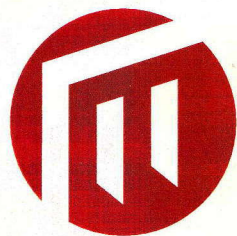


MIGRATION AND HEALTH: DIFFERENCE SENSITIVITY FROM AN ORGANISATIONAL PERSPECTIVE

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MIGRANT FRIENDLY HOSPITALS: ORGANISATIONS LEARN SENSITIVITY FOR DIFFERENCES

Ursula Karl-Trummer and Karl Krajic

Migration, Health and Hospitals

Numerous studies prove that there is a relationship between migration and ethno-cultural diversity on the one hand and health status and healthcare quality on the other.

Due to worldwide migration, globalisation and European expansion, communities in Europe are becoming more and more diverse – and posing challenges for health systems and services alike. Both service users and providers are facing problems: language barriers and misunderstandings due to cultural diversity, a scarcity of resources and low levels of minority purchasing-power and entitlements (Bischoff 2006). On the provider side, this emerges as new challenges for professionals and for the management as well as for quality assurance and improvement – especially for hospitals which play a particularly important role in serving this segment of the population.

In order to cope with consequences of migration and increasing diversity, hospitals have to change. Like any other organisation, hospitals have a natural tendency to preserve existing structures and processes, but a significantly changing environment forces them to change. As Cattacin and Björngren Cuadra state in the introduction of this book, the first reaction is blindness and the development of strategies to mask this blindness. Using cleaning staff as “random” interpreters to compensate communication problems is an example for such a strategy. But as the pressure increases, organisations eventually get to a point where problems caused by staying the same in a changing environment start to “feel” worse than the difficulties of actively adapting to the new situation.

Systemic transformation management talks about the “Energy for Transformation” necessary to cope with change and that develops through

three factors: a deficient presence, an attractive future, and a realistic way from one to the other (Janes, Prammer and Schulte-Derne 2001: 19)

How Can Hospitals Learn to Deal with Diversity?

Individual and Organisational Learning

In the discussion of migration and health, interventions concerning the development of personal resources are often stressed as important elements of improvement. At the provider level this includes language skills and the cultural competence of staff members, while at the client level empowerment issues like health literacy are mentioned. These are important attempts to influence personal priorities, knowledge and skills and make changes of individual behaviour possible. Nevertheless these attempts are insufficient, as individual behaviour is not only dependent on individual preferences and resources, but also on preferences and resources in the social situation or setting. Social situations are not only influenced by general political, legal and cultural environments, but also more directly by organisations that define the concrete and specific relevance of structures: What is expected? What will be positively valued, what will be sanctioned? Organisations also decide on the resources available and the specific opportunity structure.¹⁵

Sustainable development in healthcare must therefore systematically address the level of health organisations and thus include organisational development strategies. Development requires processes of learning. How organisations can develop and learn is an issue of ongoing discussion within the different communities, and several models have been proposed (Argyris and Schon 1978, March and Olson 1975, Kim 1993, Nonaka and Takeuchi 1995, Nick Bontis et al. 2002), all of which try to distinguish between learning processes at the individual and organisational levels.

Following Richard Beckhard's definition (Beckhard 1969), organisational development is a planned, organisation-wide effort managed from the top that aims to increase organisational effectiveness and health through planned interventions in the organisation's processes, and that uses the theory and technology of applied behavioural science. It involves organisational reflection, system improvement, planning and self-analysis.

A variety of concepts and related tools have been made available with the development of quality management. In terms of quality improvement, they basically relate to the need for a circular process that has to be run through. A prominent model is the Shewhart Cycle (PDCA) for quality

15 See Lewin and Coleman for a brief description of a theoretical model following basic distinctions in the context of healthcare and health promotion, see also: Pelikan and Halbmayer 1999; Trummer, Nowak and Pelikan 2002.

improvement, made popular by Deming and which formulates four key elements that should be repeated over and over again for continuous improvement (Tague 2004):

- Plan: Design or revise business process components to improve results
- Do: Implement the plan and measure its performance
- Check: Assess the measurements and report the results to decision makers
- Act: Decide on changes needed to improve the process

Quality management procedures and tools provide appropriate measures with which to steer and conduct organisational development and learning processes. All methods need a starting point, however, and in this case the starting point is a decision about what is relevant for the organisation and a statement regarding what the organisation is willing to observe and consider. Everything else is a consequence of these first statements.

