous, and demanding), bridging the gap between high demand and limited pool of local labour. They are also subject to the following restrictions: 1) They may not bring family members with them; 2) They need approval from the Ministry of Manpower before marriage to a Singapore citizen or permanent resident; and 3) They are not allowed to become pregnant and give birth in Singapore.

Research team includes Rachel Hui, Marie Nodzenski, and Nicole Bacolod of Lee Kuan Yew School of Public Policy, National University of Singapore.

The undocumented migrant workers are typically “over-stayers” who enter Singapore on a tourist visa and stay on to work illegally. Dr Phua also noted that the Special Pass Holders group is probably the closest to undocumented migrant workers. These workers could have problems with claims on their pay or are injured. So they actually cannot work and they are given a Special Pass while their case is being examined. A lot of them are likely to suffer health issues.

Legislation on migrant workers’ health

- **Mandatory medical examination**: Work Permit is only issued if the migrant worker passes a mandatory medical exam including for TB, HIV, syphilis, and malaria by a registered doctor within 14 days of arrival. Employers are able to obtain a report directly from the doctor without their employees’ consent. FDWs are additionally required to go for a six-monthly medical examination to screen for infectious diseases and pregnancies. Pregnancy would be a legitimate reason for termination of work and immediate repatriation.

- **Mandatory medical insurance/personal accident policy**: Employers are required to purchase and maintain a minimum medical insurance coverage of SGD15,000 per year for each Work Permit holder for inpatient care and day surgery, including hospital bills for conditions that may not be work-related. In addition, employers of FDWs must purchase personal accident policy with minimum sum assured of SGD40,000.

- **Provisions for well-being and medical care of foreign workers**: Employers are responsible for bearing the costs of their workers’ “upkeep and maintenance”36 in Singapore, including the provision of medical treatment. Employers are expected to ensure that their workers are provided with adequate food, acceptable accommodation and safe working conditions.

36 Employment of Foreign Manpower Act 2009- Chapter 91A (Singapore Ministry of Manpower)
Exclusion of FDWs in legislation: FDWs are not covered under the Employment Act, which specifies minimum rest days, hours of work, overtime entitlements, and medical leave: this is justified by the nature of job as “personal contract”, “too impractical to impose standard terms and conditions of service”[37]. They are also excluded from Work Injury Compensation Act (WICA), compulsory medical insurance in event of accident provides less favourable extent of coverage and benefits than those of other low-skilled workers under WICA.

Policy gaps. Although legislations and tight regulations to protect migrants’ health exist, they are not diligently practiced by employers. One example is insurance liability. The major problem here is the liability limit which has recently increased to SGD30,000 based on the WICA. Dr Phua clarified that any cost that goes beyond the minimum is subject to some kind of dispute and many of the Special Pass holders are those with major injuries or health issues with claims of more than SGD30,000. Depending on the nature of accidents, employers may be liable if they are at fault. But as exiting legislation sets SGD30,000 as the maximum legally required, any claim above this limit will have to be settled as a civil suit in a court of law to decide liabilities and compensations. This creates a “no-man’s land” for care of the injured worker while the case is being settled. There are also a lot of exclusion limits on the migrants’ insurance. The lack of enforcement against errant employers who just slipped through the safety nets, by not purchasing insurance or by refusing to provide a worker with a letter of guarantee for example, also impacts negatively on the health of migrant workers.

When foreign workers are left with serious injuries, they cannot work but can legally stay in Singapore under Special Passes while their cases are under dispute which could last for at least six months. Dr Phua outlined the following scenarios that migrants may go through to illustrate the policy gaps in health and medical provisions.

- **Foreign workers left income-less during the WICA claim process**: Full course of medical treatment and compensation assessment can last from a few months to over two years. Workers are entitled to medical leave wages during this time but many receive none. Employers routinely cancel injured workers’ Work Permits and they are issued a “Special Pass” to facilitate legal stay in Singapore but may not seek employment. Many of the workers incur debts for daily expenses and costly medical treatment.

- **Dependence on employer’s letter for medical treatment forcing foreign workers to bear costs**: Workers depend on a “Letter of Guarantee” delivered by their employers in order to receive a waiver of upfront medical fees. Employers are responsible under the law for this letter and the costs of any necessary medical treatment, including conditions not work-related. However, employers often shirk their responsibilities, forcing workers to either bear the costs themselves or forgo/postpone treatment.

- **Medical expenses over SGD30,000 (“No-man’s Land”)**: Removal of health care subsidies, since 2007, for non-residents has resulted in high medical charges for migrant workers. Medical expenses for seriously injured workers can thus quickly reach the SGD30,000 ceiling. Responsibility towards any medical expenses exceeding the SGD30,000 cap under WICA relies on goodwill, rather than legal obligations, of employers or will have to be settled with a civil suit (only if the employee can prove that the employer or a third party has caused the injury).

With these difficult realities, the NGOs fill in the gaps and provide help to the migrants.

**Major health issues among migrants.** Lack of access to medical/health services is one of the issues raised in Dr Phua’s presentation as identified by the members of Solidarity for Migrant Workers. Due to the removal of subsidised medical care for migrant workers since 2007 and due to inconsistent enforcement, many are denied medical insurance/treatment by errant employers, contrary to official policy. In worst cases, workers seeking potentially costly medical treatment due to serious injury are repatriated by errant employers. Living condition is also an issue as some workers are housed in cramped, poorly equipped and unventilated, and/or unhygienic living quarters, with inadequate nutrition. In addition, long working hours is identified an issue for

[37] Further information can be retrieved from Singapore Ministry of Manpower website. [http://www.mom.gov.sg/foreign-manpower/passes-visas/work-permit-fdw/before-you-apply/Pages/default.aspx](http://www.mom.gov.sg/foreign-manpower/passes-visas/work-permit-fdw/before-you-apply/Pages/default.aspx)
many construction, marine, and service sector workers who work 12 to 16 hours a day, breaching legislation on maximum of 12 hours of work per day under Employment Act. For foreign domestic workers, psycho-social health is a concern. Well-being violations include inadequate food or accommodation (43%), psychological abuse (30%), and non-payment of salary (14%).

**Social Cost.** The study of Dr Phua's research group on social costs of migrants’ health was conducted with the help of NGOs, extrapolating direct and indirect costs from their case studies. He mentioned that indirect costs could be more substantial than direct costs considering the loss of productivity based on the numbers of the months without work. He pointed out that other kinds of social costs, which are not captured in monetary terms such as the intangible cost of pain and suffering, stigma and discrimination, stress and anxiety, exist. He added that migrant workers who often experience being in these situations also attempted suicide.

