



European Economic and Social Committee

SOC/274
Health and Migrations

Brussels, 11 July 2007

OPINION
of the
European Economic and Social Committee
on
Health and Migrations
(Exploratory opinion)

In a letter dated 14 February 2007 the upcoming Portuguese Presidency asked the European Economic and Social Committee to draw up an exploratory opinion on:

Health and Migrations
(Exploratory opinion).

The Section for Employment, Social Affairs and Citizenship, which was responsible for preparing the Committee's work on the subject, adopted its opinion on 18 June 2007. The rapporteur was Mr Sharma, the co-rapporteur was Ms Cser.

At its 437th plenary session, held on 11 and 12 July 2007 (meeting of 11 July 2007), the European Economic and Social Committee adopted the following opinion by 109 votes to 3 with no abstentions.

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1. **Conclusions**

This Opinion is about the links between health and migration and as such is not a debate about migration per se. Migration is important to the EU economy and is an ongoing process which involves a significant and increasing proportion of the EU and the global population. It is important that the policies of the EU and Member States provide a high level of health protection to migrants and their families. This means action in a wide range of policy areas including employment and health and safety at work, education, social protection as well as health promotion and health care.

This Opinion has identified a number of health issues facing migrants and implications for public health which require intervention by Member States and the European Union.

1.1 **Recommendations**

The humanist¹ and fair² globalization must be based on universally shared values and respect for human rights and respect for a high level of health and food safety for all population groups, in particular the most vulnerable; cultural and linguistic diversity and sharing and dissemination of knowledge amongst everyone.

¹ See the EESC opinion of 31 May 2007 on "The Challenges and Opportunities for the EU in the Context of Globalisation" (Exploratory opinion), rapporteur Mr Malosse and the co-rapporteur was Mr Staffan Nilsson, CESE 804/2007.

² ILO. A Fair Globalization. 2004.

With respect to universal human rights the EESC makes the following recommendations:

- 1.1.1 Information and meeting points should be set up, making it easier for immigrants to obtain information on health and social care. The information should be provided by members of the same immigrant minority, working in the centres, as well as provide a focal point of cooperation between authorities, migrant NGOs and those of the host communities.
- 1.1.2 The Member States and the EU should step up cooperation with international organisations on immigrant health and monitoring and assessing problems and benefits on local, regional, national and European levels.
- 1.1.3 Introducing national public health programmes into education taking minority cultures into consideration.
- 1.1.4 A Special Compensation Fund should be set up, together with programmes for training, resettlement and cooperation between host countries and countries of origin.
- 1.1.5 Access to medical treatment and preventive care should be provided as a human right to all persons living in the EU regardless of their status, in line with the Charter of Fundamental Rights which guarantees access to preventative and medical care.
- 1.1.6 Confidentiality clauses between patients and medical institutions should be introduced (where these do not exist) to ensure that any information about a person's immigration status cannot be disclosed to third parties and therefore should not deter migrants from seeking medical help and treatment especially in case of irregular immigration.
- 1.1.7 Member States and the EU should cooperate to improve data collection and research on migration and health throughout the EU.
- 1.1.8 Health should be included as an essential dimension of migration.
- 1.1.9 Health impact assessments should evaluate the potential impact on both health and non-health policies on the health of migrants.
- 1.1.10 Member States that traditionally offer specialist tropical medical services must offer their expertise to all EU residents and continue to undertake high quality research into treatments for tropical illnesses, particularly malaria.
- 1.1.11 Improved mechanisms are needed to assess and provide for the health needs of all categories of migrants as soon as possible after arrival. Enhanced cooperation is required between the EU and Member States to provide for the immediate needs of migrants arriving with urgent medical need, particularly through the provision of interpreters.

- 1.1.12 Health of migrants at work should be prioritised. This should involve cooperation by social partners and the competent authorities to ensure that high standards of occupational health and safety are maintained in sectors in which migrants are commonly employed. Workplace based health promotion programmes should also be further developed in cooperation with community based services to help meet the needs of migrant workers and their families.
- 1.1.13 School based health promotion programmes should also be considered as a way of providing for the health needs of migrant children. Health of migrant children is a particular priority. Pre-school and school-based health services must meet the needs of children from all backgrounds, including the children of migrants, with particular emphasis on new arrivals.
- 1.1.14 Health care treatment and preventive services should be developed which are culturally appropriate and sensitive without making any concessions to the ban on female genital mutilation.
- 1.1.15 Health professionals should receive ongoing training and professional development to assist them to provide for the changing health needs of migrant communities.
- 1.1.16 Consideration should be given to recruiting health professionals trained in developing countries, including an element of co-development, facilitating their return after a temporary stay or providing compensation to the country of origin that provided the training. The Commission needs to look at areas of good practice in ethical recruitment of medical staff from Third Countries with a view to proposing an EU Code of Good Practice.
- 1.1.17 The role of the authorities controlling public health should be enhanced and the exchange of good practices should be encouraged and here EU authorities should play a coordinating role.
- 1.1.18 Enhancing intercultural dialogue – focusing on the state of health and health care³.