The MFH Project Starting Point: A Definition of Sensitivity for Differences Concerning Migration and Ethnic Minorities

"Migrant Friendly Hospital" (MFH) is a name inspired by the WHO idea of "Baby-friendly hospitals". There was a lot of discussion about this name, and it was especially questioned by partners from countries with a long immigration history where minorities had fought to be accepted as full citizens, albeit with a different ethnic background and a different cultural identity to the "natives". But the project did not only want to look at cultural diversity, but also at acute issues raised by "fresh" migration, which was why the title was accepted as a compromise on condition that it was accompanied by a sub-title that also provided clear reference to ethnic minorities¹⁶.

A working definition of the MFH project was developed that consisted of three components. According to this definition, a Migrant Friendly Hospital:

1. values diversity by accepting people with diverse backgrounds as principally equal members of society;
2. identifies the needs of people with diverse backgrounds and monitors and develops services in accordance with these needs;
3. compensates for disadvantages arising from diverse backgrounds.

16 The Task Force in the WHO Health Promoting Hospital Network that has been engaged in the project work since 2005 has explicitly included "Cultural Competence" in its name, so that it now reads "Task Force for Migrant Friendly and Culturally Competent Health Care".

Referring to the key elements of organisational development - organisational reflection, system improvement, planning and self-analysis – the difference sensitivity of an organisation means to:

- define differences in their relation to a desired outcome: good care and good health for people who are different
- actively monitor/analyse for differences
- develop/adapt strategies that cope with difference in a way that the desired outcome is supported
- evaluate measures taken in relation to the stated objectives

A precondition for taking these measures is that sensitivity to difference becomes a central value in an organisation. This is a very different process than that where a single person decides whether or not to put a high value on something - even if that person is the hospital's director.

The Migrant Friendly Hospital Project

The process of developing a European project was initiated by an Italian local health authority from Reggio Emilia (Region Emilia Romagna) in 2001. The Ludwig Boltzmann-Institute for the Sociology of Health and Medicine at the University of Vienna, WHO Collaborating Centre for Health Promotion in Hospitals and Health Care, supported by national and regional networks of the WHO Network of Health Promoting Hospitals (HPH), managed to get a group of 12 hospitals together from 12 European countries in what came to be known as the "Migrant Friendly Hospital Project".¹⁷

The 2½-year project formally began in October 2002. Partner hospitals came from Austria, Denmark, Finland, France, Germany, Greece, Ireland, Italy, The Netherlands, Spain, Sweden and the UK. The participating hospitals represent a wide range of different types, from large metropolitan university teaching hospitals to small-town community hospitals, and range from public, private and non-profit ownership. Some of the partners already had a long-standing record in serving ethno-culturally diverse communities before they participated in the project. Several of the migrant/minority communities served are well-established and homogeneous, while others are very diverse and comprise a large number of undocumented migrants.

In the project, the hospitals collaborated with a group of high-profile experts, while a wide range of international and European organisations

¹⁷ Financially supported by the European Commission, DG Health and Consumer Protection, Public Health Programme, and co-financed by local sources like the Austrian Federal Ministry for Education, Science and Culture.

acted as "Supporting Partners". The project partners agreed on the following aims:

- To locally initiate a process of organisational development towards becoming a Migrant Friendly Hospital and implement pilot interventions selected in a stakeholder approach.
- To regionally/nationally support other hospitals in their quality development towards migrant friendliness by compiling practical, transferable knowledge and instruments.
- To actively contribute to putting migrant friendly, culturally competent healthcare and health promotion higher up on the European health policy agenda.

The "Overall Project": Organisational Development Towards "Migrant Friendly Hospitals"

The project was organised on two closely interlinked levels. The so called "overall project" was started at the general approach level of organisational development and had three main objectives:

- To develop a basic structure within the participating hospitals that could systematically work on the issue of migrant friendliness and link those organisational activities to work at the European initiative level
- To raise awareness for the importance of migrant health within the hospitals
- To provide a first diagnosis of needs, problems and existing structures and process regulations related to migrant health

Project teams were established in all partner hospitals in order to develop a basic structure. While these project teams were necessary for the partner hospitals to participate in the European project, they also formed the nucleus of an organisational development to integrate project activities in existing organisational structures and cultures of decision-making and practical day-to-day work. Project groups were therefore created in line with local definitions of quality management and local roles and responsibilities. These teams took responsibility for all further project related activities within their hospitals, acted as focal points for the European project coordination, and took the lead in marketing the idea and raising awareness at the local level. The "overall project" provided background information, guidelines and tools for local activities.

