SALTSA REPORT 2001:2

Migration and Work-Related Health in Europe

– *A Feasibility Study*

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Contents

Foreword

Work-related health among migrants has been identified as an important research gap in Europe at a time which is witnessing a significant increase in mobility, involving both voluntary and forced migration. While the numbers of forced migrants seeking asylum in Western Europe have increased significantly since the mid 1980s, the EU is also becoming more integrated as a labour market, resulting in a more mobile work force. The coming decades are likely to see further increases in labour migration as demographic changes are predicted to contribute to pre-existing labour shortages in certain skilled sectors. This is likely to lead to further increases in intra-EU migration, as well as further migration from Eastern Europe and other continents. Therefore, studies of migration and working life have been prioritised in the SALTSA programme.

Despite these trends, very little is known about the work-related health implications for migrants and the related implications for European societies. Work-related health aspects include occupational accidents among ethnic minorities employed in dangerous occupations as well as work-related stress among skilled migrants in qualified positions. A potential health hazard is de-skilling among skilled refugees. In all cases cultural components must be taken into account. To date, a major problem preventing research and more full awareness of these linkages is the difficulty of acquiring the relevant data, and in particular, data which is comparable internationally.

A pre-planning phase was carried out during 1998 and 1999. This process, for which Anders Schærström was responsible, comprised a search for references and contacts, as well as two workshops. The result of the study and one workshop have been documented in other SALTSA publications.

In order to prepare the ground for a major research effort, a planning phase has followed.

The objective of this phase was to assess the feasibility of meaningful comparative European research on the situation of different groups of migrants versus non-migrants in terms of work and health by searching for databases and other sources of information as well as academic competence and other contacts.

The feasibility study has been carried out on behalf of SALTSA by researchers at the School of Geography and Geosciences at the University of St Andrews, Scotland. This literature review, focussing the current migration situation in Europe, is one of its results. An overview of data availability and contacts in several countries has been published separately.

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Summary

Migration and work-related health in Europe has been identified as a major research gap at a time when the region has seen significant increases in mobility associated with the internationalisation of labour markets. The feasibility study recommends the key areas for future research as:

- The extent and health implications of deskilling and unemployment among refugees in selected countries. This would include the interaction of factors such as labour market discrimination, trauma and depression, and the role of mental health problems as a barrier to employment.
- The impacts of different types of integration policies and their outcomes for refugees
- An assessment of the situation of second generation migrants in the labour market.
- An examination of the extent and nature of occupational accidents and health disorders among migrants employed in dangerous and physically demanding occupations.
- An examination of work-related stress among skilled migrants, and the experiences of 'tied' migrants.
- Health problems among illegal migrants.
- Work tourism from Eastern Europe and associated health problems.

Based on current contacts and data accessibility, the following countries are recommended as the most likely viable participants in a larger project are: *Sweden, Denmark, Britain, Germany* and *Italy*.

The statistical data sources examined have been disappointingly poor, and in some countries, it is not possible to make linkages between migration, employment and health. The following issues have been identified as potentially problematic:

- While most countries (with the exception of the Netherlands) provide full coverage in their data sources, some of this only occurs at ten-yearly intervals, and census years vary by country.
- Some relatively good surveys exist, but these are based on samples, and do not give full national coverage. This can be problematic where minority ethnic groups are concerned, as their response rates are often lower.
- Some countries integrate their data sources using personal identification numbers, while others do not.
- Accessibility to data varies by country. Some countries levy very high charges for data access, while others provide it free of charge to academics working within the countries concerned.

It is proposed that the proposed future research programme should create new data through the use of questionnaire surveys. This will provide viable data for cross-national comparison, and data will be tailored directly to the requirements of the project.

Introduction

The latter part of the twentieth century saw a significant increase in mobility globally, involving both permanent and temporary migrations. Progressive globalization of labour markets has resulted in a growing spatial spread and diversity of migrant origins, and increasing contacts between different cultures. Western Europe has received many non-European migrants since World War 2, but EU integration has also created a more integrated labour market in Western Europe, and the numbers of intra-EU migrants has also increased significantly. The coming decades are likely to see further increases in labour migration as demographic changes are predicted to contribute to pre-existing labour shortages in certain skilled sectors, particularly in the health services, teaching and information technology. This is likely to lead to further increases in intra-EU migration, but also to migration from the developing world and Eastern Europe. Paradoxically, many forced migrants are being turned away from EU borders, despite the fact that many possess the relevant skills which are in demand, and many who do enter Western Europe subsequently face severe deskilling problems.

Despite these trends, very little is known about the work-related health implications for migrant workers in general, either among highly skilled or unskilled workers. Most research to date has focused either on the links between migration and downward social mobility, or on health problems among minority ethnic groups, and there has been very little work which looks at the specific links between migration, employment and health. This is an important research gap which increasingly, will require attention from policy makers across Europe. A major problem preventing more full awareness of these linkages is the difficulty of acquiring the relevant data, and in particular, data which is comparable internationally.

This study was carried out over a period of five months during 2000, to assess the feasibility of conducting a Europe-wide research programme examining work-related health problems among migrants and ethnic minorities. The countries included in the study were: Britain, Denmark, France, Germany, Italy, The Netherlands, Norway and Sweden. The study had the following aims:

- To identify major relevant data sources in the above countries and to assess their suitability for linking variables related to migration, employment and health.
- To assess the possibility of conducting comparable cross-national research using these data sources.
- To identify any pre-existing projects which have examined migration and work-related health.
- To identify and review relevant literature in this area and identify research gaps.
- To make recommendations for future research.

The following information has informed the conclusions of this study:

- A set of responses to questionnaires sent to a variety of interested parties and the views of relevant organisations contacted in person and by telephone.
- A meta-database of relevant data sources which link variables relating to migration, employment and/or health for individuals.
- A literature review of published European work in the subject area.

Identifying the key research areas

Several workshops were held prior to the feasibility study, where academics and medical practitioners met both to foster research linkages and discussion, but also to determine some possible future research agendas. A workshop held in Brussels in May 2000, provided an introduction to potential data sources, but also gave participants the opportunity to express their views as to how research should proceed. This was followed up by an email questionnaire to all members of the pre-existing network to allow those not present at the meeting the opportunity to express their views. At this early stage, some key potential research areas were identified as:

- The health implications of deskilling and unemployment among refugees
- Occupational accidents among migrants employed in dangerous occupations
- The health impacts of labour market discrimination.

Individual national reports were presented at the workshop, and the discussion which followed highlighted some of the potential problems involved in comparing different national immigration histories. It was demonstrated that there is considerable definitional variability resulting from these variant immigration histories, resulting in differences in the ways in which migrants and refugees have been perceived in receiver societies. One of the major differences highlighted was related to the way statistical categories have been developed to define migrants and their offspring. In Britain, the category of ethnicity is used in most data sources, while in the remaining countries, nationality is a more commonly used variable. It was demonstrated that there are also major differences in the way data are recorded in different countries, with Denmark, Sweden and Norway relying on extremely accurate and up-to-date population registers, containing a wide variety of information about individuals, whereas the other countries tended to rely on a combination of census and survey data. It was also noted that most countries often have their own research agendas based on their own perceived problem areas. The problematisation of immigrants as discussed in the literature review has focused on certain place-specific aspects of immigration in different countries, and research has tended to be focused on these agendas.

A Norwegian delegate raised the point that migration and health research tended to view migrants' health issues from the perspective of receiver societies, ignoring the importance of their migration histories and associated health implications. It was also stressed in this context that it is necessary to consider place specific manifestations of racism. Several of the participants also expressed strong views about the nature of the data collection and methodology, and the importance of including a major element of qualitative research in the programme.

Questionnaires

While the Brussels meeting provided an extremely useful discussion forum for the future of the programme, it was also considered necessary to consult various organisations working directly with refugees and migrants to gauge their views. A brief questionnaire was circulated to a wide range of organisations throughout Europe, including: refugee agencies, immigrant and trade union organisations, research groups and employment agencies. In the questionnaire, respondents were requested to outline

key problem issues related to their work, which in their views, should be included in this research programme.

The response rate to the questionnaires was very favourable and facilitated not only the identification of any important research areas which may have been overlooked in the workshops, but the process also represented a valuable opportunity to make research contacts, and several of the respondents expressed an interest in further involvement. It also highlighted some pre-existing projects and research groups within similar fields. Some of the respondents also provided reports about their activities, which have been incorporated into the literature review.

