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Regions for Health Network in Europe

Actions towards Health Equity

Report of the Thirteenth Annual Conference
Katowice, Poland, 24–25 November 2005
Regions for Health Network in Europe

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1. Introduction and Summary

Purpose

Equity in health has been defined as the “absence of health differences between more and less socially advantaged groups”.\(^1\) Based on principles of justice, health equity reflects opportunities for individuals and groups to be as healthy as possible.

To increase equity, health systems must be able to identify and assess health inequalities and to understand where contextual interventions can decrease them. The roadmap to increasing health equity also includes investing for health, by optimizing the health promoting impact of development and public policies across sectors, including education, labour, health care, housing and transport. Health systems must also address inequalities in health among those who are underserved by the system, whether for reasons of gender, race or ethnicity, geographic location or socioeconomic status. Lastly, targeted communication and media strategies should be employed to target disadvantaged groups and to raise awareness of the plight of the underserved.

The objectives of the conference were to explore, share, and analyse regional case studies, and then to propose actions to increase health equity in the following areas

- measurement of health inequalities and equity
- investment for health to tackle health inequity
- serving the underserved
- communication for health equity

Context

Each year, the WHO Regions for Health Network (RHN) organizes an annual conference on a timely topic related to health policy development for regions. The conferences provide a unique opportunity for policy-makers at the regional level to convene in an international setting. Recognizing that tackling inequalities in health is an overarching aim in all public health policies and that achieving equity in health is a challenge faced by all regions, RHN organized this conference to renew discussion on actions for health equity.

Outcome

The outcomes of the conference were to identify some powerful lessons for improving health equity, which were that

a) high quality information must be available, or else it is impossible to assess what problems exist and whether services are effective. In developing this:

• it is important to use the right tools in the right situation and separate out different levels which needed to be monitored, for example
  – needs for the service
  – access to the service
  – benefit from the service

• data needs to be supplemented by a clear understanding that the basis of organization should not be managing the standard patient but managing the difference that exists between patients;

b) the *Investment for Health* approach can be hugely valuable in reducing health inequity, as every public policy decision affects health, no matter where it is taken. In developing this:

• systems of governance are needed to clarify who does what, how, who carries responsibility, and where the resources are to be found, so that accountability is clear;

• regions must find ways to support local level activity – at present policies are integrated at the local level and often are not at the regional level;

c) there must be explicit efforts to improve services to underserved populations, otherwise health across the community will be damaged and there can never be social integration and social cohesion. In developing this:

• efforts must be directed at
  – communicating better with the underserved groups themselves
  – empowering them both as groups and as patients
  – training staff and adapting policies and systems to make services responsive to individuals from all across the community
  – the general population – to reduce prejudice

• regions with very different minorities can benefit from sharing their experiences;

d) there must be a well-focused, well-resourced strategy for communicating health messages to all groups in the population. In developing this:

• it is essential to recognize that health promotion and communication needs to start early – in kindergartens and schools, with messages integrated across the school curriculum, and careful use of adult role models;

• there must be a firm rejection of the notion that information alone will automatically result in the desired action; rather a social marketing approach. Learning to listen to the needs and desires of the target audience themselves and building the programme from there should be used to reach different social groups, particularly those that are excluded or not integrated into health care systems.
2. The Conference – Summary

The meeting opened with a welcome from Mr Michal Czarski, Marshal of the Voivodship of Silesia. There followed an address delivered by the co-ordinator of the Network, Mrs Wendy Tse Yared.

Five presentations then set the scene, providing information and perspectives on a number of issues as background for later discussions. They addressed (1) a local example of how better access can improve health, (2) tools and methods for measuring health inequalities and equity, (3) the use of the Investment for Health approach as a way of tackling the problem, (4) action to make health care systems more migrant-friendly and culturally competent, and (5) using information and communication to reduce inequalities.

Professor Lech Polonsky from the Silesian Centre for Health spoke first on the Silesian strategy and outcomes on acute coronary events. Dr Bakhuti Shengelia, Regional Adviser, Health Policy and Equity, WHO Regional Office for Europe followed, and spoke on measuring health inequalities and equity – an overview of tools and methods. Mr Dominic Harrison, Deputy Regional Director for Public Health, from the North West Region of England, in the United Kingdom spoke on three aspects of using the Investment for Health approach to tackle health inequity. These were the development of the North West England Investment for Health Plan; progress on the WHO Regions for Health Investment for Health Collaboration Project; and economic impact issues.

Dr Antonio Chiarenza, from the Coordinating Centre of the Health Promoting Hospitals Network of Emilia-Romagna, Italy, and a representative of the WHO-HPH Task Force on Migrant-Friendly Hospitals, spoke on migrant-friendly and culturally competent health care systems – the experience of Emilia-Romagna. Finally, Mrs Tamsin Rose, Executive Director of the European Public Health Alliance, spoke on Using information and communication to reduce inequalities.

In the afternoon, there was an opportunity for those attending the conference to choose among facilitated discussion groups, drawing on the presentations and experiences in their own regions. The topics covered by the four groups were: Measuring health inequalities and equity – an overview of tools and methods; Investment for Health to tackle health inequity; Serving the underserved; and Communication for health equity. Each group fed back to a plenary session. Dr Jacek Czapla, the RHN focal point for the Silesia Region, closed the meeting.

3. Presentations and discussion

Session A: Introductions and welcome

Mr Jacek Czapla, Director of Hospital at the WHO Collaborating Centre for Environmental Health Impact Assessment and Training in Environmental Health at Sosnowiec, and the RHN focal point for the Silesia Region, welcomed those present and introduced Mr Michal Czarski, Marshal of the Voivodship of Silesia. Mr Czarski expressed his pleasure that Silesia was hosting the conference of Regions for Health.
Network, and hoped that his presentation on the province would help those attending understand the issues in the province and form the basis for future co-operation.

The topic was very appropriate and timely especially for Poland, as both the host and the representatives of the health institutions of the region would recognize that they still had a major task to achieve in this topic area. Poland is one of the ten new members of the European Union. Silesia’s regional programme, along with those of the other 15 provinces, had been negotiated through the national government. From 2007 to 2013 new financial arrangements would give the province a greater role.

Health responsibilities in the province were explained. Nationally the Ministry of Health has executive power, with a National Health Fund, acting as the general health insurer, almost in a monopoly position. There is no local body that corresponds to the Ministry of Health so that some issues are managed by the governor of the province as the representative of the state. Local bodies with health competencies include the municipality, the city, the province, the Medical Academy, and also health services relating to the police and the military authorities, and private institutions which are growing in importance. The need to establish a unit to co-ordinate and plan services remains, and it would be useful to learn about good practice from elsewhere in Europe.

Silesia province owns 59 health care institutions and their contracts account for a quarter of the budget of the regional health fund. A billion euros a year is paid to these bodies. The province works through its own institutions and collaborates with the other levels of administration to create a sustainable health policy for the whole region, but difficulties remain. One is an excess of supply. There is strong cooperation with the Medical Academy, which has an important role. The region includes over 40,000 doctors and other clinical staff. A great deal remains to be done, but there are also great opportunities to improve policy and services.

The region lay on the crossroads linking Poland, Germany and the Czech Republic. At one period, through its coal and steel resources, it had accounted for a fifth of the Polish economy. While covering only 4% of the area of Poland, and so only the 14th province in terms of area, it is second only to Warsaw in population and its people are their greatest asset. Since 1999, it has begun a huge process of restructuring away from traditional industries towards automation, information technology and especially services. It has huge educational potential, with 200,000 students in 40 institutions. Its health services are very strong in cardiology and radiology. Tourism is also important in the south and north of the region, and culture plays an important role also.