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See the EESC opinion of 20.04.2006 on the "Proposal for a Decision of the European Parliament and of the Council concerning the European Year of Intercultural Dialogue (2008)" - COM(2005) 467 final – 2005/0203 (COD), rapporteur Ms Cser (OJ C 185, 8.8.2006).

1.1.19 The EESC re-emphasises its previous recommendations saying that the Member States should implement the ILO conventions on migrants⁴.

2. Background

2.1 The European Economic and Social Committee welcomes the on-going interest of the Portuguese Presidency to investigate the issue of public health and migration. The German, Portuguese and Slovenian presidencies agreed that "the health policy plays a crucial role as better prevention and cross-border health care bring direct benefit to European citizens"⁵.

The three Presidencies committed themselves to actively pursue work to address the existing inequalities affecting migrants in terms of access to health services. It has also been agreed to support a wide range of Community activities to contribute to a high level of health for all citizens, focusing on health promotion, disease prevention, innovation and access to healthcare.

2.2 The Committee has adopted a wide range of opinions concerning the issue of regular and irregular migrations⁶, therefore this exploratory opinion will focus on health issues. We invite the Portuguese Presidency and other stakeholders involved to refer to our previous work in the field of migration.

⁴ The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, adopted in 1990, came into force in July 2003. This complements the ILO Migration for Employment Convention, 1949 (No 97) and the ILO Migrant Workers (Supplementary Provisions) Convention, 1975 (No 143). Together, these three International Conventions provide a framework for addressing the rights of migrant workers and questions of irregular migration. They operate within a broader policy context including recently-adopted UN treaties that address trafficking, smuggling and exploitation, such as the UN Convention against Transnational Organized Crime (2000), its Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (2000) and Protocol against the Smuggling of Migrants by Land, Sea and Air (2000), the Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography (2000), as well as the earlier 1951 Convention and 1967 Protocol relating to the Status of Refugees. While relatively few countries and, where relevant, regional economic organizations have ratified these conventions to date (with the exception of the refugee treaties), these instruments provide important elements for a more comprehensive agenda.

⁵ **Council of the European Union**, 18-month Programme of the German, Portuguese and Slovenian Presidencies, **Brussels, 21 December 2006**.

⁶ See the following EESC opinions :

- 13.9.2006 on "Immigration in the EU and integration policies: cooperation between regional and local governments and civil society organisations", rapporteur Mr Pariza Castaños (OJ C 318 23.12.2006).
- 15.12.2005 on the "Communication from the Commission to the Council and the European Parliament: The Hague Programme: Ten priorities for the next five years – The Partnership for European renewal in the field of Freedom, Security and Justice" - COM(2005) 184 final, rapporteur Mr Pariza Castaños (OJ C 65, 17.3.2006).
- 20.4.2006 on the "Proposal for a Regulation of the European Parliament and of the Council on Community statistics on migration and international protection" - COM(2005) 375 final – 2005/0156 (COD), rapporteur Ms Sciberras (OJ C 185, 8.8.2006).

3. **Introduction**

3.1 Much has been written about migration and health and this report draws upon the recent paper prepared for the Policy Analysis and Research Programme for the Global Commission on International Migration (Carballo & Mboup, September 2005). Other references are noted throughout the Opinion.

3.2 The World Health Organisation defines health as: "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". This Opinion contends that "health" as defined, is a human right.

3.3 The health of migrants and refugees is important for many reasons, including:

- Universal human rights and respecting human dignity
- The extent of loss of life, disease and risk to health experienced by some, especially illegal migrants
- The health risks experienced by a wide range of migrants moving to a new country
- Variable access to health and social care
- Risks to the wider population and
- Risks to the country of origin from loss of health professionals.