**Health of Migrants: Hong Kong Perspective**
Professor Huo Yi, The Jockey Club School of Public Health and Primary Care, The Chinese University of Hong Kong, Hong Kong SAR

**Immigration flows.** The mainland Chinese migrants are the main contributors to Hong Kong's immigrant population due to the rapid economic expansion of mainland China in the past 20 years, and increased legal movement of people between Hong Kong and Shenzhen, China after the Basic Law of 1997. Since 1 July 1997, the day Hong Kong became a Special Administrative Region of the People's Republic of China, immigration policies have changed and an increasing number of migrants from mainland China have been coming to Hong Kong. The Basic Law allows right of abode to selected Chinese citizens in Hong Kong. Between July 1, 1997 and the end of 2011, about 189,900 Certificate of Entitlement holders entered Hong Kong from the mainland. In 2011, about 43,400 mainlanders joined their families in Hong Kong under the “One-Way Permit” scheme, which imposes a daily quota of 150 Chinese with family ties in Hong Kong. Furthermore, with the “One Country Two Systems”, migration is encouraged across the Hong Kong — mainland border. And since the law provides the right to abode and permanent residency to any person born in Hong Kong to mainland parents, the mainland baby boom has become a social issue. The number of children born to non-Hong Kong permanent residents has been increasing significantly for the last 10 years. Thousands of women from the mainland come to Hong Kong to give birth because it entitles their babies to permanent residency benefits, which include a free education and subsidised healthcare as part of Hong Kong's British-inspired welfare policies. It was also noted that this trend is due to the one-child policy in China; mothers from mainland would go to Hong Kong for succeeding births. Thus, welfare policies in Hong Kong granting children born in Hong Kong with social and health benefits coupled to the restrictive one-child policy in China have contributed to an increase in cross-border migration of Chinese women in Hong Kong.

Among the labour migrants, the foreign domestic workers (FDWs) comprise the highest proportion of ethnic minorities in Hong Kong, accounting for almost two thirds of the city's non-Chinese population. In 2010, there were 284,901 FDWs which represented 4% of the Hong Kong population, and the majority of these FDWs were from the Philippines and Indonesia. Undocumented immigrants were mostly from the mainland working in the construction sector, and the rest were migrant sex workers. There is no reliable data on the number of migrant sex workers in Hong Kong, but in 2010, 1,588 women working in the sex industry were arrested and deported for illegal immigration. Hong Kong is primarily a transit territory for undocumented immigrants, some of whom are trafficked for sexual exploitation and forced labour in their destination country. Women were lured to Hong Kong by criminal syndicates or acquaintances with promises of financial rewards or prospective work. Upon arrival, migrants are forced into prostitution to repay money owed for their passage to Hong Kong.

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39 Research team also includes Prof. Sian Griffiths, Dr Hildy Fong, Prof. Roger Chung, The Jockey Club School of Public Health and Primary Care, The Chinese University of Hong Kong.

Eligibility of migrants to access healthcare services. Public healthcare services in Hong Kong are available to all regardless of migration status. Per residence status, those categorised as eligible persons are entitled to subsidised public rates. This group includes One-Way Permit holders and other non-permanent residents, who hold Hong Kong Identity Card, and FDWs. Non-permanent residents receive the same range and quality of services as permanent residents. By law, employers in Hong Kong are mandated to provide healthcare insurance services to their migrant employees, otherwise, they cannot hire. For undocumented migrants, they are eligible to public healthcare services if there is an urgent need, but they will need to be reported to the Hong Kong police or authorities. Thus, some refuse to go. NGOs fill the gap left by public health services for migrants.

Migrants’ health problems and healthcare needs. Prof. Yi presented some literature review to illustrate migrants’ health problems and healthcare needs. With Chinese adult migrants, depressive symptoms are the most prominent factor affecting quality of life. Preventive measures must be developed by providing professional counselling and psychological support services. A recent study reported that among FDWs, 40% of respondents felt discriminated against in Hong Kong hospitals\(^\text{41}\). Human rights abuse claims include physical and sexual abuse, ill treatment by employer, lack of time-off, and insufficient food affecting the quality of health. For female migrant sex workers (FSW), who are extremely vulnerable to abuse and ill health, stigma in Hong Kong contributes to their poor health, mainly by impacting on their psychological and emotional well-being. Illegal status prevents FSW from seeking healthcare or protection from crimes committed against them. As non-residents in Hong Kong, they are charged a high fee when accessing health services, meaning that like most non-resident/undocumented migrants, who are not entitled to healthcare benefits, they do not seek medical assistance when treatment is needed. To provide better access to healthcare services for migrants, Prof. Yi emphasised that more culturally acceptable and affordable mass screening programmes should be provided. He added that service providers should also acknowledge the limited free time these women (e.g., FDW and FSW) as well as construction migrant workers have to attend to healthcare, and should ideally be open on Sundays. Equally important is the availability of health information in migrant’s own language for those who are non-Chinese.

Health equity framework. Prof. Yi shared the World Health Organization’s conceptual framework on the social determinants of health and health inequities\(^\text{42}\), as a basis for the current ASEF-commissioned research to ensure that the system can cater to the health needs of migrants. He mentioned that case study interviews to be conducted in the next phase of the research would highlight the following issues: 1) “One Country Two Systems” policy — this is the main context for migration in Hong Kong. The potential long-term effect of the Basic Law on the HK health system requires that the policy for the health of migrants should be a high priority. Particularly to be prioritised are: children of mainland Chinese women who are born in Hong Kong, raised in mainland China until their school year, and return to Hong Kong for schooling; and cross-border school children from mainland who come to Hong Kong daily to attend school; 2) costs to the system — the mainland mothers’ issue (mainland Chinese women giving birth to children in Hong Kong, children who are then entitled to same welfare benefits as nationals whether or not they are raised in Hong Kong) and Basic Law make the situation quite complex in determining the cost to providers; 3) labour shortage and need for migrants — migration is essential and an integral part of the social and economic structure for Hong Kong. With increasing wealth being generated by migrant workers in the system, Hong Kong has a responsibility to provide them with social and health benefits; 4) cultural sensitivity — the health status of migrants is likely to improve by addressing discrimination, problems with mental and social well-being, and health care providers’ health knowledge, attitudes, and practices for ethnic minorities; 5) human rights — the primary responsibility for ensuring the respect of the human rights of migrants lies with States’ governments; 6) access to health and social care for undocumented migrants and temporal migrants — little is known about health access of such groups as Chinese construction workers and sex workers, and it is becoming crucial to analyse and evaluate the challenges faced by undocumented migrants in accessing health care in Hong Kong; and 7) need for social

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networks — it is necessary to acknowledge the fundamental role of NGOs and civil activism in providing services to migrant workers; there are approximately 20 to 30 non-governmental and civil society organisations for migrant workers in Hong Kong. NGOs fill a gap in healthcare services and positively impact the health status of migrants. They are able to provide access to migrants with little or no entitlements to public health care, to reach more communities and individuals and can therefore play a positive role in health prevention for migrants. They also play a major part in advocating for the protection of migrants’ basic rights. It is important to acknowledge their role in order to foster political and financial support for NGOs to work more efficiently.

The case studies would be conducted in May 2013 and Prof. Yi’s group has worked with NGOs and services in churches/missions with strong ties to migrant communities to recruit cases. Using these case studies, the next objective will be to identify best methods to measure economic and social costs.

**Recommendations.** Prof. Yi’s recommendations addressed both the national and community levels, including migrant sector specific responses to illness and health. At the macro-level, Prof. Yi highlighted the need to understand the diversities and heterogeneities within the communities of migrants based on their socio-economic, occupational, and religious status; social position in or ties to a large “host”/mainstream society (e.g., civic engagement for migrant health policy); and the fluidity of cultures and identities as communities are bound up with place and with wider socio-economic circumstances and processes. At the community level, researchers need to understand migrant-community networks, the ways in which migrants shape risk-facilitating or protection-enabling environments through their engagement in “every day” practices in diverse sectors of their communities, such as market places, religious institutions, and service resources. At the micro level, policy makers need to understand the trajectory of migrant subjectivity, the ways in which migrants’ perceptions of illness and subsequent responses to health-seeking behaviours are transferred, persist, or evolve temporarily and spatially with an individual or a group of individuals.