The responses largely confirmed the potential research areas identified at the Brussels workshop, particularly the importance of deskilling among refugees. While discrimination and high ethnic minority unemployment were perceived as problematic across Europe, and the difficulty of having previous qualifications recognised as fairly universal, there were some place-specific problems outlined. In Sweden, a major problem related to deskilling was cited as the length of time required to complete basic language courses before entering the labour market, which often results in the loss of previous skills. In Denmark, one of the major barriers to upgrading professional qualifications was cited as the difficulty in acquiring the necessary practical placements (due to discrimination) required to complete qualifications. In Britain, specific problems were highlighted relating to the status of asylum seekers and their access to funding and 'fee-waivers' in higher education.

Other issues raised were related to health, and a high proportion of respondents stressed the importance of mental health. This was the one issue which dominated the questionnaire responses, and which had perhaps therefore been underemphasised at the Brussels workshop. An associated problem in some countries was the lack of appropriate psychiatric care for those affected by mental health problems, particularly the lack of cross-cultural psychiatric services. Language barriers and lack of knowledge about access to health care services were also cited as obstacles to well-being. Other organisations cited concern for the elderly among the ethnic minorities. Often, they face the difficult combination of isolation and the cumulative health effects of many years of hard physical labour, but also severe socio-economic disadvantage due to inadequate pension provision.

Refugee programmes

The Scottish Refugee Council

The Scottish Refugee Council responded very favourably to our questionnaire and provided some very useful supplementary information. A meeting was arranged with several key staff members working in the areas of employment and health at the Refugee Council in Edinburgh and Glasgow, with the aim of clarifying the ways in which the deskilling problem should be conceptualised in relation to health. A number of important issues were discussed in considerable depth, resulting in new insights into the relationships between employment and health for refugees. Previously, most discussions on this topic revolved around the health *outcomes* of deskilling and unemployment. Discussions in Edinburgh revealed that ill-health, and particularly poor mental health, could also act as a significant *barrier* to retraining and unemployment. In

some cases, this process can operate both ways simultaneously and create a cycle of mutually reinforcing ill-health and unemployment, from which it is very difficult to escape. It was also raised that mental health should be conceptualised not only in terms of crude data such as records of hospital admission, or incidences of severe mental illness such as schizophrenia and psychosis (the types of variables which tend to be recorded in official data sources), but also in a more general sense. Mental health problems can occur at a variety of levels from stress, anxiety and depression to severe mental health problems such as schizophrenia. However, the Refugee Council reported that the majority of mental health problems experienced by their clients was related to less severe mental health problems such as stress, anxiety and depression (often not reported to doctors), but that these problems were often significant enough to act as barriers to retraining and employment.

Other issues highlighted:

- The skill profile of refugees in Scotland. A high proportion of the Refugee Council's clients are highly educated and skilled professionals. Over 50% of refugees in Glasgow are university graduates.
- Many refugees arrive as healthy young adults and their health worsens due to poverty and social exclusion.
- The importance of gaining employment to reduce social exclusion and building confidence.
- The importance of retraining and acquiring English language competence.
- The potential of approaching universities and training colleges and raising awareness of specific refugee retraining issues.
- Discrimination in job interviews.
- The stigma many refugees face when claiming social security benefits. Most come from countries where there is no social security system.
- The waste of skills through deskilling. The costs of training a British doctor far outweigh the costs of retraining a refugee doctor, and Britain is currently facing a severe shortage of doctors.
- The importance of voluntary work. This provides work experience as a step towards paid employment, it improves language ability and it helps to counteract social exclusion.
- The struggles faced by refugees who arrive individually. They were reported to have found resettlement much more difficult than refugees who arrived in groups.
- The absence of coherent cross-cultural mental health care, often resulting in the blanket prescription of anti-depressant medication instead of more targeted and appropriate care.

Although this meeting addressed issues specific to Scotland, many of the problems raised were of a more general nature and could easily be applied to refugees in other countries, a factor confirmed by the questionnaire responses, and by issues arising from the literature review. However, some key policy issues related to Britain were discussed in depth, with a view to preparing the groundwork for further research in Britain. A key event of importance for refugee resettlement in Scotland and the rest of Britain has been the Immigration and Asylum Act 1999. As a result of this act, new measures were introduced for resettlement of refugees and asylum seekers from April 2000:

1. A national dispersal policy to key 'cluster areas' with the stated goal of relieving pressure on London and the south-east of England
2. A voucher system to replace social security benefits. The value of the vouchers is set below the basic level of Income Support (deemed to be the minimum amount needed to cover very basic living requirements).

The following implications of this new policy were discussed:

- Clusters of refugees were already breaking down in the Glasgow area. Resettlement had been largely housing-led, and in socially deprived areas. Adequate refugee support services had not been provided, and the psychological, health and welfare needs of the refugees were not being met. Some of the refugees had been dispersed from the London area where they had formed good networks, which had been broken by dispersal. Policy implementation in Scotland makes no linkages with pre-existing refugee communities.
- A plan to create a cluster area in Edinburgh in October 2000 has created the opportunity to plan more thoroughly and establish proper support systems. In addition, an educational roadshow is planned to prepare the pre-existing residents for the arrival of the new refugees and to promote a positive view of the situation.
- The voucher system stigmatises refugees and causes severe financial hardship (recipients receive 10-15% less money than social security claimants). This hardship makes it difficult for refugees to afford bus fares to interviews, excludes them from social activities which entail travel, and is often compounded by pressure to send money to family members at home.

The Refugee Council also provided information about specific refugee support programmes under way in the region. Details of these can be found in the appendix.

The Refugee Council in London

Contact made with the Refugee Council In London confirmed that it is involved in a much wider range of activities (some of which are EU-wide, and some in partnership with other agencies), some of which are listed in the appendix. The city and its surrounding region has until recently been the focus of most refugee resettlement in Britain, and therefore has a much longer history of dealing with refugee resettlement. Mental health care provision for refugees is much more developed in London than in Scotland, and the General Medical Council there has become very experienced in dealing with refugee-specific health issues such as torture rehabilitation and support. Some of these are listed in the appendix. Most of the projects undertaken by the London Refugee Council deal with employment and health issues separately, and there is not really any integrated approach in any of the projects which overlaps specifically with the migration and employment related health combination to be explored in this project.

One notable project of particular interest is 'Breathing Space', an innovative initiative set up to address the mental well being needs of refugees and asylum seekers both in London and other regions of Britain. Started in April 2000, the project is run jointly between the Refugee Council and the Medical Foundation and is funded by Camelot. The focus of 'Breathing Space' is on 'mental well-being' rather than specific mental health disorders, and it uses a cross-cultural perspective on mental health. Its development approach is holistic, covering areas from advocacy, casework, policy,

research and training. Although employment is not specifically mentioned in the project, the stated aim to improve the situation of refugees in Britain and to help them to make a positive contribution to British society has implicit connections with employment and retraining issues.
The project has three main working areas:

- Advocacy and training – the delivery of training programmes to help organisations to provide high quality mental health services to refugees.
- A bicultural team which provides mental health care for individual refugees.
- Research investigating the impact of the resettlement experience on the mental well-being of refugees. This will focus on the impacts of the recently introduced dispersal policy.

The direction of this research programme is action-orientated, which means that findings will feed into the Refugee Council's policies on refugee care. Focus groups will be used as a medium to raise problematic issues, but also as a forum to explore solutions. The research aspect is being carried out by Dr Charles Watters at the Tizard Centre, University of Kent, who is also carrying out a Europe-wide survey of mental health services for minority groups and refugees. This may be complete when the migration and work-related health research programme is commenced, and could potentially be an extremely valuable resource, particularly as its focus is cross-national.

Refugee programmes in Europe

A wide range of other refugee programmes are currently under way in other European countries, many in partnership with other countries and organisations. The most significant project undertaken has been the *ECRE Task Force on Integration (TFI)*. The broad aims of this EU funded project, which started in 1997, have been to develop strategies to combat the social exclusion of refugees throughout Europe, and to improve their integration. The ECRE task force consists of six main agencies dealing with separate aspects of integration, and a secretariat, which carries overall responsibility for the project. An inventory of agencies and their areas of responsibility can be found in the appendix, along with the many other organisations involved http://www.refugee.net.org.