4. **Size and scope of the issue**

4.1 Internationally, it is estimated that more than 200 million people move every year to find work and a better life; at least 30-40⁷ million of them are unofficial. The number of the migrants worldwide would constitute the fifth most populous country in the world⁸. Women accounted for 49.6% of global migrants in 2005. There are between 7 and 8 million undocumented migrants in Europe⁹.

4.2 For the purposes of this exploratory opinion the committee has considered migration and health issues mainly in relation to third country nationals migrating to the EU. Presently there are around 18 million citizens of third countries living in the EU. There are also a significant number of foreign born citizens and irregular or illegal migrants. The vast majority of migrants entering into the EU entered legally.

⁷ United Nations' Trends in Total Migrant Stock: The 2003 Revision.

⁸ US Census Bureau, IDB - Rank Countries by Population, <http://www.census.gov/ipc/www/idbrank.html>.

⁹ Migration Information Source, <http://www.migrationinformation.org/Feature/display.cfm?id=336>.

4.3 Asylum seekers represent a relatively small proportion of the migrant population as a whole and the number of asylum seekers has fallen in recent years because of EU policy rather than an overall decrease in the number of people requiring protection.

	2006	2005	2004	2003	2002
EU Asylum Applications	266 270	350 103	421 236	532 300	640 347
Number accepted	38 857	46 742	35 872	41 823	59 705
% accepted	22.71	20.55	13.36	12.4	14.73

In recent years, migration both legal and irregular, has increased in a number of countries in Southern Europe, including Portugal, Spain and Italy. Many of these migrants come from North or sub Saharan Africa, Latin America and Asia and the CIS countries.

4.4 Whilst migrants are generally healthier than people in their country of origin, they may experience more health problems than average for their host community. This is due to a variety of reasons, including:

- Psychological and social stresses (resulting from unknown culture, illegality, change of environment, lack of knowledge of foreign languages, lack of trust and information, mental health issues)
- Risks acquired in their country of origin
- Poverty and working in risky conditions
- Poor access to health care and information about healthcare services, health promotion and preventative services
- Additional risks in their country of destination
- Housing conditions.

4.5 Migrants from some areas have a higher incidence of communicable diseases and long term conditions such as mental health problems, coronary heart disease, respiratory diseases and diabetes are often more common.

4.6 Irregular migrants, including their families and especially children, experience worse health problems than legal migrants which can relate to the health risks taken gaining entry, worse economic and social conditions and insufficient access to services.

5. Different types of migration

5.1 Voluntary migration

5.1.1 Economic factors are the main driver for migration into the EU with escape from conflict or persecution also forming important reasons. People move and continue to move for different reasons. Some move with the intention of settling and beginning new lives, others with the intention of earning enough to return home.

5.1.2 Some move with legal status to work for a period of time, others move in unregistered way but find work and stay for an indeterminate period. Both of these can present health challenges often related to national policies and social attitudes to migrants and the wider determinants of health such as education, employment and housing.

5.1.3 Circular migration is increasingly being recognised as a key form of migration¹⁰ that, if well managed, can help to match the international supply of and demand for labour, thereby contributing to a more efficient allocation of available resources and to economic growth. It can be an answer of the need of the EU offering a credible alternative to illegal immigration.

5.2 Forced migration

5.2.1 The health care implications of forced migration are severe and far-reaching; each year people are forced to leave their own countries and become refugees with UN protection, millions are forced to leave their own homes and stay within their own borders.

5.2.2 Often people have to pay large amounts of money to be helped across borders causing financial hardship. Migrants live in fear and are easily exploited by employers. For women rape and sexual exploitation are not uncommon.

5.2.3 Trafficking people is a crime that violates basic human rights and destroys lives. Trafficking people is acknowledged to be the modern form of slavery and each year it is estimated that the total number of people living in some form of forced servitude around the world (according to the ILO) is 12 million, while more than 1 million people are sold as commodities into prostitution or forced labour. US State Department data suggests that 80% are women and girls and up to 50% minors. The data also suggests that the majority are trafficked into sexual exploitation.

5.2.4 Trafficking generates enormous profits for traffickers, some estimates suggest that as much as USD 10 billion¹¹ is made each year. (iii: UNICEF)

5.3 International travel

5.3.1 The World Tourist Organisation reports that in the last decade of the 20th century international tourism made up for 30% of global service industries and estimated that international "arrivals" will exceed 1.55 billion by 2020. Of these 0.4 billion will involve long-haul travel across ecological zones.