For a first diagnosis of problems and needs, as well as existing solutions - structures and process regulations - within the partner hospitals, a needs assessment was conducted that integrated the perspectives of clients,

staff and the hospital management. Results showed that there was widespread consensus that the main problems are language barriers in communication with patients, patient education and the cultural competence of staff members.

Along with the needs assessment, a literature review on available knowledge relating to problems and possible solutions of health and healthcare related to migrant/minority status was provided by the Swiss Foundation for Migration, University of Neuchâtel, Switzerland (Bischoff 2006). This review grouped interventions into four specific areas – communication, responsiveness, empowerment and monitoring – and highlighted the relevance, principle options and evidence for the effectiveness of interventions in these areas.

A generic assessment instrument was developed in order to obtain a first diagnosis on structures and process regulations at the organisational level. The Migrant Friendly Quality Questionnaire (MFQQ)¹⁸ assesses the status quo of overall “migrant-friendliness” (see the definition above) of services and (quality) management structures. MF Indicators are defined on two levels: The level of services and the level of facilitating quality structures. The MFQQ is available in two versions: the original English version, consisting of 163 Items, covers basic items and specific items of special interest for single partner hospitals. A short German form consisting of 67 items was developed in the framework of an initiative of the Austrian Ministry of Health (Karl-Trummer, Schulze, Krajic et al. 2006).¹⁹

The results were used to monitor the project’s progress and to allow for benchmarking within the group of participating hospitals. The MFQQ was used for two assessments (2003 and 2004) within the 12 European Partner Hospitals.

The main dimensions of monitoring at the Service level included:

1. Interpreting services available at the hospital
2. Information for hospital access and information in hospital
3. Hotel services
4. Medical/nursing treatment
5. Discharge Management
6. MF patient education/health promotion/empowerment

¹⁸ Available via the MFH website www.mfh-eu.net and the website www.hph-hc.cc.

¹⁹ Both forms were included in the Manual for Swiss Health Care Institutions (Saladin et al. 2006).

At the level of facilitating quality structures, the main dimensions included:

1. General quality systems in hospitals
2. MF budget
3. Written MF policy
4. Management Structure
5. Marketing of MF
6. MF training and education for staff
7. Monitoring of migrant clientele
8. Partnerships and partner alliances

One central result was that monitoring itself makes a difference. The process of using the MFQQ and discussing the results fostered awareness of crucial elements of organisational structures and processes. It also provided directions of where to go and created energy for change. Some hospitals used the results of the first assessment as an engine for further action. They integrated migrant-friendliness criteria into their strategy development (definitions of common values, EFQM self-assessment, strategic aims and Balanced Scorecard), improved hotel and religious services for an ethnically diverse clientele, and implemented adequate information material (translation of relevant information about the department, discharge and follow-up procedures, improving signposts using pictograms).

Results of the second assessment after one year of project work also showed that considerable progress is possible in a rather short time-frame. One project hospital used the dynamics of the European project to implement a comprehensive interpreting service practically "from scratch". Changes related to engagement in thematically focused "sub-projects" of the MFH project were apparent in all the hospitals. These sub-projects were defined on the basis of the results of the needs assessment, the first MFQQ assessment of structures and quality systems, and the review's identification of the most common problems and solutions.

Three Implementation Areas: Communication, Client Empowerment and the Cultural Competence of Staff

Based on the results of the needs assessments, the literature review on problems and promising interventions and the MFQQ assessment, the partners decided to systematically work on improvements in three specific intervention areas:

- Facilitate communication: improve the interpreting services
- Empower clients: migrant friendly information and training for mother and child care
- Facilitate understanding: staff training towards cultural competence.

Three so called "sub-projects" were started in these three inter-vention areas. Hospitals chose to participate in one or more of the sub-projects according to their problems (indicated by the results of the needs assessment) and available resources. Development and planning was started in European Sub-groups, managed by LBISHM as the project co-ordinators and supported by international experts. The European project level developed fact sheets and pathways for the implementation of common solutions and provided materials, such as manuals and guidelines, developed outside the project.