Cooperation with other European Regions is very important, especially those that are also in a process of restructuring their economies to move away from traditional industries. Among these, the long-standing link since 1991 with the Nord-Pas de Calais region of France stands out.

Mrs Wendy Tse Yared, the co-ordinator of the Regions for Health Network, thanked Silesia for hosting the Network’s 13th Conference, and for its continuous support of RHN over the years. Silesia had hosted the meeting in 1998, when the Network was only six years old and the topic was Healthy Ageing. This time it would address the increasingly recognized issue of improving health equity at the regional level.
Equity in health means equal opportunity to be healthy for all population groups. This was already recognized by WHO as a major aim in 1998, when the EURO Health for All policy (HEALTH21) was published. This policy specified that the health gap between countries and between socio-economic groups within countries should be reduced by at least one fourth in all member states by 2020.

Achieving health equity remains a priority concern for the WHO Regional Office for Europe. Equity, along with effectiveness and efficiency of health systems, was a critical determinant of population health status. Improving health equity is moving up the international agenda, and is a main concern for WHO’s Division of Country Support, in its work on optimizing the health systems of WHO Member States. WHO aims to improve health and to be responsive to population needs focusing on four key functions in health systems: resource generation; financing; service provision and stewardship. A health system could serve a population well only if it was built on equity, effectiveness and efficiency.

The main objectives of the conference were to explore, share and analyse regional case studies, and then to propose actions to increase health equity. This would be done through two stages. In the first, experts would introduce four themes – improving equity, tackling inequity, recognizing the needs of underserved populations, and using information to reduce inequalities. In the second working groups would discuss these themes, taking advantage of the abundance of regional expertise present at the conference.

Elected as joint chairs were Mrs Małgorzata Ocheduszko Ludwig, Vice Chairman of the Regional Parliament of Silesia, and Jacek Czapla, the focal point for the Silesia Region. Dr Christopher Riley from Wales was appointed as rapporteur.

**Session B: Setting the Scene**

Five presentations addressed major issues relevant to equity.

*Silesian Strategy and Outcomes on Acute Coronary Events – Better Access improves Equity in Health* by Professor Lech Polonsky, Silesian Centre for Health Disease, Śląskie Centrum Chorób Serca w Zabrzu, Katowice, Poland

Diseases of the cardiovascular system are responsible for more than half of the deaths in Poland. Special focus is on acute coronary syndromes (ACS) since both morbidity and mortality in ACS are high. In 2003, the Silesian Centre for Heart Diseases in cooperation with National Health Fund, set up the Polish Registry of Acute Coronary Syndromes (PL-ACS Registry). It is based on an unrestricted grant from the Ministry of Health and a part of the POLKARD. The main aims of the PL-ACS Registry are to assess epidemiology and outcomes of ACS patients treated with different strategies in all Polish regions. Data for more then 60 000 hospitalizations due to ACS were collected in the Registry during 3 years. It is now one of the largest registries in the world.

Each year, about 140 000 patients are presented with acute coronary syndromes (ST-segment elevation myocardial infarction – STEMI, non ST-segment elevation myocardial infarction – NSTEMI, unstable angina – UA).
The PL-ACS Registry confirms a well-known fact, that invasive treatment of ACS patients is the most effective strategy which reduces both early and long-term mortalities. There is an increase in the availability of invasive procedures in Poland, reaching more of the population. This progress is particularly evident in Silesia, where more than 50% of STEMI patients have been receiving in recent years. The Silesia region uses the most current and advanced methods of treatment of ACS which are available for almost every patient who is qualified to receive the treatment. The number of ACS procedures performed per 100,000 inhabitants in Silesia makes this region one of the European leaders in providing this care.

However, the region’s services for in-hospital pharmacotherapy services have not progressed as well. The guidelines of European Society of Cardiology are not fully applied mainly in terms of antiplatelet treatment, which is key for achieving optimal outcomes. Administration of other very important drugs as beta-blockers, ACE-inhibitors or statins is accurate. The underuse of antiplatelet agents (mainly thienopyridines) is most probably due to the high costs of thienopyridines and not due to the underuse by physicians, who are well aware of the guidelines. Intensive efforts should be made soon to correct the situation.

**Conclusions**

- The most effective treatment in acute coronary syndromes is invasive strategies. It is demonstrated by Polish Registry of Acute Coronary Syndromes operated by Silesian Centre for Heart Diseases.
- Increased availability of invasive treatment in Silesia has resulted in lower mortality among ACS patients.
- Effectiveness of angioplasty procedures could be improved if modern antiplatelet drugs are available for all patients with ACS. A prompt improvement in this area is warranted.

*Measuring health inequalities and equity – overview of tools and methods – Dr Bakhuti Shengelia, Regional Adviser for Health Policy and Equity in the WHO Regional Office for Europe*

While mortality had fallen in Europe, the gain had not been shared by all equally. Data prepared by Mackenbach and colleagues showed a growing gap between the most and least advantaged groups in several countries in the 1980s and 1990s. In the United Kingdom, the life expectancy gap had grown from five years in the 1970s to nine in the 1990s. Traffic injury mortality showed a marked age-related trend. Although death rates are falling in many areas, the gap remains. It would be impossible to eliminate it – but it could be reduced.

Inequality is merely the difference between two measures. Inequity, however, involves unfair and avoidable or remediable differences among populations or groups defined socially, economically, demographically, or geographically. Action requires recognition of the distinction also between the determinants of health and the determinants of inequities in health.
What then could and should be measured. There are four different categories: health measures (such as mortality, morbidity, life expectancy, self-reported health, disability and health risks); health financing (including health expenditures and the risk of catastrophic payments); health care (covering issues such as access to care, responsiveness, coverage and quality); and health system inputs (including human resources and physical resources).

Health measures often focus on mortality, morbidity and disability, though self-reporting was also used. Assessment of risks is possible, but is difficult and relies on surveys. Healthy Life Expectancy (HALE), which looks at expected years of life lived free of disability, is a useful measure of how well prefect health was distributed in a population.

The sort of issues that need to be taken into account in measuring health include population characteristics, with, for example, age and sex standardization required to allow objective assessment and comparison; the linking of mortality with socio-economic status data to allow an understanding of the underlying situation; careful attention to selection bias, controlling for the characteristics that might produce systematic error; and looking to ensure that self-reported health reporting addressed comparability issues. Expectations could be very different across countries and cultures, and so cultural and psychological issues need to be allowed for in planning of data collection.

Looking at health care, important issues include access – the opportunity to use health care without obstacles when needed; utilization, including the number of visits, hospitalization rates, and other measures; responsiveness, involving issues such as communication, respect and dignity; quality of care, looking particularly to health outcomes; and effective coverage, the probability of receiving health gain conditional on need.

Measurement issues include capturing needs, again selection bias, and comparability. It is important to check the relationship between utilization and true need.

There are three issues related to health financing. The first is the financing approach – whether the system was progressive (when the rich pay higher proportion of their income), regressive (when the poor pay higher proportion of their income) or proportional (when both the poor and rich pay the same proportion of their income even if the absolute value paid by rich is higher). The second relates to catastrophic expenditures on health. It is possible to measure people’s need to fund health care when extreme cases forces them below some threshold value, such as a poverty index. This is an issue in poorer countries and needs to be taken into account during economic transition. The third is the fairness of financial contributions – an index could be constructed to measure this.