ECRE is attempting to build on pre-existing expertise in the area, and with the help of NGO's, to develop ways of tackling integration problems. The six key areas which have been the focus of the work carried out by ECRE have been: employment, education, vocational training, housing, health, community organisation and culture. The research, including in-depth interviews and expert meetings has led to the production of a 'good practice guide' for each of the six areas.

Literature review

The literature review identifies migration as a key issue for the 21st century, particularly during the coming decades, when skill shortages are expected in a number of countries. It also stressed the importance in this context, of the distinction between voluntary and forced migration, as voluntary migrants move primarily for economic reasons, and would therefore expect to see a general improvement in their living

standards after migration, and would therefore be less likely to suffer from health problems.

The changing nature of labour migration

Some basic migration trends relating to changes in global labour markets can be established from the literature, as there are clear phases in the history of migration to Western Europe. During the 1950s and 1960s, a new system of mass movements developed, where largely unskilled labour migrants moved to Europe's economic core from the less developed periphery. By the end of the 1970s, around 10 million migrant workers were living in Europe, primarily in the unskilled, low-pay sectors of the labour market, in the poorer housing areas of most cities, and often without any rights or trade union protection. It is perhaps this period which has shaped both the views of migrants in the minds of those resident in receiver countries, and the problematisation of the migrant presence in many countries. However, this period of mass migrations ended during the 1970s, though many labour migrants who remained brought in their family members after the labour migration halt of the early 1970s. The profile of international migrants to Europe has now changed considerably, and has become more polarised between highly skilled voluntary migrants, and refugees and illegal migrants, often responding to push factors. Since the end of mass labour migration during the 1970s, it has become extremely difficult for migrants from the developing world and Eastern Europe to enter the labour markets of western Europe, and most migrants from these regions have arrived as refugees or illegal migrants. Very recent trends have, however, witnessed relaxation of these restrictions in some countries such as the UK and Germany, where acute skills shortages in certain key sectors have resulted in controlled immigration through the issue of temporary work permits.

Intra-EU migrants

European integration has created a new and growing category of voluntary migrants, intra-EU migrants, now the most common type of labour migrants in Western Europe. Intra-EU migration occurs at a range of skills levels, form the highly skilled to the unskilled. Highly skilled migrants often move within the labour markets of multinational companies and tend to work on temporary contracts and return to their native countries at some stage. Often this type of migration is related to upward career mobility, where opportunities to enhance career prospects often involve moving in more internationalised labour markets. Some organisations have reported a significant problem of work-related stress among relocated workers and their families, though this is endemic to many professional occupations, not only among migrant workers. However, it is possible that the added burden of migration and adaptation to a new environment could increase levels of stress among some workers. Perhaps more importantly, company reports cite difficulties with family members as the major reason for failed international relocations. It would therefore be useful to examine the health impacts of migration on 'tied' migrants in this context. Emerging evidence also suggests that intra-EU migrants within lower skilled sectors are working abroad on a temporary, rather than a permanent basis, often responding to labour shortages in certain sectors. Clearly, work-related health problems are not as potentially serious for intra-EU labour migrants at all skills levels as they might have been for earlier post war labour migrants, or as they currently are for refugees.

‘Work tourism’

Since the removal of exit restrictions on citizens of Eastern European countries, another significant voluntary migrant group has emerged, which potentially faces work-related health problems. Increasingly, seasonal workers from Eastern Europe are being recruited by agencies to fill temporary labour shortages in some areas, working for limited periods of up to three months on work visas. This typically occurs in low paid sectors such as agriculture, where the migrants work long hours for very low rates of pay, and do not have trade union protection. There are issues relating to exploitation which need investigation, and there may also be specific health-related problems such as exposure to toxic agricultural chemicals and physical consequences of hard physical labour. This is a relatively new and as yet unresearched phenomenon, rendering this a potentially valuable research area. However, the short-term nature of this migration means that any research would have to be carried out within a very short period (normally during summer months), as 3 months is the maximum length of stay.

Refugees and asylum seekers

Of considerably greater concern is the situation forced migrants. Refugees potentially face serious work-related health problems after migration, particularly as many are highly skilled. Political migration is essentially a selective process, where those with financial means are in a much stronger position to flee to a developed country than poorer political migrants, who tend to be displaced to neighbouring countries. It is also the professional classes who are more likely to fall foul of repressive political regimes, particularly if they are intellectuals, writers, lawyers or doctors or in similar professions. The speed of flight and the fact that many asylum seekers need to travel with forged documents which they then destroy, means that they often arrive with no documentation of their professional qualifications. Even when these are available, they are unlikely to be recognised without some further study being undertaken. This results in unemployment and immediate downward social mobility for most refugees, which is an unexpected complication to deal with for many refugees, particularly when it is combined with trauma. This therefore represents an extremely important research area, and it is clear from the literature that to varying degrees, this is a problem across Europe. The importance of this research area is magnified by the fact that refugees, in numerical terms, constitute the largest category of migrants in most European countries. There is a real danger that they will become a permanently socially excluded group, and unnecessarily so considering the skills profile most refugees bring with them. Considering the emerging skilled labour shortages in Europe, it would seem imperative that this group of migrants is given the opportunity to achieve its potential through well-targeted and appropriate retraining and health-care provision. It is therefore proposed that deskilling and its associated health implications among refugees should form a major component of the research programme.

Illegal migrants

Although illegal migrants are generally portrayed as opportunistic economic migrants, many are de facto forced migrants, often responding to very strong push factors, but cannot enter Europe by legitimate means. Illegal migration is a particularly important issue for southern European countries such as Italy, where the numbers of illegal migrants are relatively high. Numbers are likely to be augmented due to the

development of new channels through the Former Yugoslavia, which is now described as the ‘back door’ into Europe. It is well documented that traffickers are using Sarajevo as a staging post in the transportation of illegal immigrants from all over the world to the EU. Although illegal migrants form an integral part of the economy of the low-wage sectors in some countries, their situation is very precarious, and the health implications of being an illegal migrant are potentially serious, as access to health care may be impossible. Further, illegal migrants have no legal protection in their workplaces, often experience abuse by their employers who understand their powerlessness, and often face serious health risks in their work, particularly in occupations such as the sex industry. Indeed there is growing concern over the numbers of illegal bonded migrants held in virtual slavery in Europe. Clearly, this is a very difficult and dangerous area in which to undertake research, and data sources would be very limited, but the issue is nevertheless of great importance.

Table 1 Foreign nationals in selected European countries.

	Belgium 1996	Denmark 1996	France 1990	Germany 1996	Italy 1994	NL 1996	Norway 1996	Sweden 1996	UK 1996
Total	909,769	222,753	3,596,602	7,173,866	624,108	725,421	396,644	531,797	1,991,835
Europe	661,757	137,500	1,661,486	5,950,652	236,568	397,553	227,645	370,062	971,238
EU&EFTA	557,937	63,529	1,345,778	1,857,193	132,438	194,885	177,230	218,465	835,053
EU	554,517	46,531	1,321,529	1,811,748	120,132	191,074	170,185	178,960	817,918
EFTA	3,420	16,998	24,249	45,445	12,306	3,811	7,045	39,505	17,135
Central Europe	14,795	7,495	63,039	540,716	28,980	9,614	14,795	26,542	38,744
Other Europe*	94,249	66,476	252,669	3,552,743	75,150	193,054	35,620	125,055	97,441
Africa	179,498	15,727	1,633,142	291,169	208,377	196,840	25,465	28,729	235,163
Americas	20,882	9,081	72,758	183,019	68,827	40,062	49,299	33,776	231,899
Asia	25,368	48,900	226,956	672,595	105,763	71,429	92,109	83,105	436,995
Oceania	644	1,026	2,260	9,186	3,087	2,512	2,126	1,865	88,576

Table 2 EU foreign nationals as a percentage of all foreign nationals.

Belgium 1996	Denmark 1996	France 1990	Germany 1996	Italy 1994	NL 1996	Norway 1996	Sweden 1996	UK 1996
61.0	20.9	36.7	25.3	19.2	26.3	42.9	33.7	41.1

*Includes Former USSR and Former Yugoslavia

Source of data: Eurostat (1998)

Summary migration data

In order to quantify the trends discussed above, some numerical background data have been tabulated and presented below. The category 'foreign national' is somewhat inadequate as it does not include naturalised migrants, but the data do give some indications of the overall trends.