¹⁰ COM on Circular Migration of 16 May 2007.

¹¹ The New Global Slave Trade, Ethan B. Kapstein, from Foreign Affairs, November/December 2006.

- 5.3.2 An estimated 14 million people a year travel from industrialised countries to the tropics in Africa, Asia, Latin America and Pacific Islands. A significant number return with a disease that needs treatment. Diarrhoea is the most common problem, but malaria has become a common problem in terms of diagnosis, treatment and cost to the countries that tourists return to.
- 5.3.3 Without protection, tourists run the risk of Hepatitis A infection and sexually transmitted diseases, including HIV.

6. The impact of migration on health and the public health

6.1 Policy

- 6.1.1 Many EU countries have policies regarding right to enter, length of stay and when people must leave. On the whole these policies are restrictive rather than permissive and make migration complicated. This may create social and economic environments that are detrimental to the health of migrants.
- 6.1.2 Approaches to public health and health screening vary from country to country as does the approach to access to health and social care. However there appears to be a lack of comprehensive information comparing national practices.

6.2 Data

- 6.2.1 Few EU countries gather routine data on the health of migrants and this makes providing reliable information on the health experience and health needs of migrants difficult. In many countries health recording systems are not designed to identify people by migration status.
- 6.2.2 While a few countries collect these data others focus on region of origin or ethnic group. There can be a lack of clarity about who is a migrant and who is a descendent of a migrant. In some cases people are described by ethnic origin alone and no distinction is made between for example children who are migrants themselves, or who are children of migrants.
- 6.2.3 There are also an unknown number of irregular and so unrecorded migrants who may be reluctant to seek health care when it is needed.
- 6.2.4 Furthermore migrants may be reluctant to provide information about their migration status to health service authorities in case it could be used to their disadvantage. This compounds the lack of good quality information available.
- 6.2.5 Reluctant behaviour might be rooted at cultural and religious reasons. Furthermore authorities and health services providers also lack the appropriate knowledge and are not prepared to

meet their special needs. For these reasons there is not enough information on migrants and their state of health.

6.3 Migration and psychosocial wellbeing

6.3.1 For both legal and irregular migrants challenges such as language, culture and policies are exacerbated by fear of the unknown (v: Tizon 1983). Other issues such as:

- Separation from families, partners and children
- Exploitation by employers
- Sexual exploitation
- Anxiety and homesickness
- Lack of integration with local communities
- Impaired physical or mental health.

All affect the health of individuals and communities.

6.4 Migration and mental health

6.4.1 Research¹² has shown that some migrant groups in Europe exhibit the highest rates of schizophrenia, the highest suicide rates, high incidences of drug and alcohol abuse and high risk of depression and anxiety. The research also suggests that access to health and social support for these groups is not adequate.

6.4.2 Some of the factors identified as contributing to the mental ill health of migrants are: changes in diet, family and social support; culture, language and climate; hostility, racism and xenophobia from the host populations; people fleeing war with the attendant horrors of torture, loss of family and sexual abuse.

6.4.3 The research suggests that two thirds of refugees experience anxiety or depression and post traumatic stress disorder symptoms, such as nightmares and panic attacks which are common.

6.4.4 Poor access to treatment, help and support for these disorders is particularly poor for asylum seekers and undocumented migrants, who are the people in most need of these services

6.5 Migration and physical health

6.5.1 All people have a health "footprint" related to where they come from and social environment they live in. In general economic migrants tend to move from poorer to wealthier countries and so a proportion of them will have health profiles linked to poverty.

¹² M.G. Carta, M Bernal, MC Harday and JM Abad: Migration and mental health in Europe 2005.