Different bases could be used to measure inequalities. Occupation is useful, as it correlates with income and education, but a drawback is that occupational classification differs across countries. Income is the most popular measure as it is a more direct measure of resources than occupation, education or social class, and more comparable across the population. However, it is often difficult to measure, as people’s reluctance to disclose their true income might result in a low response rate and inaccurate reporting.
Various status measures could serve as a proxy for income. One is expenditure – this is more measurable and less prone to error than income, it has a good correlation with income and could be broken down by expenditure categories. Other options to consider are assets, as these could signal income and social status; employment status; the number of single mothers; and the status of ethnic minorities.

Yet another possibility is to look at area date, on the premise that occupation, education, income, housing conditions, unemployment rates, proportion of immigrants and ethnic minorities are correlated at the area level. Composite measure of deprivation (e.g. the Townsend or Carstairs index) could be used for ecological studies but the drawback here is that geographical areas are never homogeneous, and the aggregate figures would hide inter-group inequalities.

Surveys (including large-scale household surveys and small-scale, ad-hoc household surveys) should be distinguished from routine date (including censuses, vital registration systems, epidemiological and surveillance data, and administrative health service statistics) and both need to be used, as both have strengths and weaknesses. Local surveys could be used to corroborate national data.

In conclusion, for an equity analysis, a census and a vital registration system, coupled with a major household survey or the potential for effective record linkage, are required. Only 39 of the 192 WHO Member States meet this requirement, most of them as developed countries. It was also vital to plan a long-term strategy for collecting the required data for addressing health equity challenges.

**Investment for Health to tackle health inequity – Mr Dominic Harrison, Deputy Regional Director for Public Health in the North West Region of England, the United Kingdom**

Three topics to be covered are current issues of relevance to the development of the North West England Investment for Health Plan; progress on the WHO Regions for Health Investment for Health Collaboration Project; and economic impact issues.

**The North West England Investment for Health Plan**

The United Kingdom government sets national health and health service policy in England, and public service targets. Within North West England these are implemented through Local Strategic Partnerships for each major sector including health. Over a period of 30 years, a number of policy objectives has been brought together with the LPH concept. They are the WHO Health for All Agenda; reducing inequalities in health; reducing demands on the health and social care system; sustainable development; regional economic regeneration; social exclusion; neighbourhood renewal; local government reform; community wellbeing. The economic sector has increasingly been attracted to this developing agenda. The World Bank Development report for 2006 was entitled *Equity and Development*\(^2\) and equity is an essential prerequisite for development.

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\(^2\) *World Development Report 2006: Equity and Development*

In 1999, the Region issued a document *Health A Regional Development Agenda* which in 2003 led to the publication of *Investment for Health: A Plan for North West England/Draft Action Plan*, which was updated in 2004 by the *Revised Action Plan*. Continual changes made a fixed long-term plan unviable, and so the approach chosen in his region aimed at identifying and implementing the health improvement dimension of all policies alongside developing and applying health and integrated impact assessment. The focus for the health investment plan are health, prevention and inequalities, aligning strategies, and targeted investment with short, medium and long term objectives aimed at tackling the wider determinants of health, exploiting the health service contribution to achieving wider regeneration and sustainability objectives, mainstreaming action on inequalities within health services and strengthening primary care. Implementation involves a number of agencies, including the health services and local government.

In support of a new government policy for health improvement, *Choosing Health*, action would be across three areas – research, evidence and information; systems for local delivery; and workforce capacity and capability.

**Progress on the WHO Regions for Health Investment for Health Collaboration**

The Region of North West England was leading a project on applying the Investment for Health approach in the development of health policy at the regional level, working with the WHO European Office for Investment for Health and Development, Venice, and with Tuscany, Veneto, South Moravia, Liberec, Västra Götaland, and Mura regions.

A Framework for Policy Evaluation is being developed based on evaluating the health policy process and developments supporting Investment for Health and analysis of the local public health systems. This allows an evaluation at the strategic levels of barriers, system characteristics, infrastructure and tools, in relation to policy, capacity and delivery, so as to identify development issues. This in turn would support guidance which would address: developing health policies, priorities, and programmes across sectors; building systems for delivery; and building capacity and capability in terms of research, evidence and information and of workforce development.

**Investment for Health Economic Impacts**

Under the European Union’s 2004 Lisbon Strategy for Growth and Employment, Europe needed to increase investment in human capital as productivity and competitiveness were dependent on a well-educated, skilled and adaptable workforce. Health and healthcare would play a key role in generating social cohesion, a productive workforce, employment and hence economic growth.

Health and health care has a considerable impact on the economy. The macro-economic impacts include the impact of human capital, health and life expectancy on the size of the economy, economic efficiency, and labour market competitiveness. There would also be the impact of health care system expenditure, the cost of ‘disease’, and the unrealized and potential impacts of health sector investment leverage.

Research suggests that a one-year improvement in a population’s life expectancy contributes 4% to the economy and that, if all other conditions were equal, a five-year advantage in life expectancy would give a country 0.3-0.5% higher annual economic growth than its less healthy counterparts.
In the United Kingdom a report by Derek Wanless for the government had, when assessing the engagement of the public with its own health, identified three future scenarios for health – ‘slow uptake’; ‘solid progress’; and ‘fully engaged’. The last of these foresaw high levels of engagement in health, a responsive health service, especially on disease prevention, and more efficient use of resources. It would also reduce the need for health spending in the longer term, compared with the other scenarios. This would necessitate action to clearly state priorities and accountabilities both in and outside the health service and improved incentives, performance and inspection.

In the United Kingdom, 50% of health service costs are on secondary care and 60% of this is on long term/chronic disease. The Investment for Health work would aim to prevent this disease and treat it where possible outside the secondary care system.

Health service as a major employer and as a major business in virtually every locality has a role to play in tackling inequalities and addressing regeneration through its investment in staff and assets, the purchase of services, and the development and regeneration of local economies. In North West England, the public sector accounts for 49% of GDP, and the health and social care sector directly employs 340,000 people. It could use its power better to strengthen the economy, support marginalized groups, reduce waste and reduce avoidable transportation of goods from other areas. Another issue is the failure to prevent or to detect and treat illness effectively; here too there are huge potential benefits to the economy and community. Depression in children is an example, where failure to act effectively early could result in ten-fold higher economic costs later. In North West England there is close correspondence in the geographical distribution of measures of social cohesion, health and economic capacity such as skills.

North West England has a document called Good corporate citizenship and the NHS – a regional mapping – a survey of recent regional health policy developments in nine English regions.

In conclusion, health is a metaphor for, or the embodiment of, social justice, and there need to be a strong link to market mechanisms as a way of developing population health. The business case for Investment for Health as an economic development strategy is increasingly strong. Partnership with economic development agencies and with budget managers with a responsibility for economic development at regional and local levels is essential, and the best possibility was to establish joint posts. McKnight (1996) was quoted, “Communities have never been built upon their deficiencies. Building community has always depended upon mobilizing the capacities and assets of people and a place.”

As an addendum the RHN Coordinator provided a short note from Dr Erio Ziglio, Head, WHO European Office for Investment for Health and Development in Venice. Dr Ziglio expressed regret at being unable to be at the conference and recalled that at the formal opening of the Venice Office in December 2003, the basis was established for a special programme (Investment for Health) managed by the Venice Office that could both strategically and pragmatically contribute to strengthening the population health policies work within the RHN.