**Discussion highlights**

**Role of NGOs.** A participant from Spain inquired about sources of NGO funding. All country case studies from presentations cited that the NGOs play an important role in servicing people that are not entitled to public health services. She noted that, paradoxically, in Spain, a number of these organisations are called non-governmental organisations but they live through government money. Some of them do not have any income. She wondered if this is the same for NGOs in Austria, Singapore, and Hong Kong.

Dr Karl-Trummer confirmed that in Austria, NGOs do apply for public money, although they have to face the uncertainty in securing the fund. These NGOs heavily rely on unpaid workers who volunteer. Dr Phua from Singapore disclosed that the issues related to NGOs are heightened now in Singapore. Some of them cannot cope as they do not get compensated by public funds. They do have charity status and thus enjoy tax deduction and are allowed to raise funds, but like all institutions in general, they have to be accountable and transparent. This transparency issue is often linked to accounts and funding sources of NGOs not being made public and the authorities therefore have to ensure they are bona fide. In Hong Kong, Prof. Yi stated that NGOs he knows would usually get funds from government grants. They also often collaborate with a university or they get funding from other foundations. Oxfam, for example, would provide funding for NGOs.

**Welfare of pregnant foreign domestic workers and their children.** A participant from Italy addressed her question to Dr Phua and Prof. Yi, on foreign domestic workers who get pregnant, their options to go to hospitals or get an abortion, and the rights of their children.

In Singapore, Dr Phua shared that the domestic workers who become pregnant need to stop working as per Ministry of Health regulations. He admitted that it can be a very serious human rights issue, but by the law, any foreign worker under a work permit, should not get pregnant. Explaining the rationale behind this, he shared that for policymakers, the current ideology stemmed from a past rule issued when Singapore was a very small, poor country; they could not afford to have additional mouths to feed. For now, the law is still there but leniently applied. Decision is on a case to case basis, foreign workers who become pregnant may appeal to the members of the parliament. Should a Singaporean be involved, his responsibility would be engaged and both parties would for example have to get married to avoid deportation. In many cases, the worker will
get deported. In the event of an abortion, the migrant worker has to take care of the fees and there are no subsidies. He added that there are liberal laws about abortion in Singapore. However, there have been cases of “unsafe” abortions\(^4\) and it has become a health issue. Singapore has liberal policies regarding both abortion and contraception (condoms are readily available for example). In Hong Kong, Prof. Yi confirmed that there is no law against migrant women being pregnant.

**Migration and Health in Austria**  
Dr Charlotte Wirl, Social Scientist, Public Health Institute Austria, Austria

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**Resource allocation for healthcare.** Describing the Austrian healthcare through comparison of healthcare expenditure with other OECD countries, Dr Wirl highlighted that the Austrian government spends more than the rest of OECD on average. Based on the OECD Health Data in 2012, total expenditure for health accounted for 11% of GDP in Austria and 76% of total health expenditure is financed by public sources. Austria’s other health indicators are also higher than the OECD average (Figure 3).

**Migrants by country of origin.** Migrants in Austria are mostly from EU countries (over 90 %) particularly Germany. Other migrants are from the former Republic of Yugoslavia and Turkey, who are usually considered to be “the migrants” by the public. Around 16% of the population in Austria are born abroad and 11% hold another citizenship. Notably, most of the migrants hold a strong legal status.

**Health indicators.** Dr Wirl presented data on life expectancy in Austria and noted that the population has very high life expectancy in general. Looking at the data on self-reported health status, there was no difference between those born in Austria and residents born outside the country. But focusing on two groups of migrants from Turkey and Yugoslavia, data revealed that the rest of the population has a better health status than these migrants. They have lower quality of life, higher risk for pain and obesity, higher odds for smoking, and lower vaccination rates. Migrant population is generally covered by health insurance though they tend to be less healthy than the national population and have a different use of the healthcare system. Migrants tend to use outpatient hospital care more and tend to go more to general practitioners. They have lower visit rates to specialised physicians and lower usage of preventive services, such as vaccination.

**Role of other sectors and recommendations.** Dr Wirl pointed out the role of education, housing, and other sectors in improving the health of migrants. She highlighted making information accessible and taking prevention initiatives. Furthermore, she stressed the need to put evidence into practice; the need to translate evidence for policymakers, healthcare and health prevention providers; and the need to come up with effective

---\(^4\) Some female migrant workers stop their pregnancies by taking Cytotec, a prescription drug to treat ulcers which can be bought at Lucky Plaza easily. Others ask friends back home to send abortion-inducing drugs which they take ahead of their half-yearly check-ups. Information retrieved from [http://www.healthxchange.com.sg/News/Pages/100-pregnant-maids-sent-home-a-year.aspx](http://www.healthxchange.com.sg/News/Pages/100-pregnant-maids-sent-home-a-year.aspx)
practices to target and reach vulnerable groups, not those who are already privileged. She shared her belief that in Austria, the main issue is inciting individuals, both nationals and migrants, to use more and make better use of health services.

**Discussion highlights**

**Best practices and the long-term costs and benefits of existing policies.** A participant from Singapore commented that with the number of initiatives that have been taken in the past, and with studies and data presented on health issues, the objective should now be to determine the best practices. He suggested looking at the overall cost to society, whether it is worthwhile to socially exclude migrants or embark on temporary solutions which are politically motivated. It is important to know if a societal or an economic perspective should be considered to determine the long-term costs and benefits, and whether government can sustain the discriminatory policies that are based on exclusion. Dr Wirl responded against the practice of social exclusion in the long-term. However, she does not see and expect any changes in policymaking. Based on her experience, the health interventions were designed based on rather short term interests of the politicians, who financially support the interventions (in health promotion particularly, low-threshold interventions targeting those in need are still broadly lacking).

**Health behaviour and allocation of resources for migrants.** A participant from Austria shared the difficulty in creating evidence to differentiate between migrant effects and socio-economic effects as both effects influence health status and health-seeking behaviour. She also added the need to explore the issue of being unable to provide appropriate services to vulnerable groups despite the higher than average amount of money that Austria puts into healthcare. A participant from Hong Kong also commented on the provision of resources and services to protect migrants, pointing out whether the real objective of such protection system is to protect the migrant as an individual, or it is merely meant to protect the sectors where these migrants are needed. In response, Dr Wirl mentioned the ethical question related to spending in the healthcare sector targeting those who are already privileged, rather than those who are really in need. However, the main decision on health is dependent on other sectors (such as education and housing), and she raised the need to further bring awareness on the proper use of resources.

**Policies and strategies at the local level.** A participant from Italy shared his thoughts on the presentation and the objectives of the workshop, citing the need to reflect, given all the information and interventions shared, on what should be done to improve the situation. He insisted on the importance of setting up a strategy at the local level, rather than at the national level, and a strategy within their respective health organisations. This should include a mechanism to measure effectiveness and monitor the gaps in relevant interventions. Translating policies into action means having a plan and real strategies that need to be institutionalised at a level that healthcare providers can directly influence, instead of waiting for what other sectors can do in terms of integrating their policies to healthcare. Otherwise, very little would be done. The same is true in waiting for policies to change at the national level. The participant also stressed the importance of working together with the end-users and community groups and find ways to be more effective in fostering participation. This starts by recognising diversity and treating the migrants as part of the community and engaging them in the development and evaluation of service plans and programmes. Dr Wirl added that Austria also managed to develop ten health goals though the main goals are addressed to other sectors. Likewise, a participant from Spain echoed the aforementioned insights on working at the local level, as it is almost impossible to get immediate results at the national level. She also shared Spain’s experience in creating an inter-departmental plan to work with the education sector, social services, and other sectors. The aim is to raise understanding of the factors related to education that can improve health and to explore the possibility of integrating a health focus in other sectors such as housing or labour. Difficulties in getting interest and confusion on which steps and measures to take resulted in lack of progress on the inter-departmental plan initiative. She called on participants at the workshop to look into creating plans to work with education and other sectors for health and raise awareness among authorities of other sectors of the influence they have on the health status of some population groups.