In view of the limited time-frame, these instruments could thus be used for both local planning and implementation in a soft benchmarking approach and allow for local adaptation. Evaluation design and instruments to assess the implementation of interventions (and where possible their effects) were either developed or adapted from international examples provided by the European Sub-groups and used at local level. The Sub-groups also served as a social framework for benchmarking and mutual consultation in the various stages of implementation and eventual joint assessment/evaluation. This mutual consultation took place in both face-to-face meetings and electronically, thus involving all the groups and the partner hospitals.

Sub-project A: Improving Interpreting Services in Clinical Communication

Patients that are non-local language speakers or who come from migrant populations or ethnic minority groups are not always able to communicate effectively with their clinicians to receive comprehensive information about their care. At the same time, clinical staff are not always in a position to understand the patients' needs or to elicit other relevant information from the patient. Correspondingly, the MFH needs assessment results show that language and communication is regarded as the most important problem area when dealing with migrant populations and ethnic minorities in clinical routine.

Nine Pilot hospitals (DK, EL, ES, FI, IR, IT, NE, SW, UK) participated in this sub-project to improve clinical communication with migrant and ethnic minority patients, which had the following four aims:

1. Professional interpreting services should be made available whenever necessary to ensure good communication between non-local language speakers and clinical staff.
2. Patients should be informed which language services are available and how to obtain them.
3. Clinical staff need know how to work competently with interpreters to overcome language barriers and obtain better outcomes.
4. In addition, education materials for patients should be made available in non-local languages to assist with communication.

Measures were both developed and implemented to improve clinical communication through telephone interpretation, face-to-face interpretation, intercultural mediation and the use of written material as supporting communication. In a benchmarking evaluation design, a pre- and a post-intervention staff survey and patient survey were conducted. General evaluation results show that the implemented measures were effective:

- The rate of responses stating that interpreters were available in a timely manner (always or often) increased by 17%.
- Improvements were observed in all the defined quality indicators of interpreting services, such as the interpreter's introduction and role explanation, an accurate transmittance of information, the interpreter's clarification, clarification of cultural beliefs and the interpreter's identification of patients' further needs.
- The overall rating of interpreting services improved, with the number of responses rating them as either excellent or very good increasing from 26% to 47%.
- 55% of staff members identified an improvement in their work situation as a result of the measures implemented in the context of the sub-project.²⁰

Sub-project B: Migrant Friendly Information and Training in Mother and Child Care

Mother and child healthcare for migrants and ethnic minorities has been highlighted as an area of particular concern for health policies and programmes, since the birth rates of migrant populations are significantly higher and the incidence of health problems among mothers and their children is also above average. Improvements in the health of mothers and children require a high level of awareness among the parents-to-be concerning which services are available, what is important in pre- and postnatal

²⁰ For a more detailed description see Novak-Zezula, Schulze, Karl-Trummer and al. 2006.

care and which behaviour is relevant for the health of both mother and infant. The importance of awareness and self-management ability - by raising health literacy levels and increasing their ability to act - makes the empowerment of clients a key intervention.

Sub-project B aimed at empowering women and families in parental care by providing culturally adequate information and training programmes. Six hospitals (AT, IT, FI, NL, SP, UK) developed information materials such as brochures and videos, and, on the basis of a needs assessment conducted among migrant women about what kind of information they felt they needed concerning pregnancy and early motherhood, also provided training courses tailored to meet these needs. The courses and information materials were developed in line with four quality dimensions: (1) appropriate access to services, (2) relevant information, (3) culturally sensitive design and format of information, and (4) an empowering and culturally sensitive relationship between providers and clients.