Over the two years, there had been close links between the Office and the regions that had identified as a priority Investment for Health, and the related issues of tackling the
wider determinants of health especially the North West Region of England, the Veneto Region and the Tuscany Region. The Venice Office had undertaken a special assessment of Tuscany’s system capacity to address the social and economic determinants of health using the Investment for Health approach (the relevant report would be available through the Venice Office website).

The process of engagement with regions would result in establishing the Investment for Health and Development Strategic Lab, specifically tailored to support the sub-national level of decision-making. The Lab would bring together those regions, within and outside the RHN, that had expressed an interest in addressing the social determinants of health through an Investment for Health approach. It would offer a unique opportunity for regions to share information, knowledge, training and know-how in this area.

Towards Migrant-friendly and Culturally Competent Health Care Systems – the experience of Emilia-Romagna – Dr Antonio Chiarenza, Coordinating Centre of the Health Promoting Hospitals Network of Emilia-Romagna, Italy and a representative of the WHO-HPH Task Force on Migrant-friendly hospitals

Due to worldwide migration, globalization and European Union enlargement, Europe was becoming increasingly diverse. The 2005 International Organization for Migration report suggested that the enlarged European Union (EU) plus Switzerland, Iceland, Norway and Liechtenstein contained some 36 to 39 million legal immigrants and irregular migrants. Irregular migration continues to have a significant impact on EU countries, although less so in recent years. It is estimated that 500,000 illegal migrants enter Europe every year. Since the 1980s, EU member States have regularized 3.2 million irregular migrants in total. European communities include migrant populations with widely different migrant experiences, motivation, life-conditions and legal status. Italy has people with more than 180 different national origins. People who are well-integrated with the rest of the population cohabitate with irregular migrants and with people who had decided to move from one place to another within Europe or to go back and forward from their country of origin. Localities where migrants settled differed greatly, and their skills varied considerably. After a period of having mainly single young male migrants, women are now leading today’s migration.

Migration can have significant health implications for both migrants and the receiving communities. Migrants and minority groups are more vulnerable, due to low socio-economic status in their home country and often too in the country of arrival; sometimes due to traumatic migration experiences and to the feeling of exclusion after arrival; and finally through inadequate social support due to the absence of integration policies and specific social and health policies.

The highest risk is when irregular the migration journeys lead to migrants arriving undocumented, posing risks to the health of the migrant – especially for trafficked persons. There are public health risks linked to communicable disease control, reproductive health, occupational and environmental health and sanitation. Social exclusion, discrimination, poor living conditions and poverty affect the mental health and social adjustment of migrants. Even when services are available and access is granted, migrants might not use them because they do not know about or understand them, or because the services offered are not adequate to their cultural and religious beliefs, or because of low levels of cultural competence among health professionals.
Dealing with these challenges give an opportunity to improve the overall quality of services for all. Emilia-Romagna is a good example in responding to those challenges successfully.

The migrant population in Emilia-Romagna has grown to 7% of the population, one of the highest percentages in Italy, with people representing over 130 countries. Regional policy aimed at facilitating the social integration of migrant groups has resulted in increasing numbers of migrant family units settling down in the region. Health services have negatively impacted through migrants’ use of emergency departments rather than primary care, and through the rise of certain infectious diseases which had previously disappeared, like TB and hepatitis. Responses include use of intercultural mediators to assist communication and understanding, the creation of specific centres for migrant women and their children, and above all the attempt to ensure free care and treatment for all, irrespective of their legal status.

In Emilia-Romagna, legal resident foreigners have full access to the regional health care system with equal treatment to Italian citizens. Irregular migrants also have the right to urgent and essential hospital treatment and care, even if continuous, for serious illness and accidents. Migrant women can access free antenatal care and assistance during pregnancy, as well as sexual health services, and children received free medical assistance, vaccinations, and tests for TB and other infectious diseases. There is a network of volunteer GPs providing primary care. Local government also provide a number of services to facilitate communication and information for migrants, such as a multilingual dedicated web site, a help line and a co-ordinated intercultural mediation service.

The region was able to take these experiences into the Migrant Friendly Hospital (MFH) project, a European project funded by the EU Commission aimed at improving hospital services for migrants and ethnic minorities. An Emilia-Romagna health authority was engaged in a two-and-a-half year project together with 11 other European health organizations, representing a wide range of hospital types, from large metropolitan university teaching hospitals to small-town community hospitals, and from both the public and with private, non-profit sectors.

The general aim of the project was to develop models of good practice for promoting the health and health-related competence of migrants and for the improvement of hospital services for these groups. The project established a network of pilot hospitals engaged in a European benchmarking project.

The hospitals aimed at becoming migrant-friendly organizations by developing an overall project that ensured the implementation of the concept or principle of “migrant-friendliness and cultural competence” in management and quality management structures. Migrant-friendliness meant striving for more equity by sensitivity to and acceptance of diversity and compensating for disadvantages. Patient orientation had to be complemented by improving staff orientation in hospitals, which included accepting and using the ethnic and cultural diversity of staff. By strengthening quality for the most vulnerable, quality for all patients would be improved in the direction of more personalized services, taking the specific individuality of each person into account. Investments in increased responsiveness to the needs of populations at risk would be an important step towards overall quality assurance and development.

In each hospital, a needs assessment and an organizational service evaluation were conducted in order to identify problems and effective solutions. These solutions
addressing specific aspects of migrants’ health care needs were then implemented and evaluated. The outcomes of these comparative experiments served as the basis for the development of the recommendations for health policy and health care launched as the Amsterdam Declaration in December 2004 (Annex I).

A two-part assessment instrument, the Migrant Friendly Quality Questionnaire, was developed. The first part looked at the core processes of hospital services such as access, admission and discharge. The second looked at the quality system including issues such as policy, staff training, partnerships and alliances in the community.

Self-evaluation results were used for benchmarking across the participating hospitals. The questionnaire proved useful in systematically assessing migrant-friendly structures such as interpreting services, information material for migrant patients, culturally sensitive services (religion, food), and whether the quality management system promoted migrant-friendly services, i.e. the integration of migrant-friendliness into mission statements, budgeting, and staff development programmes.

The needs assessment survey addressed to migrant patients, health staff and managers used individual interviews, focus groups, and staff meetings. It identified many common problems for migrants/ethnic minorities and staff, the top six which are as follows:

- the need to improve communication between health staff and patients in care and clinical encounters;
- the need to improve information and education to facilitate access and an appropriate utilization of hospital services;
- the need to improve staff knowledge, competence and awareness on cultural diversity in order to overcome cultural barriers;
- family visits;
- the lack of culturally adequate food; and
- spirituality and social support.

Patients who did not understand the language of the professionals caring for them were doubly at risk: both as members of a minority community, and as a consequence of communication difficulties. This was particularly true when correct diagnosis and treatment required that relevant clinical information be elicited from and conveyed to the patient in a correct and appropriate manner. Effective communication was a prerequisite for both clinical decision-making and client-provider trust, and hence for the patients’ successful treatment and co-operation in protecting their own health. Language barriers had adverse effects not only on the accessibility of care but also on quality of care, patient satisfaction and health outcomes.

Poor information and education led to difficulty for migrants in making appropriate use of services, in adhering to treatment recommendations, in managing their own illness adequately and in following healthy life style programmes. Improving information and education meant enhancing their knowledge and competence in accessing health services and in managing their own health. Improved health literacy for migrants allowed for a higher level of participation in the developing of appropriate health services, in co-operation with health professionals and ultimately in fostering social integration through their involvement and empowerment.
Culture, ethnicity and migration experience create specific models of behaviour and perceptions of health and illness which influence how symptoms are recognized and interpreted and have a direct impact on how and when health services are accessed. Therefore health staff need to acquire specific transcultural competence, i.e. the ability to understand individual circumstances according to the specific situation and to develop appropriate treatments with this understanding.