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More information can be retrieved from Rahmengesundheitsziele website at [http://www.gesundheitsziele-oesterreich.at/](http://www.gesundheitsziele-oesterreich.at/) (in German) or Health in all Policies website at [http://www.hiap2013.com/?p=126](http://www.hiap2013.com/?p=126) (Abstract in English)
SESSION 4 – POLICY OPTIONS FOR IMPROVING SOCIAL INCLUSION OF MIGRANTS

Group 1
(Moderated by Dr Poonam Dhavan, Public Health Specialist, International Organisation for Migration)

The first group was tasked to look at potential strategies, methods, or tools to channel research findings in order to improve policies which have an impact on the health status of migrants. Stakeholder analysis, alignment of national and regional policies, conduct of social marketing, and getting community engagement were identified as important tools to translate research findings into policy.

Stakeholder analysis. Dr Wirl of the Public Health Institute of Austria exposed conclusions from the group discussion. Looking at stakeholder analysis as an important tool to translate evidence into policies, she identified the government, employers, workers, and the community and civil society as stakeholders. The government as a stakeholder refers to both provincial and national levels which should be engaged at an early stage, not just as a source of information, but also as a resource in getting involved with dissemination and integration of relevant information. Employers are also considered important stakeholders in providing and promoting migrants’ access to health services. Employers can be the closest resource to inform the migrants on how and when to use health facilities and take better use of these benefits. Employers should realise that the good health of a migrant also plays well to their advantage. Another key stakeholder is the migrant worker himself/herself. The group mentioned the possibility of integrating labour unions and involving them in policymaking, dissemination of information, advocacy activities, and provision of services for example, although this can come with challenges. Lastly, communities and civil society should be also involved as stakeholders in terms of being an important source of information and dissemination. One group which should be included in the early stages of the research translation into action is that of healthcare providers.

Alignment of national and regional priorities. Dr Wirl mentioned the need to find an indicator that politicians can easily relate to in terms of assessing the value of interventions for migrants. Another way is to sense the political environment and assess when would be a good opportunity to include the concerns of migrants as one of the priorities. The role of the media was also mentioned as a way to raise awareness of the need for a migrant-related agenda. Role models from the migrant groups can be used to show their relevance and contribution to the community, thereby, possibly influencing national and regional priorities and policies. Involving the countries of origin (“sending countries”) was also suggested.

On the issue of best practices, Dr Wirl sounded off that the group considered a number of indicators in finding one, and discussed options on how to translate or apply them in other countries or at different levels, which can be very tricky. The group then pointed to “benchmarking” (e.g., with other projects or by applying quality criteria) instead of relying on identifying the best practices alone. She gave an example on the issue of aligning the regional (sub-national) and national levels in Asia, citing that the national to regional approach in policymaking seems to be more effective than starting at the regional level. Still, this depends on the authorities in charge with improving the situation and the issues and ways of addressing them. One of the main points here is that health researchers need to adapt to the “language” and needs of the policymakers in order to address them effectively (e.g., long term costs). Little effort in terms of co-ordinating with other sectors was also brought up, suggesting that lessons should be learned from whatever consequences this little or lack of effort has brought.

Social marketing/new ways of marketing. Dissemination of information both in the countries of origin and destination was the main idea in social marketing that was stated by the group. Dr Wirl gave an example by which this can be done; publishing information on migrant workers’ rights in newspaper or coursing it through
recruitment agencies and involving returning migrants in the dissemination process. The community approach was also given importance in terms of putting out the information and reaching the target groups. Any new policy should be translated into specific guidelines. Finally, with all the activities and ideas mentioned, assessment of effectiveness and benefits of these interventions should always be conducted and reported. Transparency and monitoring of the activities and ideas should be requested from the health experts to the policymakers.

Confidentiality of information. Dr Osteria of the Yuchengco Center in the Philippines reminded the group of sensitive information which needs to be disseminated and which is critical for migrants disclosing of important issues related to health, which is the confidentiality of the clinical information. If migrants are aware of this, then exchange of information can be more efficient and they will not be afraid to divulge health problems.

Feedback on presentation. A participant from Italy, posed a question on why there is still no solid solution that can address the migrants’ health issue, despite the existing policies and vast information from studies, which have been conducted on the topic. Another participant from Italy responded that the problems may be related to the roles of different stakeholders; there should be a clear definition of their respective roles and proper delegation and accounting of responsibilities. Dr Wirl concluded by saying that in addition to creating the guidelines and further research reports, relevant stakeholders should learn to secure the appropriate funds and prioritise them in the process of putting into practice the evidence that has already been produced.
Group 2
(Moderated by Ms Marie Nodzenski, Research Associate, Lee Kuan Yew School of Public Policy, National University of Singapore)

Group 2 discussed the following issues: 1) What are the health policy issues faced by undocumented migrants? 2) What are the best practices of research projects and findings that led to informing and translation into policymaking for the health of undocumented migrants in a meaningful way? 3) What are the key health policy issues and best practices that can be applied to Asia-Europe collaboration on the challenges faced by undocumented migrants?

Protection framework and human-rights approach. From the group’s discussion on health policy issues faced by undocumented migrants and how to better inform policymaking for the protection of undocumented migrants’ health, the first point raised is that policies should be designed within a protection framework. Participants in Group 2 highlighted that both conflict of policies at different levels of governance (i.e., international, national and regional) and immigration policies not being aligned with other policies at national level impact on the health status of migrants. The group also raised the need to change perceptions about migrants by making them more visible, countable, and empowered. Possible ways could include moving away a discourse on migrants’ issues away from security narratives and disseminating information on migrants’ rights.

Another question raised was on how to translate the human-rights approach into practice. The provision of protection to unprotected migrants will certainly reduce social costs, if this issue can be dealt with within a cost-benefit analysis argument. Dr Phua added that, in using the social protection framework and human-rights approach, the providers/societal perspective should be considered in terms of estimating what the cost and benefits are. With the presence of different stakeholders, governments and policymakers have to prioritise what is best for society as a whole. Dr Phua added considering in the cost argument whose vested interest is stronger. For example, in the economic argument to lower labour costs, the interest is stronger on the part of the employer. And if other voices from the civil society or non-political constituents are not heard, then the process of costing is lopsided. Thus, it beholds that all stakeholders’ interest be considered as all are affected by the decisions. Dr Phua expressed his intention to consider these factors in the next phase of their research with the hope that the NGOs and the people who are dealing with the migrant workers could be more active on this part of analysis and understand the language of the policymakers. Considering other sectors’ priorities and interventions that governments have to finance (whether fully or partially), the stakeholder analysis as well as estimation of cost and benefit is critical in convincing why it is worthwhile to invest in the provision of health services to undocumented migrants.