Evaluations showed that women who attended the courses and used the information material were very satisfied with all the quality dimensions and experienced a remarkable improvement in their knowledge. Access is an issue that needs to be worked on further, however, because even though the courses were free of charge and women were supported by various measures including child care, participation rates were low. One hypothesis is that influence from husbands and/or family, who often decide whether such courses are taken or not, might have led to low participation rates. Further development should therefore take the important role that men play in mother and child care into account.²¹

Sub-project C: Staff Training in Cultural Competence: enabling hospital staff to better handle cross-cultural encounters

Within the framework of the MFH project, a lack of cultural competence among hospital staff - identifiable as cultural unawareness and misunderstandings and prejudices that inhibit communication - was identified as a significant problem by the needs assessments in the participating European hospitals. On the basis of a systematic review of international literature, the solution chosen to help to solve this problem focused on an intervention in which a staff training course was held to improve cultural competence. This intervention is widely acknowledged by experts as a quality improvement measure for healthcare services. Training courses are widely practised, especially in classical immigration countries like the USA, Canada and Australia. The aims of this intervention include improving hospital staff's awareness, knowledge, skills and comfort levels relating to the care of a diverse patient community.

21 For a more detailed description see Karl-Trummer/Krajic/Novak-Zezula et al. 2006.

Nine pilot hospitals participated in the staff training project (AT, DE, ES, FR, IR, IT, NL, SV, UK). Several tools – a fact sheet, a pathway and modules for implementation and instruments for evaluation – were developed by LBISHM in collaboration with experts (all the tools are outlined in this report). Results and experiences are summarised according to 5 criteria (for details see the evaluation report and the keynote speaker presentations at the final conference):

- Feasibility could be demonstrated; acceptability among staff varied in the hospitals but altogether a total of 149 staff members participated.
- Quality was operational in terms of the following dimensions: content, structure, number of training units, qualification of trainers, composition of participating staff, management support, systematic needs assessment at the department level, integration in ongoing quality assurance, etc. Quality was measured as “conformity with the recommendations of the pathway” and, so defined, varied extensively, mainly due to a very narrow project time-frame that forced hospitals to rely on readily available resources.
- Effectiveness could be confirmed by improvements in the staff’s self-rated awareness, knowledge, skills and comfort levels concerning cultural diversity issues, as well as by increases in interest levels regarding cultural competence and in the staff’s self-rated ability to cope with work demands.
- Cost-effectiveness: while external training costs were low, developmental costs were rather high, despite personal costs being mainly covered through voluntary work.
- Sustainability: training was recognised as an effective way of equipping staff with important competencies and although this will be continued, it will be modified in all the participating hospitals.²²

Prioritising the Issue on European Agendas: The Amsterdam Declaration

In December 2004, European recommendations for a migrant friendly health policy at hospital level and for other stakeholders were launched as the “Amsterdam Declaration Towards Migrant Friendly Hospitals in an Ethno-culturally Diverse Europe”.²³

²² For a more detailed description see Krajic/Straßmayr/Karl-Trummer et al. 2005.

²³ On the occasion of the closing conference of the project, December 2004, Amsterdam.

The document starts with a summarised analysis of the current situation of hospital services for migrants and ethnic minorities in Europe and highlights quality-related problems for patients and staff. It assumes that improving quality for migrants and ethnic minorities as specific vulnerable groups would also serve the general interest of all patients in more personalised services, which is an issue high on the agenda of healthcare quality development and reform and especially the WHO Network of Health Promoting Hospitals. The Declaration argues that everybody would benefit if hospitals became more responsive to the ethnic, cultural and social differences of patients and staff.

In the second part of the Amsterdam Declaration, recommendations are made for specific contributions from the main stakeholders - hospital management, hospital staff and professional associations, health policy and administration, patient and migrant/minority organisations and the health sciences. The Declaration was welcomed at the MFH project's closing conference by a large number of European and international organisations: the European Commission, DG Health and Consumer Protection, WHO Centre for Integrated Care (WHO), International Labour Organisation (ILO), International Organisation for Migration - IOM, International Alliance of Patients' Organisations (IAPO), Standing Committee of the Hospitals of the EU (HOPE), International Union of Health Promotion and Education (IUHPE), Migrants Rights International, United for Intercultural Action, PaceMaker in Global Health. Partners expressed their expectation that the Amsterdam Declaration would serve as a European platform for improving hospital and healthcare services for migrants and ethnic minorities.²⁴

Supporting Sustainability and Facilitating Ongoing Networking: The WHO Task Force on Migrant Friendly and Culturally Competent Healthcare within the Framework of the WHO Network of Health Promoting Hospitals

In order to sustain the European momentum created by the MFH project, a Task Force on Migrant Friendly Hospitals has been established within the WHO Network of Health Promoting Hospitals (HPH). The Task Force brings together practitioners, managers, scientists and community representatives with specific expertise and competence in policy-relevant knowledge in the field. It aims at keeping the issue on the agenda of the HPH network by providing inputs at workshops and conferences at European, national and local levels. It also aims at the development of specific tools

24 The final text is available in this report in eleven European languages (German, Greek, Danish, Spanish, Finnish, French, English, Italian, Dutch, Swedish and Portuguese): http://www.mfh-eu.net/public/european_recommendations.htm.