Tables 1 and 2 demonstrate that source regions vary considerably by country. The numbers of EU foreign nationals are very high in Belgium, but much less significant in countries such as Denmark and Italy. Migration from Eastern Europe is not clearly defined by the categories used by Eurostat, as they would appear in both 'Central Europe' and 'Other Europe'. However, as Turkish nationals are also included in 'Other Europe' (as demonstrated by the high figures in Germany), it would seem that the numbers of Eastern European nationals in most of the countries is relatively small. It is also difficult to distinguish the numbers of refugees, as they could potentially appear in several of the categories used.

Research questions

The potential research questions have evolved from a combination of the contexts discussed above, and from the findings of the literature review. Clearly, deskilling has been identified as a major problem among migrants, but particularly among refugees, and is universal to all western European countries. This is therefore proposed as a major focus of the research programme. There are serious health implications which result from deskilling, but it has been argued by the participants that research should also focus on mental and other health problems as a *barrier* to successful retraining and labour market participation. This can be viewed in a variety of ways, but it is important that any research should be action-oriented, and that the research outcomes should feed into potential solutions. Initially, although deskilling has been clearly established as a major problem in the literature, it requires more clarification in terms of the extent of the problem and its place-specific manifestations.

It is therefore proposed that this topic should be approached with the following aims:

- To establish the extent of refugee deskilling in selected countries.
- To identify both place-specific and universal issues which contribute to the deskilling problem.
- To clarify the relationship between deskilling and mental health (well-being). This will include the interaction of factors such as racial discrimination, trauma, depression and non-recognition of qualifications.
- To compare the impacts of different types of integration policies and their outcomes for refugees.
- To use the knowledge gained to inform public policy on refugee integration.

The causal mechanisms of deskilling are complex, but there is a strong body of thought supporting the claim that *the* major causal factor is racism and discrimination. Previous research in this area in some countries such as Denmark, has demonstrated that second generation migrants with high levels of education and training are failing to compete with Danish school leavers in the labour market, despite the fact that language

skills or other cultural factors, cannot be considered a barrier to employment (one of the major reasons cited by employers for not employing migrants). As a result, there is a growing feeling among the ethnic minorities that discrimination is the key to this problem. If this is the case, measures to facilitate retraining and access to employment will be of limited value. If it could be demonstrated within the study that second generation migrants also face significant discrimination, then successful policy measures to tackle the problem would necessarily include measures to combat labour market discrimination, a conclusion which could be integral to the successful integration of refugees. It is therefore proposed that the following aim should also form part of the project:

- To assess the situation of second generation migrants in the labour market. Does their career achievement match their potential, and are their differences in the achievements of second generation migrants and non-migrants with the same qualifications?

It has also been clearly established that migrants in general are more prone to work-related accidents and health disorders. Due to their disadvantaged position in the labour market, they are more likely to be employed in dangerous occupations, or in occupations which are physically demanding. This should therefore also be included as a major research focus.

- An examination of the extent of occupational accidents and health disorders among migrants employed in dangerous and physically demanding occupations.

The literature also discusses the problems experienced by skilled migrants, who are increasingly operating within international labour markets. The effects of relocation abroad can be variable, as it may be seen as a means to experience other places and travel, while obtaining promotion at the same time. However, relocation can also be associated with new stresses in adapting to a different way of living. The most significant factor in the failure of international relocations is reported by companies to be related to family issues. The experiences of 'tied' migrant is therefore very important among this group, as it is often these migrants who experience the problems rather than the relocated workers. It is therefore proposed that this subject be approached by the inclusion of partners the interview process.

- An examination of work-related stress among skilled migrants, and the experiences of 'tied' migrants.

Illegal migrants, particularly those working as sex workers, potentially face severe work-related health problems, particularly as their labour-market participation is not monitored or regulated by legal mechanisms, or by trade unions. This is therefore an important, and as yet, largely unexplored research gap, though there would potentially be methodological problems involved in approaching this topic.

- Work-related health problems among illegal migrants.

Eastern Europeans on temporary work visas were identified as a group potentially facing relatively short-term health problems related to working in poorly regulated sectors where there may be exposure to contaminants. The potential for conducting meaningful research among this group would largely be limited to the summer months, and potential problems of access could be a problems, as such employers have much control over the

activities of their workers and are likely to be reluctant to their workers to participate in the research process. However, work tourism is a growing phenomenon, and, as yet, has received minimal attention from researchers.

- Work tourism from Eastern Europe and associated health problems.

Data sources

During the feasibility study, major statistical data sources which incorporate aspects of migration, employment and /or health were identified and evaluated to assess the degree to which the three areas can be linked. By then creating a meta-database using these data sources, it has been possible to evaluate the comparability potential for cross-national statistical research.. After evaluating the most commonly used variables, the meta-database was condensed to form a series of tables which have been incorporated into the report.

The experience of accessing these data sources should be considered as a useful indicator of the feasibility of conducting research in the specified countries at a future time. There was a surprising degree of variability, both in the quality of the data available in different countries and in its accessibility. Constructing the database was by far the most difficult, time-consuming and frustrating part of the feasibility study, and any researcher considering conducting research using these data sources should be fully aware of the potential barriers and language problems.

Denmark, Sweden, Norway and Britain have good on-line access to information and data sources, and communication poses little problem for English-speaking researchers. However, the other countries in the study were much more problematic, and perhaps the outcome would have been better if native speakers had been used to collect information, as communication problems represented a serious barrier to effective completion of the task. This extends beyond the scope of language issues alone, but also to the nature of the organisations contacted. Non-response to email, written, telephone and faxed requests was endemic, and it was very difficult to obtain a satisfactory overview of the ways in which the various data sources were linked within the given time frame. For these reasons, the database can be considered a partial coverage only for the countries concerned.

Details of data sources are shown in tables 4 to 8, and fairly detailed information is given about some of these. However, at this stage, a general comparative overview of the different sources will be provided to help elucidate the major findings.

Register data

Clearly, there are major differences in the ways in which data are recorded in the different countries. Sweden, Norway and Denmark record their data in statistical registers, which contain many variables about individuals, all of which are linked by a key (personal identification number). Each country has many different registers which record different kinds of data, and these registers are constantly upgraded. The registers provide an extremely valuable data source for researchers due to the detail they contain, and the accuracy and up-to-date nature of the data. They also provide considerable scope for longitudinal research. The registers are kept separately, but when certain details are

requested by researchers or government agencies, they can be combined using the key, which is then discarded.

The Scandinavian population registers are very versatile in terms of the combinations of data which can be produced for individuals, however, it must be noted that combining health data with other register data is somewhat problematic. Health data is not kept by the central statistical offices, but by the health authorities. In Sweden, health data is held by Socialstyrelsen, and stored in a range of individual registers, numbering 44 in 1999. There are registers for different types of cancers, mental illness, circulatory diseases, respiratory diseases, musculoskeletal diseases and many others. A similar situation exists in Denmark, and with special permission, these registers can be linked with other register data, though this is extremely costly. It has not been possible to outline the variables contained in the numerous health registers within the scope of this study, and it is unlikely that their quality could be replicated in the other countries in the study. Further, in Norway, health data is not registered using the personal identification number, so it is not possible or legally permissible to make these linkages.

The Swedish population registers do, however, provide some basic health data (from 1996), as do the Danish registers, though the variables are not the same and therefore cannot be used for comparability purposes. However, the countries, and could be used to make specific linkages between migration status and unemployment.

The statistical offices which hold the data are private institutions and therefore require to charge fees for the use of their data. The prices for data can vary enormously, but in general, the more registers which have to be combined, the greater the cost. This is a particularly important issue to consider where variables incorporating information about migration, employment and health are to be combined, as this is likely to be an extremely costly combination. Costs for specified data can run into thousands of British pounds for relatively small data sets, but a cheaper option exists for researchers who are prepared to work on databases within the statistics offices. However, charges are still significantly high for this service, and the potential project would have to be fairly large to justify the financial outlay required. It is therefore extremely important to establish data costs fairly accurately before embarking on any research projects. The statistical offices provide a useful consultancy service which can cost any potential research project at the planning stage (there is a charge for this service).

A special longitudinal database LOUISE has been set up by Statistics Sweden, partially to offset these costs to researchers. A number of variables in the areas of education, training, occupation and income, from different registers have been combined over time to provide a more coherent and cheaper dataset for researchers. LOUISE does not provide any health data. More details about LOUISE are provided in the following section.