Policy integration. Policy integration in migration and health needs to be conducted simultaneously at different levels of governance to ensure coherence. The group used the example of “The Stockholm Programme — An open and secure Europe serving and protecting citizens” (2009-2014), which raises a bone of contention regarding deportation of undocumented migrants and may constrain positive changes of national legislation promoting protection frameworks for undocumented migrants. This illustrates the potential influence of international legislation on national laws and highlights the need to deal with this issue at different levels of policymaking simultaneously.

Co-ordination in policymaking has to occur at different levels of governance but also across different sectors. There is a need to support NGOs by providing them with more financial and human resources. This is very important point in promoting inter-sectoral collaboration and avoiding miscommunication among sectors.

Research and data collection. Research and data collection should be used to provide better information for policy making. Data need to be made more public, more transparent, and of good quality. The group suggested the need to switch from the need to design more evidence-based policies to evidence-based policymaking, enhance the involvement of migrants, and have monitoring systems in place.

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**Best practices for translation into policy making.** The group highlighted examples of good practices, which have impacted positively on migrants’ health status, and shared the difficulty in defining and identifying them. Best practices are contextualised and one cannot be applied to all different countries. The national context can change very quickly; one system may work only for a period of time. The group suggested that there should be an improved information system for incoming migrants on the pre-departure stage. It was cited that the Philippines actually have valuable experience in that area, having established a specialised government agency dealing exclusively with Filipino migrant workers (the Philippine Overseas Employment Administration). The Philippines have been very proactive in protecting the rights of migrants workers at all stages of the migration process (at pre-departure stage, for example, information is provided through a Pre-departure Orientation Seminar and a Pre-employment Orientation Seminar). In Spain, civil servants in government administration register migrants regardless of their legal status to make migrants more visible and accountable for public health services. In Italy, national law allows undocumented migrants to access healthcare, and now the country is improving availability and quality of information. In Australia, advocacy activities based on economic modelling are conducted and community-based interventions are done by NGOs, mainly funded by the government.
SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

Challenges in migrants’ health policies

**EU Countries**

- For documented migrants in Europe, migrants are provided with in-principle rights to access health care services (EU-countries migrants are entitled to same benefits as nationals while third-country nationals benefit from same level of access after filling some preliminary requirements). Countries like Italy and Spain have established policies targeting the needs of migrants. The challenge, however, is in the migrants’ utilisation of available services, which points out to the need to improve access to healthcare services.

- The issues of access to healthcare are common among the countries that were presented in the workshop. In Europe, language and culture are identified to be the main barriers. Others include: legal and financial barriers (especially for undocumented migrants), language and communication barriers, migrants’ low level of knowledge on health services, including lack of information on how to access them, and healthcare providers’ low level of competence on understanding migrants’ needs.

- In Austria, in principle, migrants are treated equally and have equal rights once they are legally employed and registered through insurance schemes. In practice, however, studies show that migrants are at higher risk of getting insufficient/inappropriate treatment, mainly because of a low level of sensitivity to diversity in healthcare organisations. It can be attributed to a low cultural sensitivity, which is still a marginal issue in the Austrian healthcare system. For example, there is no implementation on the broader bases mainstreaming of translation or interpretation services in health care institutions. Without interpretation services, regular migrants also have the high risks to be a subject of treatment errors due to miscommunication.

- The legal and financial barriers to healthcare apply more to the undocumented migrants. Services can only be available when paid out of their own pocket. Undocumented migrants in Europe are denied access to healthcare until their condition becomes an emergency, except for those in some European countries that provide partial to full access to healthcare. Cost has been the main argument for exclusion policy, but considering its implications on several dimensions (economic, humanitarian, and social costs), the cost of exclusion may actually be higher than the costs of inclusion. The most obvious implication would be the high cost of emergency services and the fact that undocumented migrants who are delaying treatment due to legal and financial barriers may constitute a higher health risk for the host population (e.g., infectious diseases). Exclusion also undermines human rights regulations and equity policies (humanitarian cost); and inequity in health weakens communities (social cost).

- The economic crisis in Europe is also creating challenges to the health policies and interventions for migrants. In Spain, the government will not be providing the same services it used to offer. Budget cuts have been made healthcare providers to adjust their resources (e.g., decreasing number of cultural mediators who play a key role in improving migrants’ access to and utilisation of healthcare). Spain used to have a universal healthcare system that covered all health needs of the population, but the laws have changed after the economic crisis. Those who do not pay taxes will have poor access to healthcare. In addition, because of job losses, the number of irregular migrants is increasing, at least in the case of Italy where the number of permits not renewed was higher than the number of new permits released. This has increased the number of irregular migrants to half a million. \(^{46}\)

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Data based on the presentation during the 2nd ASEF Research Exchange Workshop of Dr Antonio Chiarenza of the WHO HPH Task Force on Migrant-Friendly and Culturally Competent Healthcare. Retrieved from the ASEF website at [http://www.asef.org/images/docs/Session%201_3_Antonio%20Chiarenza_Case%20of%20Italy.pdf](http://www.asef.org/images/docs/Session%201_3_Antonio%20Chiarenza_Case%20of%20Italy.pdf)

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40  Bringing the Migrant Health Discourse into Policy
Asian Countries

- In Asia, the main challenge is linked to some governments’ regulations which tend to be inadequate given the growing number of migrants in the region and the increasing reliance on foreign labour in the case of major receiving countries. The restrictive immigration policies are preventing the settlement of migrant workers and offer very little protection. Consequently, there is a large flow of irregular migrants (estimates of 1.5 to 2 million irregular migrants)\textsuperscript{47} in the region. Like in the case of Singapore, both the government’s reluctance to deal with migration flows and the temporary nature of migration impact on the health of migrant workers\textsuperscript{48}. Psycho-social health problems were raised consistently as one of the most prominent concerns among migrants, especially in China, as evident in the Foxconn mass suicides in 2010. This showed the importance of working conditions in the labour intensive industries and its impact on the health status of migrants. In most countries presented in the workshop, preventive measures are yet to be developed by providing professional counselling and psychological support services.

- In China, with the population movement to urban areas in search for employment, the main concern is the difficulty in getting access to welfare services including healthcare services, brought about by the local government’s policy on social exclusion; migrant workers still remain at the bottom of the society with the government’s lack of provision of basic labour benefits and social protection. The residency (\textit{hukou}) system significantly restricts the access of migrants to public services including health. The exclusion by the host society and government is the major reason for the complicated health problems of migrants in China. Health policies should consider the high mobility of migrant workers and eliminate the economic burden of healthcare for them.

- In Korea, there are no specific regulations for migrant workers’ health and the government practices the same policies applied to the local population. Problems on access to health insurance abound, particularly the non-mandatory health insurance provision by employers. There are no penalties to the employers who do not provide insurance. Korean-Chinese migrants, who are usually not covered by insurance and who are not required to undergo medical examination (only self-reported health form), pose a potential burden to Korea’s health system without their proper medical examination, legal status, and employment insurance.

- In Singapore, despite the existing legislations and tighter regulations to protect migrants’ health, they are not diligently practiced by employers. The removal of subsidised medical care for foreigners since 2007 has considerably raised the cost of treatment for migrant workers. While employers are responsible for providing insurance, many are denied medical insurance and treatment by errant employers, as official policy is loosely enforced. This constrains workers to either bear the costs themselves or forgo and/or postpone treatments. In worst cases, workers seeking potentially costly medical treatment due to serious injury are repatriated by errant employers.