On the basis of the results of the European cross analysis and the review of effective interventions, and despite the diversity of health care systems and hospitals, the project was able to identify and tackle three priority areas through specific sub-projects:

- Improving interpreting services in clinical communication;
- Migrant-friendly information and training in mother and child care; and
- Staff training towards cultural competence: enabling hospital staff to better handle cross-cultural encounters.

Within the three sub-projects different measures were implemented and tested over a six-month period by the 12 pilot hospitals. The benchmarking process and the continuous exchange of ideas allowed partners to develop and put in place appropriate measures and evaluate their effectiveness.

The project had two main results. First, the Amsterdam Declaration, available in 11 languages on the web site, set out a series of EU Recommendations on how to develop culturally competent health care organizations in Europe. Second, in order to guarantee the sustainability of the MFH movement after the end of the project a “Task Force on Migrant-Friendly Hospitals” had been established in the framework of the Health Promoting Hospital Network of WHO Europe, which would serve as a focus for further initiatives, organize workshops, and use annual international conferences, the newsletter and the website of that Network as a channel for communication.

Using information and communication to reduce inequalities – Mrs Tamsin Rose, Executive Director of the European Public Health Alliance

Information is an essential component of good health. Policy-makers need accurate data in order to make decisions. Healthcare professionals use information as a tool for diagnosis and treatment and individuals need to be able to make informed choices in their lives. In the context of rising demand for healthcare and associated costs, the explosion in chronic diseases and lifestyle-related ill health is a strong political backing for initiatives to encourage individual responsibility for health. Information and communication are key tools to support behaviour change, but unless carefully targeted, they can increase health inequalities because take-up and use of information is greatest among higher socio-economic groups. In addition, commercial organizations and other entities with a vested economic interest produce a huge amount of information about health.

Policy-makers and health professionals are generally comfortable and competent in their use of information, but the public less so. The challenge for the health community is to ensure that appropriate and accurate messages are delivered and can be heard above the background noise.
There is the evidence of strong links between social deprivation and addiction, and risky behaviour. Health inequalities are often reinforced by poor awareness among disadvantaged groups of services available and low levels of understanding of the system and how to navigate through it. Physical barriers, such as accessibility and transport, and intangible barriers, such as language and culture exist. Poverty can be a barrier, as can be mistrust of authority and its intentions, and low self-esteem and inability to control the social and physical environment.

In the context of the growing burden of chronic disease, action needs to be taken on determinants and risk factors, beginning health promotion early in life and integrating the key messages into daily living through the whole life span. Traditional health education campaigns has been based on central top-down planning, driven by experts, based on best practice and literature reviews. These might appeal to the literate middle classes, but are less and less appropriate in complex, diverse societies. Accordingly, they tend rather to increase health inequalities by addressing only some sections of the community.

The need now is for a social marketing approach, using vivid, personalized information, locally relevant, responding to local needs, and aimed at involving the target audiences in defining the messages they can understand and react to. There need to be more imaginative use of media of all sorts.

Previous public health information campaigns were provided as examples. The use of seatbelts is often cited as a success, but in Sweden, as an example, where 96% of people use belts, 50% of accident deaths still involved someone not using a belt. So, even where there is a clear message, high levels of compliance and an easy intervention that can protect health, a small group can still fail to receive or respond to the information. On childhood immunizations, coverage fell because the public had responded to a not very high quality study suggesting a connection between autism and immunization. There are many other areas too – oral dehydration salts and diarrhoea, hygiene and hand-washing, breastfeeding, cancer screening (breast, cervical, bowel), binge drinking, safe sex and HIV prevention, harm reduction for drug use – where the public health message, though clear, well-founded and persuasive often failed to change behaviour.

Expected, desired outcomes for health information are clear for general healthy behaviour patterns measured by reduced incidence and severity of ill health. Other outcomes should be greater awareness of health services, more appropriate use of health products and services, enhanced user satisfaction rates and better compliance with treatment regimes.

However, there might be difficulties, through a concern that messages might encourage unhealthy behaviour by creating visibility and awareness or reducing stigma relating to activities that some may consider inappropriate, immoral or illegal, so making it seem normal and acceptable. One example is harm reduction campaigns for drugs, another is a newly developed vaccine for cervical cancer, which would have to be given before the age when sexual activity is legal in most countries.

In framing information campaigns, a key target group should be young people. Evidence is clear that six health risk behaviours particularly contributed to the leading causes of death, disability and social problems: 1) tobacco use; 2) unhealthy dietary
behaviours; 3) inadequate physical activity; 4) alcohol and other drug use; 5) sexual behaviours that might result in HIV infection, other sexually transmitted diseases, and unintended pregnancies; and behaviours that contributed to unintentional injuries and violence. These behaviours are often established during childhood and early adolescence. It is becoming increasingly clear that action on these needs to start very early as children could learn at a very young age patterns of behaviour that would last throughout life.

If health information was to be useful and influence behaviour, it must be
• available,
• seen as useful and new,
• easy to understand and act on,
• trustworthy, and
• aimed at a positive outcome for the recipient.

Information is not issued in a vacuum. There are many sources of information. For instance, producers and sellers also issue food information. So information must be carefully presented to be distinctive and have an impact.

Reducing inequalities mean communicating with hard to reach communities:

a) rural communities, which tend to have lower incomes, poorer health, a higher percentages of older people and fewer local medical practitioners than the general population, and proportionally the fewest telephones, the fewest personal computers, internet connections and leisure facilities; not only does this mean their personal resources are poorer, but also their opportunities for social engagement and inclusion are less;

b) excluded groups such as the homeless people, intravenous drug users, and sex workers, who often have multiple health conditions, chaotic or disorganized lives, little awareness of or access to services, low literacy rates, and limited resources and options;

c) migrants and ethnic minorities, who face linguistic barriers, cultural and religious taboos, and may not be registered for services, and may find health messages irrelevant to their lives and cultures.

The key lesson must be to adopt a social marketing approach developed initially in the 1970s. Philip Kotler and Gerald Zaltman state that “Social marketing seeks to influence social behaviours not to benefit the marketer, but to benefit the target audience and the general society”. This involves using commercial approaches to communicate messages, through relating to what people want. There is a need to get the right mix – linking the mass media and personal communication; and learning to listen to the needs and desires of the target audience themselves, and building the programme from there. This focus on the "consumer" involves in-depth research and constant re-evaluation of every aspect of the programme.

Core ideas are:
• Action is the objective;
• The target audience is the focus;
• The exchange is critical – create understanding and trust;
• Segment the market you are addressing;
• Use all four Ps – Price, Product, Places, Promotion;
• Analyse and beware of competition; and
• Monitor and be flexible.

In conclusion, the essential issues and questions to ask in putting together a communication campaign to reduce inequalities are as follows:

• Communication – this must marry together the information and the context.
• Background – what is the issue, the processes and timeframe?
• Define your messages – what needs to be said? How should it be differentiated for the audiences?
• Identify your targets – who takes the decisions? whom do they listen to? what is important to them?
• Select your vehicles – activities, events, information releases, meetings, conferences, media relations, demonstrations, publicity stunts.
• Check the landscape – who are your allies and opponents? Track their messages and respond.