6.6 Communicable diseases

- 6.6.1 Support for migrants affected by HIV or TB is variable and presents challenges in respect of culture, language and religion as well as the legal and economic status of migrants. Young generation, women and girls are at greater risk contacting HIV/AIDS.
- 6.6.2 There are no consistent policies for screening and even locally how pre-entry screening is carried out varies. Apocryphally, local screening responses are widely different. Some services report more than 50% non-attendance for follow up appointments and service providers relate this to poor communication, fear of authority and a lack of understanding about what might be available. The EESC is aware that Commissioner Kyprianou has asked the European Centre for Disease Prevention and Control to provide an EU Action Plan on TB. The plan is to be published in autumn 2007 and will take account of the situation in different Member States.
- 6.6.3 Between 1995 and 2005 the EU has seen a steady increase in reported cases of TB. The latest Epidemiological report from ECDC points out that "cases of a foreign origin" accounted for 30% of all cases reported in the 25 countries (vi: The First European Communicable Disease Epidemiological Report, European Centre for Disease Prevention and Control, 2007)). It must also be acknowledged that migrants are often located in areas where housing conditions are poor with crowded living and working accommodation, with the attendant risk of the spread of respiratory infections. Migrants are also likely to be over represented amongst the homeless.
- 6.6.4 With regard to HIV, the EU Report: "AIDS & Mobility – HIV/AIDS Care & Supports for Migrants and Ethnic Minority Communities in Europe" (vii: EU – Edited Clark K & Broring G) presents reports from countries on:
- National Policy
 - Access to health and social support
 - Care and support services.
- 6.6.5 The report highlights the fact that the situation of migrants (number of people, ethnic background and epidemiology) and the responses of society vary greatly across Europe.
- 6.6.6 There is a possibility that people from parts of the world with high HIV rates are likely to bring the disease with them. In fact, between 1997 and 2005 47% of all heterosexually transmitted HIV infection in the EU was diagnosed from countries with high HIV prevalence.
- 6.6.7 Conversely, migrants from countries with a low prevalence of HIV do not appear to be at any greater risk (and may be at less risk) than nationals in the host country.

6.7 Non-communicable diseases

6.7.1 Long term conditions such as Coronary Heart Disease (CHD), Chronic Obstructive Pulmonary Disorder (COPD), stroke and diabetes present a great challenge to health services in most parts of the world and account for about half of the deaths that occur each year.

6.7.2 CHD is the leading cause of mortality and has the most impact in terms of treatment, cost and impact on individuals, carers and communities. CHD in migrant communities can be related to ethnic pre-disposition, diet and stress. In the UK, Asian men appear to be more prone to CHD than others (viii: Baljaran & Raleigh, 1992;McKeigue & Sevak, 1994, BMJ 2003)

Both men and women of South Asian origin have 30-40% higher CHD mortality rates than others (ix: Balajaran, 1991).

6.7.3 Data from the UK suggest that migrants from the Caribbean have an incidence of stroke, twice that of the "white" population (x: Stewart 1999). In Sweden high rates of obesity and CHD have been reported amongst Finnish migrants linked to diet and alcohol consumption (xi: Jarhult et.al 1992).

6.8 Inherited diseases

6.8.1 Migration of people from different parts of the world can also mean the movement of genetic diseases. Sickle-cell anaemia and thalassaemia have become more apparent as a result of migration from Africa, the Caribbean and the Mediterranean. Sickle-cell anaemia is relatively common in the EU and estimated to affect 6 000 adults and between 75 and 300 babies in the UK each year (xii: Karmi 1995). A high prevalence of sickle-cell anaemia has also been found in migrants in Portugal (xiii: Carrerio et al, 1996).

6.8.2 Thalassaemia is an inherited blood disease of Mediterranean origin found in the UK amongst ethnic minorities of Middle Eastern and Cypriot origin and there is evidence that it may be common in people from Pakistan, China and Bangladesh.

6.8.3 These diseases require specialist diagnostic and counselling services which are not always available.

6.9 Occupational diseases

6.9.1 Migrants tend to secure lower skills jobs that have become unattractive to the local population. Some of these jobs, such as mining, asbestos, chemical industries, or heavy manufacturing involve health risks. In the agricultural sector exposure to pesticides and other chemicals has been associated with high incidence of depression, headaches and in women miscarriage.

- 6.9.2 In the case of highly educated, skilled or "brain-drain" as well as circular migrants work-related stress appears very often, as they have worse conditions than the employees of the host countries (different rights, etc.); however, they have no choice due to their economically dependent status¹³.

6.10 Accidents

- 6.10.1 Occupational accidents are approximately twice as high amongst migrant workers in Europe. (xiv: Bollini & Siem, 1995). In Germany, accidents tend to be high amongst migrants, particularly those working in industries with poor health and safety measures (xv: Huismann et al, 1997). Data also from Germany suggests that immigrant children in the 5-9 year old age group are more vulnerable to road traffic accidents and other injuries than German children of the same age (xvi: Korporal & Geiger, 1990). In the Netherlands children of Turkish and Moroccan origin appear to be at more risk of domestic accidents, including poisoning and burns, as well as road traffic accidents (xvii: de Jong & Wesenbeek, 1997).