- In Hong Kong, undocumented migrants are eligible to use public healthcare services if there is an urgent need, but they will need to be reported to the Hong Kong police or authorities. Thus, some refuse to seek healthcare services for urgent cases. There are also migrant sex workers whose illegal status prevents them from actively seeking health treatment for STDs and other matters, or seeking protection from crimes committed against them. With Chinese migrant adults, depressive symptoms are the most prominent factor that affects quality of life.

How to drive changes in policy and practice in relation to migrant health and social integration

The presentations and discussions in the workshop brought about useful evidence and insights on the improvement of policies related to migrants’ health that is challenged by a lot of factors. Representatives from major receiving countries which have a long history of migration shared specific methodologies, programmes, and interventions from which lessons can be learned in driving necessary policy changes and in translating


\textsuperscript{48} Data on migration in Asia is based on the presentation during the 2\textsuperscript{nd} ASEF Research Exchange Workshop of Dr Kai Hong Phua of the National University of Singapore. Retrieved from the ASEF website at http://www.asef.org/images/docs/Session%203_2_Kai%20Hong%20Phua_Preliminary%20results%20of%20studies%20of%20Singapore%20and%20Hong%20Kong%20in%20SAR_1.pdf
evidence into policy inputs and practice. This section consolidates and highlights the major points, and the roles that different stakeholders play to foster co-operation for a coherent policy and practice for migrants’ health and social integration will be addressed in the final section.

- **Establishment of local-level policies and strategies.** Translating evidence into policies and action means having a plan and strategies that need to be institutionalised at a level that can be directly influenced. Participants who are from countries like Italy and Spain, where specific interventions and strategies are already established echoed the same opinion that it is better to start locally, saying that it is very difficult to get immediate results when waiting for the policies to change at the national level. In order to enhance the implementation of such interventions and strategies, it is important for local governments to develop monitoring and evaluation tools to assess and record the effectiveness of relevant interventions.

- **Building the capacity of healthcare providers and mediators.** Among the recommendations made to address the multiple barriers in access to healthcare, improving the competence of healthcare providers is of primary importance in the process. Skills pertaining to building and improving interactions with migrants can be strengthened by listening to and learning from the patients, rather than assuming to know what the patient needs. The actual knowledge of the healthcare providers comes from the direct interactions with the patients by using their own cultural knowledge and focusing on specific needs of the patients.

Based on the research findings on Chinese and Filipino migrants living in Italy and Spain, critical issues point to the importance of organisational support in building capacity of healthcare workers to make the role of linguistic and cultural mediators relevant. Language barrier is also cited to be the most serious obstacle to quality health service provision. Cultural mediators have to translate not only the word but the meaning and the context of statements to both the patients and the health providers. To do this, considerable knowledge of the patient’s socio-cultural and health context is necessary as well as the basics of illnesses diagnosis and management.

- **Getting support and commitment from the government or healthcare organisations.** In aligning policies and regulations to the needs of the migrants, getting support from and convincing the top management in government or healthcare organisation requires presentation of quality evidence and data. One of the methods of producing evidence is through the cost and benefit analysis which is something that may work for the government, especially on the issue of exclusion policy towards the undocumented migrants. Showing the government can easily relate to analysis and data on the monetary implications of exclusion. Considering the different stakeholders, researchers need to account for what is best for the whole society. This approach could also prevent embarking on temporary solutions which can be politically motivated.

- **Collaboration of policymakers and researchers.** The need to establish collaboration between researchers and policymakers can help ensure that relevant issues on migrants’ health are aligned with government policies and priorities. This will be crucial in responding timely to government and society’s needs. Opportunities for both sectors to exchange need to be created. This will foster effective communication between both parties, ensuring that content of research is understood by policymakers but also that government priorities are taken into account by the research community. Only then can the bridge between evidence and policymaking be built.

- **Sharing and adapting best practices.** Reviewing and adapting effective solutions in the healthcare sector was brought up several times during the workshop. The presentations confirmed that many problems and issues on migrants’ health are similar in Asia and Europe. Although some factors may be different, lessons can still be learned from policies and approaches that have been proven to work.

- **Preventive services.** The need for health prevention policies, programmes, and services to prevent potential health issues (which could be a strain on national health systems) was highlighted throughout the workshop. Prevention policies and services tend to be more cost-effective as they prevent recurrent usage of expensive emergency services (especially in the context of an economic crisis). As governments may lack resources to address healthcare needs of all segments of the population, the most vulnerable groups (including migrants) face higher health risks. More investment should therefore be directed towards such services. Migrants are one of the main target groups of such services. Indeed migrants may lack
in-principle access (when undocumented) or effective access to healthcare services, which puts them at higher risk. Preventing diseases or promoting healthy or health-seeking behaviours among migrants is therefore crucial. Nevertheless, research has shown that migrants tend to use less health prevention services (such as vaccination). This points to the need to raise awareness on migrants’ own health at the community level. It has been suggested during the workshop that including migrants themselves in awareness-raising initiatives would impact positively on the use of preventive services by migrants.

- **Policy or initiatives for returning migrants.** Returning migrants need assistance to reintegrate well within their families and communities back home in order to avoid social and psychological health problems and help them be productive.

- **Prospects of migrants’ integration in the mainstream society.** Based on the papers presented and considering that migrants are documented and conferred with citizenship by the receiving country, the prospect of their integration in mainstream society should be explored to facilitate the utilisation of health services to which they are entitled. Measures to promote migrants’ integration could include free language courses offered by sending countries’ embassies. Health education could also be provided by local governments through the use of translated media. While effective access to health services is a pre-condition to successful integration of migrants, a degree of integration is necessary to ensure effective access to and usage of health services. Non-discriminatory and effective access of legal immigrants to healthcare and social protection, and effective application of EU law providing third country nationals with the same treatment as nationals with regards to the co-ordination of social security schemes across the EU are crucial to further integration of migrants and in fostering cohesiveness into mainstream society.

**Roles of multi-sectoral players in fostering co-operation for a coherent policy on migrants’ health**

- The participation of healthcare organisations in producing the data comparing socio-demographic indicators is useful in producing strategies and evidence. Involving different groups of migrants in policymaking would increase the participation of potential users and will enable researchers to set priorities. Data can be gathered (e.g., conducting a survey and interviews) through the different migrants’ associations and religious groups and this will, in turn, lead to dissemination of relevant information on available healthcare.

- On the part of sending countries, consulates act as contact points and have a role to play in promoting the rights of their nationals. More than with advocacy activities, promotion takes place through initiatives such as meetings and gatherings of migrant communities where researchers or healthcare organisations/providers can directly ask questions, disseminate information, or promote healthcare services. The need for consulates to take responsibility was highlighted in the discussion as their presence can help in preventing miscommunication. Related government units should include in their policies or strategies the pre-departure orientation and provide information that migrants would need. For returning migrants, the sending country should also provide assistance in psycho-social health related matters.

- The issue in obtaining financial support to develop and sustain the programmes for migrants’ health, especially in the midst of the economic crisis, is where the private sector can contribute by collaborating with the government (private-public partnership) and NGOs. The emphasis is to identify common interests in improving services given the challenges brought about by the current economic conditions.

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Capacity building
Building capacity of governments and civil society by increasing their knowledge and enhancing their skills. Capacity building can take the form of substantive direct project design and implementation with a partner government, training opportunities, or in other circumstances facilitation of a bilateral or multilateral agenda for dialogue development put in place by concerned authorities. In all cases, capacity building aims to build towards generally acceptable benchmarks of management practices.