**Session C: Working Groups and Feedback**

Four groups were formed to discuss particular aspects of the application of the themes presented earlier:

Group I: Measuring health inequalities and equity  
Group II: Investment for Health to tackle health inequity  
Group III: Serving the underserved  
Group IV: Communication for health equity

**Group I: Measuring health inequalities and equity**

This group was chaired by Dr Bakhuti Shengelia, and the feedback provided by Dr Ricard Tresserras, the focal point for Catalonia. The group had initially had a presentation from Dr Shengelia on measurement issues and techniques. This covered four areas:
a. There are two types of measures when studying inequalities:
   - measures of the effect on health – the impact of decreasing socio-economic status on health – mainly concerned with risk.
   - measures of the impact on health – in addition to the effect of the decreasing socio-economic status on health, these take into account the impact of inequalities of socio-economic status, e.g. by taking into account the size of the groups with lower socio-economic status.

As an example, measure of the effect of health inequalities by level of income would calculate the difference in the prevalence of the health problem between two income levels. A measure of total impact would also take into account how income was distributed and what was the size of each income group in the population. The larger the income inequalities the bigger the size of the total impact would be.

b. When comparing health status of different socio-economic groups, there are various modes of comparison – for example, comparing a group with the best, the norm or the mean or comparing all groups with all.

c. Relative and absolute measures:
   - Relative measures – e.g. morbidity or mortality rates of the lowest groups as a percentage of that of the highest socio-economic groups (or other reference category, e.g. the national mean) – effectively looking at the probability.
   - Absolute measures – e.g. difference between the morbidity or mortality rates of the highest and the lowest socio-economic groups – identifying the size of the problem.

d. Ways of presenting differences – through using methods such as
   - the index of dissimilarity
   - the Lorenz curve and the GINI coefficient
   - the concentration index.

Discussion had followed, covering a broad area relating to information. The conclusions included:

- Information on socio-economic issues is available only in some countries and on some issues, usually as a result of special studies. It is not available routinely through standard systems such as those reporting mortality, morbidity and hospital activity.

- Information is needed on groups, not just on areas, because otherwise sub-groups will be hidden. Simply moving money from rich areas to poor areas will not help poor people.

- In some regions, rules on confidentiality effectively block the collection of data that would be useful to track and analyse inequities. Politicians need to understand this.

- Without inequality information, it is impossible to assess whether health services are effective, or what problems existed. The issue might not be the level of
resourcing, but intangible barriers to access. There is a need to separate out different levels which need to be monitored, for example:

- needs for the service;
- access to the service;
- benefit from the service.

On this point Emilia-Romagna had an important case study, which used a qualitative approach to investigate the ways in which health service organization might be creating inequity through establishing routines based around a ‘standard patient’. Useful findings included:

- Routine procedures, e.g. a queue could effectively discriminate against some groups who might not understand the rules;
- the basis of organization should not be managing the standard patient but managing the undoubted difference that existed between patients; and
- social networks could be of more help to service users than formal systems.

The overall conclusion was that to improve health equity, there must be better information.

**Group II: Investment for Health to tackle health inequity**

This group was led by Mr Dominic Harrison and Irina Lisenkova, the focal points from North West England and the Chuvash Republic. The aim had been to share information on policy from an Investment for Health perspective, especially as regards policy drivers and policy priorities.

The group had started with a case study from Tuscany presented by Dr Alberto Zanobini, the focal point for the Tuscany Region. This outlined the region’s acceptance that population health needs relate to individual, social, environmental, economic and health factors. Hence, a strategy that balances all these factors could strongly contribute to health. A strong interaction between local, regional and national government would be useful to deepen understanding of the broad determinants of health. The challenge is a new system of governance for health, and a system was being developed to integrate planning at the local level – profiling needs, establishing priorities and establishing a programme. This would acknowledge the role of Public Health as above all a resource for territorial development. It is very important to focus attention on the positive impact that health development could have on the economic, social and occupational status of the region. There would be a refocusing of management training to develop management skills in investment for health.

This led into a discussion of what was driving the broader strategy. In Russia a driver is a fall in life expectancy, with harmful effects for the economy. This cannot be resolved only through the health care system. A local intersectoral team is monitoring the achievement of health targets. In Canada, it is cost, with the present model of services judged unsustainable in the longer term. All the regions are trying to link health and other planning, but only at the local level, and not at the regional level, where the danger is emerging of ‘competitive policy making’, with agencies working against each other.
Intergenerational mobility is another issue, with evidence suggesting that the Anglo-Saxon model offers children now less opportunity of achieving higher levels of income, education than their parents had had a few decades ago, because now those with wealth reserve the best options for their own families, creating an underclass. Alcohol is also creating major problems, and is outside the control of the health system. Rural health is also a driver. In Armenia, life expectancy for men in the country is seven years and for women ten years less than in towns.

In Veneto, there are complex issues related to the slowing of economic growth since the 1980s, though life expectancy has risen. Migration could be seen as more of an asset than up to now. In Hungary, there is an effort to take the idea forward through looking critically at several different aspects – the health infrastructure, specific health problems, and health competencies across all professions including health professionals. Collaboration with the education sector is being seen as a major success for the Investment in Health approach. Catalonia is developing local capacity to take this forward.

Overall two main issues were stressed:

- to deliver the wider strategy for Investment in Health, there is a key need for systems of governance for health – who does what, how, who carries responsibility, and where the resources are to be found; and
- regions must find ways to support local level activity – at present while the local level is integrated, the regional level is not.

A comment was that the local tier may see regional involvement as interference. It was stressed that the principle of subsidiarity should apply. The point was that every public policy decision had a health effect, no matter where it was taken. The problem then is how to introduce accountability into the system.

**Group III: Serving the underserved**

Dr Marianna Penzes, the focal point for Szabolcs-Szatmár-Bereg, fed back for the Group. A case study looking at the health and social status of the gypsy population in Szabolcs-Szatmár-Bereg Country was presented.

The findings were that this population did not trust the formal support system, and that the social system in small settlements was ineffective or lacking. Discrimination and prejudice were common, and unemployment was extremely high. The Group identified as priority areas the following in relation to communication:

- language and cultural barriers,
- lack of access to high technology, and
- the narrow windows of opportunity to reach target populations.

Possible interventions identified were special training for staff, cultural mediators, improved access in school settings and community houses, and targeted communication (through the strategic placing of television messages).

The study discovered high levels of depression and neurosis, and low levels of family planning. More than 100 Roma young people were surveyed using a questionnaire
based on the Health Behaviour in School-Aged Children (HBSC) Study. This found relatively high levels of sexual activity and depression and low levels of contraception use and self-esteem.

In relation to patient and community empowerment, the Group identified as priority areas:

- overuse of emergency services;
- unhealthy lifestyles;
- mental health problems;
- young people’s sexual behaviour; and
- low self-esteem.

Possible interventions included improved access to GPs, targeted information and education, alliances with local authorities, and health education.

As for staff training, the Group identified as priority areas:

- prejudice and lack of awareness and knowledge about Roma people’s culture and needs.
- Possible interventions suggested here were to sensitize staff, perhaps using a cultural mediator, to adapt the medical curriculum; and to use ongoing education and training.

There was a query whether the solutions might apply also to other excluded groups. Dr Chiarenza of Emilia-Romagna responded that there need to be solutions appropriate to the local group. If policies don’t address these issues, there will never be social integration. Issues such as local access and levels of care need to be studied and addressed through improving access; improving education for local minorities to define the need and the solution; and reposition health and social care services to meet the need.