Any potential users should be aware of the rules governing access to register data. The cost issue has already been discussed, but rules regarding access are also fairly stringent. Any data users must be working within the country where the data is recorded, so national representatives will be required in any country where statistical research is to be carried out. The statistical offices may not deliver any data where its use could lead to the identification of individuals, so the personal identification numbers are removed and replaced with neutral numbers (the legislation in Sweden is about to change to allow more

flexibility). Data must be aggregated before it can be passed on to a third party, and cannot be taken out of the country. Norway in particular, has very stringent rules for researchers, and access to register data is granted more readily to researchers affiliated with large, reputable research institutes. In addition, any publications resulting from the use of register data must be scrutinised by the statistical offices to ensure confidentiality has not been breached in any way.

Census and survey data

The quality of data in the remaining countries is much poorer and considerably less flexible. Most countries rely on 10 yearly censuses for their population data, while the Netherlands relies on sample surveys. The censuses are of variable quality, though health indicators tend to be fairly limited. The German census provides the most detail about health and makes reasonably good linkages with employment variables, but the data on ethnic/national origin are very limited. The British census offers the possibility of conducting longitudinal work using the Longitudinal Study (1971, 1981, 1991), which is supplemented by health records, but the health variables in the census are fairly limited (to long term limiting illness and cancer classification). The censuses in France and Italy are of much poorer quality and provide no health data at all. Clearly the indicators used in most of the national censuses are very basic and would not provide a basis for cross-national comparison, however, most of the census data could potentially provide some useful background information about individual countries.

Germany and the Netherlands have good quality survey data sources, but unfortunately, these are rarely linked together. Germany conducts a ten yearly census, along with an annual integrated microcensus and Labour Force Survey (sample survey only). Both are good sources of data, but are not linked. The Netherlands conducts a comprehensive Health Interview Survey (HIS) which has recently been integrated with other more general surveys, but this is a sample survey only, and cannot be linked with the Labour Force Survey. While good data sources exist in these countries, it is not possible to make the linkages between surveys which the register-based data in Scandinavia allows, so there are some very real differences in the quality of data between countries which use register-based data and others which rely on censuses and surveys.

The Labour Force Survey

Other sources of data have been examined, and it appears that the Labour Force Survey is the only survey incorporating aspects of migration, employment and health, which could realistically be used for cross-national comparison. All EU countries are obliged to undertake a Labour Force Survey annually, and data are transferred to Eurostat for processing. For this reason, there is a relative degree of uniformity among the Labour Force Surveys in EU countries, although there are some very clear differences in both the extent and the quantity of variables included, as can be seen in table 3. In addition, Norway's Labour Force Survey appears to be significantly different from the others, a factor which may be related to the fact that Norway is not an EU member. However, the commonality between the national Labour Force Surveys, could potentially allow some international comparisons to be made using some very basic indictors. The major variables which appear consistently are as follows:

Table 3 The Labour Force Survey: Major indicators incorporating migration, employment or health.

	Sweden	Denmark	Norway	UK	Germany	NL	France
Date of birth	✓	✓	✓	✓	✓	✓	✓
Gender	✓	✓	✓	✓	✓	✓	✓
Marital status	✓	✓	✓	✓	✓	✓	-
Household composition	✓	✓	✓	✓	✓	✓	-
Nationality	✓	✓	✓	✓	✓	✓	✓
Country of birth	-	-	✓	-	-	✓	-
Ethnicity	-	-	-	✓	-	-	-
Immigration date	-	-	-	-	✓	✓	-
Educational qualifications*	-	✓	✓	✓	✓	✓	✓
Occupation	✓	✓	✓	✓	✓	✓	✓
Unemployed	✓	✓	✓	✓	✓	✓	✓
Full time /part time empl.	✓	✓	✓	✓	✓	-	-
Permanent /temporary emp.	✓	✓	✓	✓	✓	✓	✓
Trade Union Member	✓	-	-	✓	-	✓	-
Working hours	✓	✓	✓	✓	✓	✓	✓
Income	-	-	✓	✓	✓	-	✓
Accident	-	-	-	✓	✓	✓	-
Long term limiting illness	✓	-	-	✓	✓	✓	-

*NB The UK is the only country where qualifications from abroad are included.

The above information has been extracted from Labour Force Survey questionnaires, but it should be noted that in Denmark and Sweden, data sources are used interchangeably, and LFS information is supplemented with register data after the questionnaires are completed. Some blank spaces therefore represent variables which could be incorporated from the population registers (for details of possible combinations, refer to the meta-database). In addition, Sweden has two surveys which act as trailers to the LFS, the *Survey on the Working Environment* and the *Survey on Work-related Problems*. Both of these surveys provide very detailed information about work-related health problems, but

unfortunately, cannot be replicated elsewhere. It should also be noted that the German LFS has been combined with the microcensus to facilitate data collection and reduce costs.

The LFS has potential as a data source at a very general level, but it would not provide any detailed research into linkages between migration, employment and health. However, LFS data could potentially be useful for background research into the extent of particular labour market trends among specific groups of migrants. One of the major potential research agendas to arise from the feasibility study, refugee deskilling, could not be analysed using the LFS, as the UK is the only country which includes a variable about qualifications from abroad in its LFS. Further, the health variables included in most LFS questionnaires would not be suitable for research in this area. It should also be noted that the LFS only provides estimates based on small areas sampled, and in some cases, ethnic clusters may therefore be missed, providing an unrepresentative overview.

Use of LFS data would require national collaborators in any country where data is to be used. Survey data is transferred to Eurostat, and theoretically, this would provide a good basis for cross-national research, however, Eurostat databanks are not in SPSS format and the variables are aggregated by subject area, which means that the linkages between migration, employment and health are lost. Most of the countries in the study maintain their own databases for research purposes, usually in SPSS format. It would therefore be necessary to approach the data holders in each individual country to conduct cross-national research, and in most countries this would require to be an individual working within an institution in that country. In Britain, this service is provided free of charge to academic researchers working in Britain, but in the Scandinavian countries, the statistical offices hold the data, and the same rules and costs for access outlined above would apply. In the Netherlands, since 1994, depersonalised survey data are available to universities and recognised research institutes via the *Scientific Statistical Agency* (WSA). Data can be transferred to research institutes and universities abroad, but costs are considerable, running into thousands of British pounds.

The quality of LFS data varies by country, and factors such as the manner in which it is conducted have a significant impact on quality. In Scandinavia the LFS is not considered to be a good source of data, as register data are of much better quality. In Sweden, the LFS is conducted by telephone which raises issues such as low response rates and communication problems, particularly among minority ethnic groups. In other countries such as Britain, the LFS is conducted face to face and is actually considered to provide the most reliable data on ethnic minorities (more reliable than the census), as the presence of an interviewer increases the likely response rate on the ethnicity question.

Other useful comparative Surveys

Other surveys in Europe also make linkages between migration, employment and health. The most useful of those examined was a set of surveys of Immigrants' Living Conditions conducted in 1996 in Sweden, Denmark and Norway. Although the surveys are not identical, they are very similar and were designed for cross-national comparison. There are some very specific linkages made between migrant health and employment issues, and the results of these surveys would provide some very useful cross-national comparisons of these three countries. There is reason to believe that this work is already being carried out by the Rockwool foundation in Denmark, so their results may be useful, if made available.

This survey provides a very clear example of the type of data source which would be very useful to this research programme. One option for future research would be to create a similar survey incorporating questions which address the specific issues which would be of relevance to a future research programme. This option would permit the questions to be tailored specifically to the requirements of the research project, and address research questions directly. This approach could circumvent the problems of inadequate and incompatible data sources, and could also avoid the very high costs of purchasing register data in Scandinavia. This strategy would enable both quantitative and qualitative data analysis to be carried out using the same data source, and the interviewing procedure could be used as a forum for recruiting interviewees for more in-depth qualitative research.

The meta-database

The construction of the meta-database has been the central element of the feasibility study, as the findings drawn from it will determine the possibilities for future research. All register data sources, censuses and relevant surveys have been examined to assess the degree to which variables relating to migration, employment and health can be linked. With most data sources it is difficult to establish these linkages, and often, only two aspects are linked. The commonly occurring variables contained in the data sources have been outlined in tabular form below. Where a variable is recorded, a tick appears in the box. If a variable has been added to the data source after the register / survey was first implemented, the relevant year will also be indicated, as there may be implications for longitudinal research. In some cases, where there are issues relating to the variables which should be noted, a number is recorded in superscript, and the notes below the tables explain the issue in more depth. An outline of the characteristics of the main data sources in each country is also provided, with details such as frequency and sample size.