Country of destination
The country that is a destination for migratory flows (regular or irregular).

Country of origin
The country that is a source of migratory flows (regular or irregular).

Cultural competency
Cultural competency is a set of academic and interpersonal skills that allow individuals to increase their understanding, sensitivity, appreciation, and responsiveness to cultural differences and the interactions resulting from them. The particulars of acquiring cultural competency vary among different groups, and they involve an ongoing relational process tending to inclusion and trust-building.

Documented migrant
A migrant who entered a country lawfully and remains in the country in accordance with his or her admission criteria.

Economic migrant
A person leaving his or her habitual place of residence to settle outside his or her country of origin in order to improve his or her quality of life. This term is often loosely used to distinguish from refugees fleeing persecution, and is also similarly used to refer to persons attempting to enter a country without legal permission and/or by using asylum procedures without bona fide cause. It may equally be applied to persons leaving their country of origin for the purpose of employment.

Emigrant
A person undertaking an emigration (the act of departing or exiting from one State with a view to settling in another)

Exhausted migrant effect
Long-term residence in a host country leads to health deterioration among some immigrant groups as a result of poor living and working conditions.

GLOSSARY

UNLESS OTHERWISE INDICATED, THE DEFINITIONS ARE BASED ON GLOSSARY ON MIGRATION, 2ND EDITION, INTERNATIONAL ORGANIZATION FOR MIGRATION, GENEVA, 2011. THE COPY IS AVAILABLE ONLINE HTTP://PUBLICATIONS.IOM.INT/BOOKSTORE/FREE/GLOSSARY%202ND%20EDE%20WEB.PDF.


Happy (im)migrant effect

“The Happy Migrant Effect” is a construct, in which there is reluctance to assert healthcare rights. Patients appear “happy” and satisfied, despite problems with their hospital care. Explanatory factors for the construct include extreme powerlessness related to being unable to communicate, a positive comparison of healthcare in the new country compared with the old, patriotism for the new country, cultural norms that proscribe acceptance, politeness or social desirability, self-denigration for not having learnt the language and, for a few, a fear of reprisals if they spoke out in complaint.

Health
According to the preamble of the World Health Organization Constitution (1946), health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Healthy migrant effect

“Healthy Immigrant” Effect (HIE) or “Healthy Migrant” effect refers to the alleged health advantage of immigrants; recent immigrants tend to be in better health than the native-born population and immigrants who have lived in the country for a long time.

Immigrant
A person undertaking an immigration (a process by which non-nationals move into a country for the purpose of settlement)

Integration
While the term is used and understood differently in different countries and contexts, “integration” can be defined as the process by which migrants become accepted into society, both as individuals and as groups. It generally refers to a two-way process of adaptation by migrants and host societies, while the particular requirements for acceptance by a host society vary from country to country. Integration does not necessarily imply permanent settlement. It does, however, imply consideration of the rights and obligations of migrants and host societies, of access to kinds of services and the labour market, and of identification and respect for a core set of values that bind migrants and host communities in a common purpose. Local integration is one of the three durable solutions to address the plight of refugees. It may also be applied to victims of trafficking and unaccompanied children.

Internal migration
A movement of people from one area of a country to another area of the same country for the purpose or with the effect of establishing a new residence. This migration may be temporary or permanent. Internal migrants move but remain within their country of origin (e.g. rural to urban migration).

Irregular migrant
A person who, owing to unauthorised entry, breach of a condition of entry, or the expiry of his or her visa, lacks legal status in a transit or receiving country. The definition covers inter alia those persons who have entered a transit or receiving country lawfully but have stayed for a longer period than authorised or subsequently taken up unauthorised employment (also called clandestine/undocumented migrant or migrant in an irregular situation). The term “irregular” is preferable to “illegal” because the latter carries a criminal connotation and is seen as denying migrants’ humanity.

Irregular migration
Movement that takes place outside the regulatory norms of the sending, transit and receiving countries. There is no clear or universally accepted definition of irregular migration. From the perspective of destination countries it is entry, stay or work in a country without the necessary authorisation or documents required under immigration regulations. From the perspective of the sending country, the irregularity is for example seen in

cases in which a person crosses an international boundary without a valid passport or travel document or does not fulfil the administrative requirements for leaving the country. There is, however, a tendency to restrict the use of the term “illegal migration” to cases of smuggling of migrants and trafficking in persons.

**Labour migration**
Movement of persons from one State to another, or within their own country of residence, for the purpose of employment. Labour migration is addressed by most States in their migration laws. In addition, some States take an active role in regulating outward labour migration and seeking opportunities for their nationals abroad.

**Less/low skilled and semi-skilled migrant worker**
There is no internationally agreed definition of a less or low skilled and semi-skilled migrant worker. In broad terms, a semi-skilled worker is considered to be a person who requires a degree of training or familiarisation with the job before being able to operate at maximum/optimal efficiency, although this training is not of the length or intensity required for designation as a skilled (or craft) worker, being measured in weeks or days rather than years, nor is it normally at the tertiary level. Many so-called “manual workers” (e.g. production, construction workers) should therefore be classified as semi-skilled. A less or low-skilled worker, on the other hand, is considered to be a person who has received less training than a semiskilled worker or, having not received any training, has still acquired his or her competence on the job.

**Migrant worker**
A person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national.

**Migration**
The movement of a person, or a group of persons, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, economic migrants, and persons moving for other purposes, including family reunification.

**Multiculturalism**
Integration approach that recognises, manages and maximises the benefits of cultural diversity. Migrants remain distinguishable from the majority population through their language, culture and social behaviour without jeopardising national identity.

**Permanent residence**
The right, granted by the authorities of a host State to a non-national, to live and work therein on a permanent (unlimited or indefinite) basis.

**Push-pull factors**
Migration is often analysed in terms of the “push-pull model”, which looks at the push factors, which drive people to leave their country (such as economic, social, or political problems) and the pull factors attracting them to the country of destination.

**Receiving country**
Country of destination or a third country. In the case of return or repatriation, also the country of origin. Country that has accepted to receive a certain number of refugees and migrants on a yearly basis by presidential, ministerial or parliamentary decision.

**Regular migration**
Migration that occurs through recognised, authorised channels.

**Reintegration**
Re-inclusion or re-incorporation of a person into a group or a process, e.g. of a migrant into the society of his or her country of origin or habitual residence.
**Rural-urban migrants**
Internal migrants who move from rural to urban areas, often in response to poverty, low agricultural incomes, low productivity, population growth, shortages, fragmentation and inequitable distribution of land, environmental degradation, and the relative lack of economic opportunities in rural areas.

**Sending country**
A country from which people leave to settle abroad permanently or temporarily.

**Transnationalism**
The process whereby people establish and maintain socio-cultural connections across geopolitical borders.