(like the MFQQ form) that help the implementation and evaluation of policies, services, research activities and practices addressing migrant friendliness/cultural competence issues at the local, national and European levels. The Task Force is coordinated by the Emilia-Romagna Network of HPH, represented by the Health Authority of Reggio Emilia.

Concluding Remarks

For a migrant and ethnically diverse population, healthcare is not only influenced by political or culturally defined social frameworks on the one hand and individual preferences and skills on the other. The organisational level plays a major role and thus has to be specifically addressed. The MFH project has demonstrated that healthcare organisations will take action if they understand that cultural diversity and migration related issues impact on their core processes of healthcare delivery. Consequently, this should lead to changes in the self definition of the organisation and account for the inclusion of cultural diversity in the organisation's vision and quality criteria for monitoring and improvement.

APPENDIX: The Amsterdam Declaration: Towards Migrant Friendly Hospitals in an Ethno-culturally Diverse Europe (December 2004)

Migration, diversity, health and hospitals

Migration, ethno-cultural diversity, health and health care are closely inter-linked in many ways. Due to worldwide migration, globalisation 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.²⁵ Minority groups are at risk of not receiving the same level of

²⁵ World Health Organization (WHO): Report International Migration, Health and Human Rights, Iss.No.4, 2003.

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 (Bischoff 2006).

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 give 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 organisations.

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 long-standing 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 organisations joined the initiative as supporting partners (see list at the end of this document).

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 organisational structures and cultures to become migrant-friendly and culturally competent organisations. For the partners, becoming a (more) “migrant-friendly” organisation 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, organise 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 organisational cultures can be identified:

- 1.1. 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.
- 1.2. 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, organisational routines and resource allocations.
- 1.3. 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.

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- 1.4. Developing partnerships with local community organisations 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 organisational 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 organisations:

- 2.1. It will be important to define aims and objectives (mission, vision and value statement, policies and procedures)
- 2.2. Adequate resources (working time, financial resources, qualification) must be provided if changes are to be realised.
- 2.3. An organisational development process should be initiated, supported and monitored by leadership, management and quality management.
- 2.4. As an important step, the needs and assets of stakeholders – users (patients, relatives, community) and providers (staff) – should be monitored.
- 2.5. Outcomes as well as the structures and processes that influence outcomes should be monitored.
- 2.6. Concerns, complaints and grievances related to service delivery should be tracked and appropriately addressed.
- 2.7. 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 organisations of which they are part should acknowledge that the issues are relevant and they should be prepared to invest in achieving competency.

- 3.1. 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 realised in everyday practice. The principles applied in the MFH project can serve as starting point for this development.

- 3.2. Professionals and other staff will have to build capacities concerning cross-cultural and communicative and diversity-related competencies
- 3.3. 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.
- 3.4. Taking the literacy and health literacy of users systematically into account at all levels of services will be an important pre-requisite. This implies monitoring, the development of adequate orientation systems/information material as well as patient education programmes.
- 3.5. 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 organisations and community groups can make most important contributions to the process by putting diversity and health and health care on their respective agendas.

- 4.1. Patient organisations should incorporate the diversity of their clientele into their strategies and policies and should act as advocates for these diverse patient populations.
- 4.2. 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.
- 4.3. 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.

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- 5.1. Health policy should provide a framework to make migrant-friendly quality development relevant and feasible for each hospital (legal, financial, and organisational regulations).
- 5.2. 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.
- 5.3. 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.

- 6.1. Ethnic and migrant background information should be included as a relevant category in epidemiological, socio-behavioural, clinical, health service and health system research.
- 6.2. 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.
- 6.3. Scientifically based efforts can contribute to combating racism, prejudice, discrimination and exclusion by providing information on the negative consequences of these processes.
- 6.4. 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 organisations 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.

Further contact / Opportunities to communicate and collaborate

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