Table 4 Meta-database, Sweden.

SWEDEN					
	REGISTER DATA	LFS	SWE	LOUISE	IMMIGRANT SURVEY
Gender	✓	✓	-	✓	✓
Date of birth	✓	✓	-	✓	✓
Address	✓	-	-	✓	-
Marital status	✓	✓	-	✓	-
Household composition	✓[1]	✓	-	✓ 1995-[4]	-
Housing tenure	✓	-	-	-	-
Country of birth	✓	-	-	✓	✓
Nationality	✓	-	-	✓	-
Ethnicity	-	-	-	-	✓[6]
Religion	-	-	-	-	-
Last country of residence	-	-	-	-	✓
Father's country of birth	✓ 1995-	-	-	✓ 1995-	-
Mother's country of birth	✓ 1995-	-	-	✓ 1995-	-
Father's nationality	-	-	-	-	-
Mother's nationality	-	-	-	-	-
Immigration date	✓	-	-	✓	-
Cause of immigration*	✓ 1991-	-	-	-	-
Migrant status**	-	-	-	-	-
Mother tongue	✓ 1993-	-	-	-	-
Mobility dates***	✓	-	-	-	-
Educational qualifications	✓[2]	-	-	✓	-
Occupation	✓ 1990-	✓	-	✓	-
Employment status	✓ 1990-	-	-	✓	-
Unemployed	✓ 1990-	✓	-	✓	✓
Reason unemployed	-	-	-	-	-
Employment commenced****	-	-	-	-	-
Location of employment	✓ 1990-	✓	-	✓	-
No. of employees at workplace	✓ 1990-	✓	-	✓	-
Full/part time employment	-	✓	-	-	✓
Working hours	-	✓	-	✓	✓
Permanent/temp. employment	-	✓	-	-	✓
TU member	-	✓	-	-	-
Occupation before migration	-	-	-		✓
Heavy or strenuous work	-	-	✓	-	✓
Noise/vibrations in workplace	-	-	✓	-	✓
Chemical/ biological hazards	-	-	✓	-	-
Socio-economic group	-	-	-	-	-
Earned income	✓ 1990-	-	-	✓	-
Other income	✓ 1990-	-	-	✓[5]	-
Unemployment benefit	✓ 1990-	-	-	✓	✓
Retirement pension	✓ 1990-	✓	-	✓	✓
Early retirement pension	✓ 1990-	✓	-	✓	✓
Illness before migration	-	-	-	-	✓
Cancer classification	✓ 1976-	-	-	-	-
Hospital admission	✓ 1996-	-	-	-	✓[7]
Use of doctor	-	-	-	-	✓[7]
Casualty patients	-	-	-	-	✓[7]
Long term illness	-	✓[3]	-	-	✓
Handicap or disability	-	-	-	-	✓
Psychiatric treatment	-	-	-	-	✓[7]
Work-related accident	-	-	-	-	✓[8]
Experience of torture	-	-	-	-	-

Table 5 Meta-database, Denmark and Norway

	DENMARK		NORWAY			
	REGISTER DATA	LFS	REGISTER DATA	LFS	IMMIGRANT SURVEY	OSLO HEALTH SURVEY
Gender	✓	-	✓	✓	✓	-
Date of birth	✓	-	✓	✓	-	-
Address	✓	-	✓	✓	-	-
Marital status	✓	-	✓	✓	✓	✓
Household composition	✓[4]	-	✓	✓	✓	-
Housing tenure	✓	-	✓	-	✓	-
Country of birth	✓	-	✓	✓	✓	-
Nationality	✓1975-	-	✓	✓	-	-
Ethnicity	-	-	-	-	-	-
Religion	-	-	-	-	-	✓
Last country of residence	-	-	✓	✓[12]	-	-
Father's country of birth	✓1980-	-	✓	-	-	✓
Mother's country of birth	✓1980-	-	✓	-	-	✓
Father's nationality	✓1980-	-	✓	-	-	-
Mother's nationality	✓1980-	-	✓	-	-	-
Immigration date	✓	-	✓	✓	✓	✓
Cause of immigration*	-	-	✓	-	✓	-
Migrant status**	✓1980-	-	✓	-	✓	✓
Mother tongue	-	-	-	-	✓	-
Mobility dates***	✓	-	✓	-	✓	-
Educational qualifications	✓1980-[9]	✓	✓1986-[11]	✓[13]	✓[14]	✓[13]
Occupation	✓	✓	✓1986-	✓	✓	✓
Employment status	✓	✓	✓1986-	✓	✓	✓
Unemployed	✓	✓[10]	✓1986-	✓	✓	-
Reason unemployed	✓1979-	✓	-	✓	✓	-
Employment commenced****	-	-	✓1986-	✓	-	-
Location of employment	✓1980-	✓	✓1986-	✓	✓	-
No. of employees at workplace	✓	✓	✓1986-	✓	-	✓
Full/part time employment	✓	✓	-	✓	-	✓
Working hours	-	✓	-	✓	✓	-
Permanent/temp. employment	-	✓	-	✓	✓	-
TU member	-	-	-	-	✓	-
Occupation before migration	-	-	-	-	✓	-
Heavy or strenuous work	-	-	-	-	✓	-
Noise/vibrations in workplace	-	-	-	-	✓	-
Chemical/ biological hazards	-	-	-	-	✓	-
Socio-economic group	✓	✓	-	-	-	-
Earned income	✓	-	-	✓	-	✓
Other income	✓	-	-	✓	-	-
Unemployment benefit	✓1984-	✓	-	✓	✓	✓
Retirement pension	✓	✓	-	✓	✓	✓
Early retirement pension	✓1984-	✓	-	✓	-	✓
Illness before migration	-	-	-	-	✓	-
Cancer classification	-	-	-	-	-	-
Hospital admission	✓1977-	-	-	-	-	✓[8]
Use of doctor	✓1987-	-	-	-	-	✓[8]
Casualty patients	✓1995-	-	-	-	-	-
Long term illness	-	-	-	-	✓	✓
Handicap or disability	-	-	-	-	✓	-
Psychiatric treatment	-	-	-	-	-	✓[8]
Work-related accident	-	-	-	-	-	-
Experience of torture	-	-	-	-	-	✓[15]