Dr Morosetti of South Tyrol agreed that this was very helpful, as problems among minorities might cause problems for majorities too. Networking by interested regions would take this forward. Dr Maria Augusta Nicoli of Emilia-Romagna said that there needed to be a change among the general population, and recognition of the rights of minorities.

Mr Harrison added that the benefits could be seen from a public health, human rights or economic development viewpoint. A study in England had found that South Asians had high levels of long term illness and hospital admission but very low levels of benefit uptake. The suggested solution was to integrate them more into the broader social security system, and not to act through the health system.

Mrs Rose said that it was also important to confront the media and politicians whose actions and statements often served to reinforce exclusion of some groups.
**Group IV: Communication to reduce health inequalities**

This group was chaired by Mrs Tamsin Rose and the feedback provided by Dr Giulia Morosetti, the focal point for South Tyrol.

The group discussed three case studies –

1. **Wales** – This related to an information campaign about policy change relating to both health and health care, and especially dealing with rural settings. The overall aim was to make individuals aware of how they could improve their own health (with a long-term goal to reduce chronic disease) and to gain acceptance for necessary reform of health care system to meet the current demands.

Discussion identified the high importance of modernization and healthcare reform which affected all of the regions in the working group. The hospital was no longer seen as the ‘heart’ of a community – rather there was a shift towards primary care, and services provided close to where people live. There was also a need to reassure people that generalist services will be maintained locally e.g. long-term care for older people, but also explain that specialist units and IT tools could provide administrative savings for reinvestment, overcome geographical distance and ensure quality.

2. **Emilia-Romagna** – Local health plans include the involvement of ‘competent citizens’ using focus groups, websites and other tools to raise public awareness of the determinants of health (e.g. what people can do themselves) and engage local people in identifying priorities for health policy-making.

Discussion noted that this kind of approach creates consensus on key priorities but at a cost (in both money and time); moreover it requires actively engaged citizens, and it was important to ensure that no groups would be excluded.

3. **South Tyrol** – Various communication strategies based on local epidemiological data were being organized e.g. to tackle a. ‘black spots’ in immunization coverage, aimed at largely middle-class, highly educated but poorly informed families; b. smoking – different tools for different targets to promote life without tobacco; c. restaurant hygiene, using communication activities to get restaurants to see hygiene rules as a desirable marker of food quality.

Discussion noted the problem of readily available but inaccurate or misleading information and the long time it can take to build the trust to respond to these concerns. Different tools would be required for different groups, to engage with the target audience, having first assessed their needs. ‘Prohibition’ messages need to be replaced by a positive approach.

The overall messages were:

1. Health promotion and communication needs to start early – kindergarten/schools. Health messages need to be integrated right across the school curriculum. The adult role model is also important.

2. Professionals need to get out of the ‘healthcare ghetto’ and interact and communicate with communities and people. Don’t over-medicalize physical activity and healthy nutrition, look for external partners and role models.
3. Regions and decision-makers have a duty to ensure that all people have a minimum level of information/awareness about public health and healthcare services and able to act on them.

4. Never assume that information alone will automatically result in the desired action.

5. Money and political will are often lacking, with the focus too often only on health care goals marginalizing prevention.

6. EU funds should only be used for prevention and networks, not for treatment.

7. Social marketing tools can be used to reach different social groups, particularly those that are excluded or not integrated into health care systems.

Ms Tse Yared gave the results of a communications questionnaire that had been circulated to member regions. The findings were that regions undertake many campaigns, and those on alcohol, drugs and tobacco seemed most common. They worked mainly with the media, and second with professionals. Few worked with patient groups. The top spokesmen were Ministers. They offered training to journalists but less often to health staff.

Regarding good examples of communications management, Dr Morosetti pointed out that regions should have a budget for communication, with ministerial staff trained, and a clear strategy to deal with the most important elements of the media. There should be clear messages related to the political objectives and careful evaluation of the impact of the strategy. The better the communications system, the better it would be able to respond in an emergency.

Mrs Rose said that it was important to trace the cause of problem – not on what fish contains less mercury, but why any fish contain mercury. Firms will sometimes try to divert attention from root issues.

Dr Nicoli noted that the media were not the only source of information to the public. Often they trust health professionals more and they could be better supported.

Dr Czapla concluded saying that action was now needed to address issues in health services and in the health system more broadly.
Annex I – The Amsterdam Declaration

Towards Migrant-Friendly Hospitals in an ethno-culturally diverse Europe

Migration, diversity, health and hospitals

Migration, ethno-cultural diversity, health and health care are closely interlinked in many ways. Due to worldwide migration, globalization and also European enlargement, European communities are becoming more and more diverse on the local level as well.

The health status of migrants and ethnic minority groups is often worse than that of the average population. These groups are more vulnerable, due to their lower socio-economic position, and sometimes because of traumatic migration experiences and lack of adequate social support. Thus, it seems only rational that human rights activists argue that access to health care services must be seen as a basic right for everyone and that they are supported therein by international conventions (e.g., the International Convention on the Elimination of All Forms of Racial Discrimination and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families). Even beyond this human rights aspect, increasing diversity is an important quality assurance and development issue for health systems and services. Minority groups are at risk of not receiving the same level of health care in diagnosis, treatment and preventive services that the average population receives. Health care services are not responsive enough to the specific needs of minorities. There are many challenges facing both service users and providers. Examples include not only language barriers and cultural diversity, but also scarcities in hospital resources and low levels of minority purchasing power and entitlements. All this poses new challenges for quality assurance and improvement in health services – especially for hospitals which play a particularly important role in serving this segment of the population.

Lower levels of health literacy among migrants is also relevant, especially as concerns the appropriate use of health care systems. Migrants in Europe often lack information about available hospital and ambulatory care services or about general health matters in the specific context of European societies. This is one of the reasons migrants often given for not using health services effectively and for not taking action themselves to prevent illness.

The current situation is thus one which poses challenges to hospitals and their staff, a staff which is itself at the same time becoming more diverse, thereby presenting an opportunity, a resource and an additional challenge for hospital organizations. To work on these challenges, a group of hospitals from 12 European countries came together as Pilot Hospitals to participate in the Migrant-Friendly Hospital project (for details see below). National and regional networks of the WHO Network of Health Promoting Hospitals (HPH) played an important role in bringing the partners from Austria, Denmark, Finland, France, Germany, Greece, Ireland, Italy, the Netherlands, Spain, Sweden, and the UK together. They represent a wide range of hospital types, from large metropolitan University teaching hospitals to small-town community hospitals, with public and with private, non-profit ownership. Some of the partners had already had a longstanding record in serving diverse communities before the project, some of these communities being rather well-established and homogeneous, others being very diverse and comprised of a large number of undocumented migrants. Some partners serve their
communities in the context of a rather well-integrated health care system, others have had to cope with rather fragmented structures.

The project received financial support from the European Commission and the Austrian government. European and international organizations joined the initiative as supporting partners. Project partners agreed on basic principles to be at the core of a Migrant-Friendly Hospital mission statement: valuing diversity by accepting people with diverse backgrounds as principally equal members of society; identifying the needs of people with diverse backgrounds and monitoring and developing services with regard to these needs; and finally, compensating for disadvantages arising from diverse backgrounds.

Based on a needs assessment, the project was able – despite the diversity of health care systems and local situations in European hospitals – to identify many common problems for migrants/ethnic minorities and staff.

For selected issues, knowledge-based solutions were successfully implemented and evaluated in the areas of interpreting, cultural competence training for hospital staff, and empowerment in mother and child care.