**Undocumented migrant**
A non-national who enters or stays in a country without the appropriate documentation. This includes, among others: a person (a) who has no legal documentation to enter a country but manages to enter clandestinely, (b) who enters or stays using fraudulent documentation, (c) who, after entering using legal documentation, has stayed beyond the time authorised or otherwise violated the terms of entry and remained without authorisation.
BIBLIOGRAPHY


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University of California Berkeley (2011) “Glossary of Terms”. Available at http://diversity.berkeley.edu/sp_glossary_of_terms


50 Bringing the Migrant Health Discourse into Policy
# Day 1: 28 November 2012

<table>
<thead>
<tr>
<th>Time</th>
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<tr>
<td>08:00</td>
<td>Registration</td>
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<td>08:30</td>
<td>Welcome Remarks</td>
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</table>
|       | **Ambassador Alfonso T. YUCHENGCO**  
         (Chairman, Board of Trustees of Yuchengco Center) |
| **Session 1 – Challenges and Opportunities of International Migration for Sending and Receiving Countries** |
| Chairperson | **Ms Ellen WONG**  
               (Project Officer, International Organization for Migration (IOM)) |
| 08:45 | I. Case of Poland  
       **Ms Bogumiła JABŁECKA**  
       (Analyst Migration Policy Programme, Institute of Public Affairs)  
       **Dr Elżbieta Anna CZAPKA**  
       (Researcher/Lecturer, Marie Curie-Skłodowska University) |
| 09:45 | Questions & Answers |
| 10:15 | Break |
| 10:30 | II. Case of Italy  
       **Dr Antonio CHIARENZA**  
       (Coordinator of the HPH Task Force on MFCCH, AUSL of Reggio Emilia) |
| 11:00 | Questions & Answers |
| 11:20 | Conclusion of Session 1 |
| 11:30 | Lunch |

**Session 2 – States’ New Approaches to Health and Migration**

| Chairperson | **Prof. André M. N. RENZAHO**  
             (ARC Future Fellow and Director, Migration, Social Disadvantage, and Health Programs, Monash University) |
| 13:00 | I. Case of China  
       **Prof. LI Ling**  
       (Director, Sun Yat-sen Center for Migrant Health Policy) |
| 13:30 | II. Case of the Republic of Korea  
       **Prof. Youngtae CHO**  
       (Department of Health Science and Services, School of Public Health, Seoul National University) |
<p>| 14:00 | Questions &amp; Answers |
| 14:30 | Conclusion of Session 2 |</p>
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<tr>
<th>Time</th>
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<tr>
<td>17:00</td>
<td>Welcome Remarks</td>
<td>Mr Junichi NITTA (Second Secretary, Embassy of Japan in the Philippines)</td>
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<tr>
<td>17:10</td>
<td>Key Findings of the Research, “The Health Dimension of Southeast Asian Migration to Europe”&lt;br&gt;ID: 00009</td>
<td>Dr Trinidad OSTERIA (President, Yuchengco Center, De La Salle University)&lt;br&gt;Dr Daniela CARRILLO (Researcher, Health and Welfare Sector, Fondazione ISMU)</td>
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<tr>
<td>17:30</td>
<td>Panel Discussion</td>
<td>Prof. LI Ling (Director, Sun Yat-sen Center for Migrant Health Policy)&lt;br&gt;Prof. Jose Maria Arcadio C. MALBAROSA (Assistant Professorial Lecturer, De La Salle University)&lt;br&gt;Dr Tona LIZANA (Head of the Migration and International Projects Division, Public Health Agency of the Catalan Government)&lt;br&gt;Ms Valentina NIGROTTI (Social Worker, Sacco Hospital Social Services)</td>
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<td>18:00</td>
<td>Questions &amp; Answers</td>
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<td>18:30</td>
<td>Closing Speech</td>
<td>Ms Sunkyoung LEE (Project Manager, ASEF Public Health Network)</td>
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<tr>
<td>18:40</td>
<td>Welcome Dinner</td>
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</table>
### Session 3 – The Impact of Migration Policy on Migrants’ Access to Health Care

**Chairperson**

**Prof. Youngtae CHO**  
(Department of Health Science and Services, School of Public Health, Seoul National University)

| Time  | Session  
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<tbody>
<tr>
<td>09:00</td>
<td>Outcomes of the ASEF-commissioned joint research, “The Nature and Magnitude of the Costs of Exclusion of Documented and Undocumented Migrants from Health Care”</td>
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<tr>
<td></td>
<td>1. Preliminary results of studies of Austria and Italy</td>
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</table>
|       | **Dr Ursula KARL-TRUMMER**  
  (Executive Director, Center for Health and Migration) |
| 09:30 | 2. Preliminary results of studies of Singapore and Hong Kong SAR |
|       | **Prof. Kai Hong PHUA**  
  (Associate Professor, Health Policy & Management, Lee Kuan Yew School of Public Policy) |
|       | **Prof. Huso YI**  
  (Assistant Professor, Jockey Club School of Public Health and Primary Care, Chinese University of Hong Kong) |
| 10:30 | Questions & Answers |
| 11:00 | Break |
| 11:20 | Migration health policy of Austria |
|       | **Dr Charlotte WIRL**  
  (Social Scientist, Public Health Institute Austria) |
| 11:40 | Questions & Answers |
| 12:10 | Conclusion of Session 3 |
| 12:20 | Lunch |

### Session 4 – Policy Options for Improving Social Inclusions of Migrants

*Please see the following page for the details of this session*

| Time  | Session  
<table>
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<tr>
<td>13:30</td>
<td>Summary of main conclusions of previous sessions</td>
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|       | **Analiza G. PEÑA; Maricar T. RICARDOS**  
  (Rapporteurs) |
| 13:50 | Working group discussion I |
|       | **Moderators**  
  **Group 1** |
|       | **Dr Poonam DHAVAN**  
  (Public Health Specialist, IOM – Manila (Global) Administrative Centre (MAC)) |
|       | **Group 2** |
|       | **Ms Marie NODZENSKI**  
  (Research Associate, Lee Kuan Yew School of Public Policy) |
| 14:50 | Break |
| 15:20 | Working group discussion II |
| 16:20 | Presentation of policy options |
| 16:40 | Closing Remarks |
|       | **Ms Sunkyoung LEE**  
  (Project Manager, ASEF Public Health Network) |
| 17:00 | End of Workshop |
### Session 4 (Day 2 13:30-16:40)

Group 1: moderated by Dr Poonam DHAVAN

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Group 2: moderated by Ms Marie NODZENSKI

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# PARTICIPANTS

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<td>Asia-Europe Foundation (ASEF)</td>
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The **Asia-Europe Foundation (ASEF)** promotes understanding, strengthens relationships and facilitates cooperation among the people and institutions of Asia and Europe. ASEF enhances dialogue, enables exchanges and encourages collaboration across the thematic areas of governance, economy, sustainable development, public health, culture, and education. Founded in 1997, ASEF is a not-for-profit, intergovernmental organisation located in Singapore. It is the only permanently established institution of the Asia-Europe Meeting (ASEM). Together with about 700 partner organisations ASEF has run more than 600 projects, mainly conferences, seminars and workshops. Over 17,000 Asians and Europeans have actively participated in its activities and it has reached much wider audiences through its networks, web-portals, publications, exhibitions and lectures.

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The **Yuchengco Center** of De La Salle University in the Philippines has for its mission the contribution to public knowledge and awareness on political, economic and social policy concerns in the Philippines and the Asian region; and the enhancement of its roles as a think tank where research results are regularly transmitted to the end users for evidence-based legislation, policy-making and programming. Therefore, its activities include: research; conference and seminar organization; publication; program and project evaluation; and capacity-building of educators, planners and policymakers in four thematic areas of globalization; regional security and foreign relations; governance and democratization; and human security, particularly health and education. Through the years, it has undertaken studies on Philippine-Japan relations, international migration, regional economic integration, aging, health, gender issues, climate change, poverty alleviation, social policy, governance, regional cooperation, political economy, corruption, transnational crimes, agriculture, and free trade agreements.