Table 6 Meta-database United Kingdom

UNITED KINGDOM									
	CENSUS 1971	CENSUS 1981	CENSUS 1991	LS	LFS	BHPS	EHPS	GHS	IPS
Gender	✓	✓	✓	✓	✓	✓	✓	✓	✓
Date of birth	✓	✓	✓	✓	✓	✓	✓	✓	✓
Address	✓	✓	✓	✓	-	✓	-	✓	-
Marital status	✓	✓	✓	✓	✓	✓	✓	✓	✓
Household composition	✓	✓	✓	✓	✓	✓	✓	✓	-
Housing tenure	✓	✓	✓	✓	✓	✓	✓	✓	-
Country of birth	✓	✓	✓	-	-	✓	✓	✓	✓
Nationality	-	-	-	✓	✓	-	-	-	✓
Ethnicity	-	-	✓	-	✓[20]	✓[20]	✓[20]	✓[20]	-
Religion	-	-	-	-	✓	-	✓	-	-
Last country of residence	-	-	-	-	-	-	-	-	✓
Father's country of birth	✓[16]	✓[16]	-	-	-	-	-	✓	-
Mother's country of birth	✓[16]	✓[16]	-	-	-	-	-	✓	-
Father's nationality	-	-	-	-	-	-	-	-	-
Mother's nationality	-	-	-	-	-	-	-	-	-
Immigration date	✓	-	-	✓[19]	-	✓	-	✓	-
Cause of immigration*	-	-	-	-	-	-	-	-	-
Migrant status**	-	-	-	-	-	-	-	-	-
Mother tongue	-	-	-	-	-	-	✓	-	-
Mobility dates***	✓[17]	✓[17]	✓[17]	✓	✓[21]	✓	✓[22]	-	-
Educational qualifications	✓[18]	✓[18]	✓[18]	✓	✓[22]	✓[18]	-	✓[18]	-
Occupation	✓	✓	✓	✓	✓	✓	✓	✓	✓
Employment status	✓	✓	✓	✓	-	✓	✓	✓	-
Unemployed	✓	✓	✓	✓	✓	✓	✓	✓	-
Reason unemployed	-	-	-	-	-	-	-	-	-
Employment commenced****	-	-	-	-	✓	-	-	✓	-
Location of employment	✓	✓	✓	✓	-	-	-	-	-
No. of employees at workplace	-	-	-	-	✓	✓	✓	✓	-
Full/part time employment	-	✓	✓	-	✓	-	-	-	-
Working hours	✓	✓	✓	✓	✓	✓	✓	✓	-
Permanent/temp. employment	-	-	-	-	✓	✓	✓	-	-
TU member	-	-	-	-	✓	✓	✓	-	-
Occupation before migration	-	-	-	-	-	-	-	-	-
Heavy or strenuous work	-	-	-	-	-	-	-	-	-
Noise/vibrations in workplace	-	-	-	-	-	-	-	-	-
Chemical/ biological hazards	-	-	-	-	-	-	-	-	-
Socio-economic group	✓	✓	✓	✓	-	-	-	✓	-
Earned income	-	-	-	-	✓	✓	✓	✓	-
Other income	-	-	-	-	-	✓	✓	✓	-
Unemployment benefit	-	-	-	-	✓	✓	✓	✓	-
Retirement pension	-	-	-	-	✓	✓	✓	✓	-
Early retirement pension	-	-	-	-	-	-	-	-	-
Illness before migration	-	-	-	-	-	-	-	-	-
Cancer classification	-	-	-	✓	-	-	-	-	-
Hospital admission	-	-	-	-	-	✓	✓	-	-
Use of doctor	-	-	-	-	-	✓	✓	✓	-
Casualty patients	-	-	-	-	-	-	-	✓	-
Long term illness	-	-	✓	✓	✓	✓	✓	✓	-
Handicap or disability	-	-	-	-	✓	✓	✓	-	-
Psychiatric treatment	-	-	✓[23]	-	-	✓	-	-	-
Work-related accident	-	-	-	-	✓	✓	-	-	-
Experience of torture	-	-	-	-	-	-	-	-	-

Table 7 Meta-database, Germany and The Netherlands

	GERMANY				NETHERLANDS	
	CENSUS 1987	MICRO CENSUS	CRF	MS	LFS	HIS
Gender	✓	✓	✓	✓	✓	✓
Date of birth	✓	✓	✓	✓	✓	✓
Address	✓	-	-	-	-	-
Marital status	✓	✓	✓	✓	✓	✓
Household composition	✓	✓	-	-	✓	✓
Housing tenure	✓	-	-	-	-	✓1997-
Country of birth	-	-	-	-	✓	✓1997-
Nationality	✓[24]	✓	✓	✓	✓	✓
Ethnicity	-	-	-	-	-	-
Religion	✓	-	-	-	-	✓1997-
Last country of residence	-	✓	-	✓	-	-
Father's country of birth	-	-	-	-	✓	✓1997-
Mother's country of birth	-	-	-	-	✓	✓1997-
Father's nationality	-	-	-	-	-	-
Mother's nationality	-	-	-	-	-	-
Immigration date	-	✓	✓	-	✓	✓1997-
Cause of immigration*	-	-	-	-	-	-
Migrant status**	-	-	-	-	-	-
Mother tongue	-	-	-	-	-	-
Mobility dates***	-	-	-	-	✓[27]	-
Educational qualifications	✓	✓[26]	-	-	✓[28]	✓[30]
Occupation	✓	✓	-	-	✓	✓
Employment status	✓	✓	-	-	✓	✓
Unemployed	✓	✓	-	✓	✓	✓
Reason unemployed	-	-	-	-	✓	✓
Employment commenced****	-	-	-	-	✓	-
Location of employment	✓	-	-	-	✓	-
No. of employees at workplace	-	✓	-	-	-	-
Full/part time employment	-	✓	-	-	-	✓
Working hours	✓	✓	-	-	✓	✓1997-
Permanent/temp. employment	-	✓	-	-	✓	-
TU member	-	-	-	-	✓	-
Occupation before migration	-	-	-	-	-	-
Heavy or strenuous work	-	-	-	-	✓	-
Noise/vibrations in workplace	-	-	-	-	✓	-
Chemical/ biological hazards	-	-	-	-	✓	-
Socio-economic group	✓	-	-	-	-	✓
Earned income	✓	✓	-	-	-	✓
Other income	✓	-	-	-	-	✓
Unemployment benefit	✓	✓	-	-	-	-
Retirement pension	✓	✓	-	-	✓	-
Early retirement pension	-	-	-	-	✓	-
Illness before migration	-	-	-	-	-	-
Cancer classification	-	-	-	-	-	-
Hospital admission	✓[25]	✓[25]	-	-	-	✓
Use of doctor	✓[25]	✓[25]	-	-	-	✓
Casualty patients	✓[25]	✓[25]	-	-	-	✓
Long term illness	✓	✓	-	-	✓[29]	✓
Handicap or disability	✓	✓	-	-	✓	-
Psychiatric treatment	-	-	-	-	✓	✓[31]
Work-related accident	✓	✓	-	-	✓	✓1997-
Experience of torture	-	-	-	-	-	-

Table 8 Meta-database, France and Italy

	france		**ITALY**
	CENSUS 1999	LFS	CENSUS 1991
Gender	✓	✓	✓
Date of birth	✓	✓	✓
Address	✓	✓	✓
Marital status	✓	-	✓
Household composition	✓	-	✓
Housing tenure	✓	-	✓
Country of birth	-	-	-
Nationality	✓[32]	✓	✓
Ethnicity	-	-	-
Religion	-	-	-
Last country of residence	-	-	-
Father's country of birth	-	-	-
Mother's country of birth	-	-	-
Father's nationality	-	-	-
Mother's nationality	-	-	-
Immigration date	-	-	-
Cause of immigration*	-	-	-
Migrant status**	-	-	-
Mother tongue	-	-	-
Mobility dates***	✓[33]	✓[35]	-
Educational qualifications	✓[34]	✓[34]	✓
Occupation	✓	✓	✓
Employment status	✓	✓	✓
Unemployed	✓	✓	✓
Reason unemployed	-	-	-
Employment commenced****	-	✓	-
Location of employment	✓	✓	-
No. of employees at workplace	-	-	-
Full/part time employment	✓	✓	-
Working hours	-	✓	-
Permanent/temp. employment	✓	✓	-
TU member	-	-	-
Occupation before migration	-	-	-
Heavy or strenuous work	-	-	-
Noise/vibrations in workplace	-	-	-
Chemical/ biological hazards	-	-	-
Socio-economic group	-	-	-
Earned income	-	✓	-
Other income	-	-	-
Unemployment benefit	-	-	-
Retirement pension	-	-	-
Early retirement pension	-	-	-
Illness before migration	-	-	-
Cancer classification	-	-	-
Hospital admission	-	-	-
Use of doctor	-	-	-
Casualty patients	-	-	-
Long term illness	-	-	-
Handicap or disability	-	-	-
Psychiatric treatment	-	-	-
Work-related accident	-	-	-
Experience of torture	-	-	-

* This allows refugees to be identified
** Enables first and second generation migrants to be distinguished.
*** Details of internal migration within receiver country
****Year current employment commenced

Notes

1. Contains information about composition of household and relationships between family members.
2. Only qualifications obtained in Sweden. The register has been partially supplemented with results from surveys in 1992 and 1997 when migrants were asked about qualifications from abroad. The response rate to these surveys was generally poor.
3. Duration of more than one year.
4. The inclusion of parents' personal identity numbers allows different generations to be linked.
5. Details of sources provided in considerable detail.
6. Member of any ethnic or religious minority.
7. During last three months.
8. During last year.
9. Only records qualifications obtained in Denmark, and from 1970. Start and finish dates are also included. The register will be partly supplemented by a survey of immigrants' education, where a sample of 160,000 migrants will be investigated. Results will be available during the latter part of 2000.
10. Includes length of time unemployed.
11. Complete coverage of qualifications gained in Norway, but includes a partial survey in 1990 of qualifications gained abroad.
12. Country of residence one year ago.
13. Norwegian qualifications only.
14. Both from Norway and from abroad.
15. Also includes details on degree of suffering, nightmares or lasting physical damage caused by torture.
16. Only if living with parents at time of census.
17. Address one year ago.
18. Qualifications gained in the UK only.
19. Gives details which enable immigration history to be constructed.
20. Uses the same categories as the census.
21. Includes: length of time at current address; address one year before; address 3 months before census.
22. Includes qualifications gained abroad.
23. Long stay in psychiatric hospital (2 years or more).
24. Only includes the following categories: German, Greek, Italian, other EU, Yugoslav, Turkish, other.
25. During last four weeks.
26. Qualifications gained in Germany only.
27. Number of years at current address, and details of previous address.
28. Qualifications gained in the Netherlands only.
29. Any incapacity for work through invalidity since 15th birthday. Also includes duration of incapacity.
30. Includes qualifications both from the Netherlands and from abroad.
31. Hospitalisation only.
32. Distinguishes between French citizenship at birth, and acquired French citizenship.