The Pilot Hospitals also aimed at generally improving their diversity management by developing their organizational structures and cultures to become migrant-friendly and culturally competent organizations. For the partners, becoming a (more) "migrant-friendly" organization proved feasible but not trivial: many stakeholders must contribute to these change processes. Project results and tools are available at www.mfh-eu.net.

In order to guarantee the sustainability of the initiative a "Task Force on Migrant-Friendly Hospitals" was set up in the framework of the Health Promoting Hospital Network of WHO Europe. This task force will serve as one focus for further initiatives, organize workshops, maintain the MFH website and conduct other activities.

**Recommendations**

Based on the experiences of the MFH project partners, international discussions and the scientific literature, the following crucial points for the successful development of services and organizational cultures can be identified:

1. Developing a migrant-friendly hospital is an investment in more individualised and more person-oriented services for all patients and clients as well as their families.

2. Increased awareness will be needed of migrant population experiences and existing health disparities and inequities, including those that are gender-related, leading to changes in communication, organizational routines and resource allocations.

3. Focusing on ethno-cultural diversity implies the risk of stereotyping – but migrant status, ethnic descent, cultural background and religious affiliation are just a few of the many dimensions of the complexity of human beings.

4. Developing partnerships with local community organizations and advocacy groups who are knowledgeable about migrant and minority ethnic group issues is an important step that can facilitate the development of a more culturally and linguistically appropriate service delivery system.
Like any other form of organizational development, the success of becoming a "migrant-friendly" hospital willing and able to serve its diverse communities in an equitable way will depend on the complementary contributions of a number of different stakeholders.

**Hospital owners/Management/Quality Management**

Hospital owners, management and quality management should put the quality of services for migrants and ethnic minorities on the agenda of hospital organizations:

5. It will be important to define aims and objectives (mission, vision and value statement, policies and procedures).

6. Adequate resources (working time, financial resources, qualification) must be provided if changes are to be realized.

7. An organizational development process should be initiated, supported and monitored by leadership, management and quality management.

8. As an important step, the needs and assets of stakeholders – users (patients, relatives, community) and providers (staff) – should be monitored.

9. Outcomes as well as the structures and processes that influence outcomes should be monitored.

10. Concerns, complaints and grievances related to service delivery should be tracked and appropriately addressed.

11. Investment in capacity building with regard to staff's cultural and linguistic competence is needed (selection, training, evaluation).

**Staff/Health professions**

Hospital staff and the professions and professional organizations of which they are part should acknowledge that the issues are relevant and they should be prepared to invest in achieving competency.

12. An important step will be to find consensus on criteria for migrant-friendliness/cultural competence/diversity competence adapted to their specific situation and to integrate them into professional standards and enforce that they are realized in everyday practice. The principles applied in the MFH project can serve as starting point for this development.

13. Professionals and other staff will have to build capacities concerning cross-cultural and communicative and diversity-related competencies.

14. Clinical practice, preventive services and health promotion action should be appropriately tailored for use with diverse populations. Preventive services and health promotion that rely strongly on communicative interventions are especially dependent on the cultural and linguistic competencies of professionals if they are to be effective.

15. Taking the literacy and health literacy of users systematically into account at all levels of services will be an important prerequisite. This implies monitoring, the development of adequate orientation systems/information material as well as patient education programmes.
16. Potentially traumatic migration experiences mean that heightened awareness of mental health issues is important in hospital care for migrants.

Users (actual and potential patients, relatives)/Representatives of community groups

Patient organizations and community groups can make most important contributions to the process by putting diversity and health and health care on their respective agendas.

17. Patient organizations should incorporate the diversity of their clientele into their strategies and policies and should act as advocates for these diverse patient populations.

18. Migrant/minority community representatives can contribute not only by advocating but also by mediating. They should act as advocates for adequate access to and quality of services, and they should also become agents for the development of greater health literacy within their communities.

19. By investing in improvements in their health literacy, all members of migrant/minority communities can contribute to their own better health and better use of health services.

Health policy and administration

Health policymakers and administration are responsible for quality standards in health care and have the final responsibility for the health of the population in their geographical areas of authority. In most countries, they are also responsible for financing health care services and are thus also interested in the effectiveness and efficiency of these services.

20. Health policy should provide a framework to make migrant-friendly quality development relevant and feasible for each hospital (legal, financial, and organizational regulations).

21. A framework for health-oriented community development for migrants and ethnic minorities has the potential to be most helpful in developing these groups' health literacy.

22. Policy and administration have an important role to play in facilitating knowledge development – for example in initiating and funding research, reviews, standards development and dissemination (networking, education, exchange of experience).

Health sciences

Scientific knowledge and expertise can be very helpful in the process. By moving diversity issues in health and health care higher up on their agendas, by including them in their theory-building and the development of systematic evidence, health science disciplines can make important contributions.

23. Ethnic and migrant background information should be included as a relevant category in epidemiological, socio-behavioural, clinical, health service and health system research.
24. Scientific experts should be prepared to assist other stakeholders in planning, monitoring and evaluating their efforts by providing reviews, assessment tools, designs and tools for evaluation.

25. Scientifically based efforts can contribute to combating racism, prejudice, discrimination and exclusion by providing information on the negative consequences of these processes.

26. Participatory, multi-method research and evaluation efforts should be carried out in partnership and consultation with communities.

All European hospitals are invited to implement the Amsterdam Declaration, become migrant-friendly and culturally competent organizations and develop individualised, personal services from which all patients will benefit. Investments in increased responsiveness to the needs of populations at risk will be an important step towards overall quality assurance and development.
ANNEX II – Programme

Thursday, 24 November

09:00–09:30  Registration

09:30–10:15  Opening session:

- Welcome by Michał Czarski, Marshal of the Voivodeship of Silesia
- Official Address by WHO Regional Office for Europe (to be confirmed)
- Welcome by the RHN Secretariat
- Adoption of the Programme, nomination of Chair and Rapporteur

10:15–11:00  Setting the scene:

Silesian Strategy and Outcomes on Acute Coronary Events – Better Access Improves Equity in Health – Professor Lech Poloński, Silesian Center of Heart Disease

Measuring health inequalities and equity – overview of tools and methods – Dr Bakhuti Shengelia, Regional Adviser, Health Policy and Equity, WHO Regional Office for Europe

11:00–11:20  Coffee

11:20–13:30  Setting the scene (continued):

Investment for Health to tackle health inequity – Mr Dominic Harrison, Deputy Regional Director, Public Health

Migrant-friendly and culturally competent health care systems - Dr Antonio Chiarenza, Coordinator, WHO-HPH Task Force on MFCCH

Comprehensive research programme to describe and improve the health status of Roma people by Dr Karolina Kosa, Course Director, School of Public Health

Information and communication to reduce inequalities - Mrs Tamsin Rose, Executive Director

Discussion

13.30 – 15.00  Lunch
Parallel Working Groups:

- **GROUP I**: Measuring health inequalities and equity – overview of tools and methods
- **GROUP II**: Investment for Health to tackle health inequity
- **GROUP III**: Serving the underserved
- **GROUP IV**: Communication for health equity

**Friday, 25 November**

- **9:30–10:45**: Reports from Working Groups
- **10:45–11:00**: Coffee
- **11:00–12:30**: Reports from Working Groups, Continued
- **12:30–13:00**: Official Closure of 13th Annual Conference
ANNEX III – List of Participants

RHIN FOCAL POINTS:

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Interpreter

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Dariusz Polok, Haller Eurobusiness