6.11 Reproductive health

- 6.11.1 Some groups of migrants such as men separated from their spouses have a higher incidence of sexually transmitted diseases. In many EU countries pregnancy-related morbidity is higher in migrant women than in local women. Termination rates tend to be higher in migrant women. In Barcelona requests for induced abortion are twice as high amongst migrant woman than Spanish women. An ICMH survey in Geneva reported the abortion rate amongst illegal migrant women was three times higher than national women of comparable age (xviii: Carballo et al, 2004).
- 6.11.2 In the UK babies of Asian mothers tend to have lower-birth weights than other ethnic groups and their risk of perinatal and post-natal mortality tends to be higher. Babies of women from the Caribbean also have higher than average post-neonatal mortality rates. In Belgium and Germany high perinatal and infant mortality rates are reported in migrant women from Morocco and Turkey. Low birth weights and problems in delivery are experienced amongst women from sub-Saharan Africa and Central and South America.
- 6.11.3 Children of migrants may have lower rates of uptake of preventative services such as immunisation.

6.12 Barriers for migrant's access to and effective use of health care systems

- 6.12.1 Migrants experience legal, psycho-social and economic problems in accessing health care. Language barriers are an obvious problem, so too is the cost of health care where even very small co payments for a migrant on a low income provides a significant barrier. Irregular

¹³ "Who Cares? Women Health Workers in the Global Labour Market", edited by Kim Van Eyck, PhD, 2005.

migrants and asylum seekers waiting for their applications to be processed face legal barriers to care in many countries.

- 6.12.2 In addition the public health services are often not in a position to cater for the specific health problems of migrants and lack the sensitivity and skills needed to deliver health care successfully to people who may have significant differences in their concepts of health and differing attitudes towards illness, pain and death, as well as other ways of voicing symptoms, coping with illness and expressing expectations towards the physician.
- 6.12.3 Furthermore the complexity of the highly developed and differentiated health sector of Member States may further complicate this situation.
- 6.12.4 The organisation of disease prevention and health promotion for migrant populations is often inadequate. This is not only true for prenatal examinations, but also for vaccination programmes and other kinds of prevention and early detection, including screening. So far, prevention programmes have rarely used culture-sensitive approaches to reach the various migrant groups.
- 6.12.5 The high prices of certain healthcare services and the cost of medicines are a heavy burden for most migrants. These factors may result in treatment not being sought early enough or prescribed treatment measures not being followed or medicines not taken. This causes an incalculable increase in individual human suffering and the overall economic costs to society.

6.13 Health professionals

- 6.13.1 The growing tendency for health professionals from poor countries to be actively recruited by EU and other developed countries constitutes another growing challenge. If it were to continue unmanaged, it would become a major detriment to the health developments in the sending (and "losing") countries and make medical and nursing education in these countries less sustainable. The exodus of trained health care professionals from resource poor countries is a significant loss of investment in the training of health professionals¹⁴. New solutions will have to be found to respond to this problem, such as Special Compensation Fund, training and resettlement. The United Kingdom's and Ireland's example of ensuring that the National Health Service engages in ethical recruitment practices are widely acknowledged as good practice. Member States must ensure that such practices are adopted and that they are applied to health recruitment agencies and private sector health facilities, as well as to public services.
- 6.13.2 Healthcare professionals (especially nurses and doctors) play a key role in maintaining and improving the health care of migrants. Member States must ensure that health care professionals are able to meet the migrants' healthcare needs and understand the cultural, religious and lifestyle related factors that influence the health habits of these specific groups.

¹⁴ Kim Van Eyck ed., 2005. Who cares?. UNISON UK: PSI.

This is necessary to ensure that migrants have access to appropriate and culturally sensitive healthcare services.

Brussels, 11 July 2007.

The President
of the
European Economic and Social Committee

The Secretary-General
of the
European Economic and Social Committee

Dimitris Dimitriadis

Patrick Venturini

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N.B.: Appendix overleaf.

APPENDIX
to the opinion of the European Economic and Social Committee

The following amendments, which received at least a quarter of the votes cast, were rejected in the course of the debate (Rule 54(3) of the Rules of Procedure):

Point 1.1.8

Delete point:

~~*"1.1.8 Introducing national public health programmes into education taking minority cultures into consideration."*~~

Voting

For:	44
Against:	51
Abstentions:	11