33. Where resident on 1st January 1990.
34. Educational qualifications from France only.
35. Where resident in March 1998.

Sweden

Register data
Various registers have been used since 1970 to collect data about individuals in an integrated manner. The various registers are linked by a key (the personal identification number), and using this key, different registers can be combined to provide more complete information. New variables are continually being added to registers, and the dates of these additions are recorded above, where applicable. Otherwise variables recorded have been available since 1970.

Register data forms the main source of data for researchers in Sweden, and the additional data sources detailed above are all used in conjunction with register data, often to supplement basic information. Many of the basic details such as gender, address and date of birth are not included in the surveys, as they are derived from register data. All surveys are therefore linked to register data using the personal identity number as a key. The table representing Swedish data sources can therefore be effectively be considered as one integrated data source, though each survey will cover a different sample of the population, so it is not, as such, a complete data source.

Labour Force Survey
Sample size: 17,000
The LFS has been carried out since 1961, and since 1995, an annual LFS has been carried out to meet EU requirements. This includes all family members in selected households. The survey is conducted by telephone.

Survey on the Working Environment
Sample size: 14,5000
Conducted every second year as a trailer to the LFS.

LOUISE
This represents an important new development to allow researchers more flexible and cheaper access to statistics. Established in 1990, LOUISE is a longitudinal database containing statistics relating to employment, training, education, and income. Statistics are derived from various registers, and combined, thus cutting costs. The basic information contained in LOUISE begins from 1990 and encompasses all individuals aged 16-64, and from 1995, new variables have been added, and individuals over 64 years of age have also been included. The database is also designed to give new insights into labour market trends, and how individuals move in and out of occupations, with the potential of aggregating data for specific workplaces. LOUISE contains information showing the following:

- The relationship between paid employment and alternative activities such as studying, military service and maternity leave
- The relationship between earned income, and income form other sources such as pensions and welfare benefits

- The developments for population groups and geographical areas which are particularly affected by changes in the labour market
- The development of welfare dependency in particular kommunes over time
- The differences in welfare dependency between particular groups such as the young, or immigrants.
- Internal migration and changes in employment
- The competence and work experience levels reached by different groups in the population
- The effects of training programmes

Immigrant Survey
Carried out in 1996, a survey of immigrants' living conditions conducted in respondents' native language.

Overall, the Swedish data sources are extremely good, and would provide ample material for an independent study of migration and work-related health. There are relatively minor problems with the accuracy of this data, particularly data relating to foreign nationals. It is estimated that failure to failure to deregister when leaving Sweden may mean that the numbers of foreign nationals recorded as resident in Sweden may be overestimated by as much as 10%. However, despite these problems, the data available are among the best in the world. Unfortunately, this quality cannot be replicated in most of the other countries in the study.

Denmark

Register data
Various registers have been used since 1968 to collect data about individuals in an integrated way. As in Sweden, the various registers are linked by a key (the personal identification number), and using this key, different registers can be combined to provide more complete information. New variables are continually being added to registers, and the dates of these additions are recorded above, where applicable. Otherwise variables recorded have been available since 1968. As in Sweden, surveys such as the LFS are integrated with register data, and conversely, register data is used to provide basic information about people sampled in the LFS, so some key variables are not included in the LFS questionnaire. Again, the data outlined can be considered an integrated data source.

Labour Force Survey
Sample size: 15,600.
The LFS has been carried out annually since 1984, and since 1994, as a continuous survey published quarterly. As the LFS can be linked with register data, basic information about individuals in the survey is taken from the registers and therefore does not appear on questionnaires. The LFS is conducted primarily by telephone, and supplemented by postal responses.

Overall, Danish data sources are of a very high quality, though there are similar problems as in Sweden, where emigrants fail to de-register. However, the availability of relevant survey data is more limited than in Sweden. A very similar version of the Swedish Immigrant Survey was also carried out in Denmark in 1996, but this survey is not included

in the study as the survey holders were unwilling to provide a copy of the questionnaire, or any details about it.

Norway

Register data
Various registers have been used since 1964 to collect data about individuals in an integrated way. The registers are linked by a key (the personal identification number), and using this key, different registers can be combined to provide more complete information. New variables are continually being added to registers, and the dates of these additions are recorded above, where applicable, otherwise variables recorded have been available since 1964. Surveys such as the LFS are integrated with register data, and register data is used to provide basic information about people sampled in the LFS, so some key variables are not included in the LFS questionnaire.

Labour Force Survey
Sample size:33,000.
The LFS has been conducted since 1972, and since 1996 has run as a weekly continuous survey. Its contents differ significantly from the other EU Labour Force Surveys, reducing its usefulness for cross-national research.

Immigrant Survey
Sample size: 2,500
Carried out in 1996, a survey of immigrants' living conditions conducted in respondents' native language. Immigrants are defined as those with two foreign-born parents from any of the following countries: The Former Yugoslavia, Turkey, Iran, Pakistan, Vietnam, Sri Lanka, Somalia and Chile. Some details are also extracted from the basic population registers to supplement survey data. The results were then compared with results from an earlier study where only Norwegians participated. The survey is very similar in format to the Swedish and Danish surveys.

Oslo Health Survey
Sample size: 51,000.
A large health survey conducted in Oslo only, and associated with a free health check. Participation is by invitation only (to people born in selected years). As health data are not recorded using the personal identification number, this data source cannot be linked to register data.

Overall, Norway provides some high quality data, with the same inherent advantages and disadvantages as data sources in Denmark and Sweden. However, as health data are not recorded using the personal identification number, it is not possible to link migration, employment and health variables.

United Kingdom

The data sources outlined below are independent and cannot be linked.

Census
The census is conducted at 10 yearly intervals (1971, 1981, 1991), and can be used in a number of ways.

LS: Longitudinal Study
This provides continuous data from 3 censuses based on 1% sample population (4 selected birthdays), and is also supplemented with the following:

- NHSCR (health service) data which has nearly complete coverage and is not subject to sampling errors. NHSCR also provides information about immigration and emigration.
- New birth registrations from 1971- (babies born on LS dates)
- Immigrants from 1971
- Embarkations from 1971 (people leaving the country as notified to NHSCR)
- Cancer registrations from 1971 (as notified to Cancer Registries)
- Death registrations from 1971
- Entry to long stay psychiatric hospital (2 years or more, 1971-83)

SAR: Sample of Anonomised Records
A complete set of census data for: 2% sample of individuals, 1% sample of households. Factors can be crosstabulated, but these only represent estimates because they are based on samples.

SAS: Small Area Statistics
A complete and very accurate set of data for small areas. Some crosstabulations are made, but these may not be variables researchers wish to use.

Labour Force Survey
Sample size: 240,000, 0.6%.
The LFS was introduced in 1973 as a biennial survey until 1983, and was subsequently conducted as an annual survey since 1984. Since 1992, an enhanced Labour Force Survey has been conducted quarterly, resulting in incompatibility of data before and after 1992. The LFS is considered to be the most reliable source of data on ethnic group, and results have been proven to be more accurate than the census, because LFS interviews are conducted face-to-face. In addition, it is the only source of data on EU nationals living in the UK. There are limitations related to the low response rate among minority ethnic groups. The response rate among the general population is generally 80-85%, but refusal rate is significantly higher among the ethnic minorities, and around 1% of respondents refuse to answer the ethnic question.

BHPS: British Household Panel Survey
Sample size: 10,000.
Established in 1991, and covering the 1990s, this is an annual survey of each adult member of a nationally representative sample of 5,000+ households. The same individuals are re-interviewed in successive waves. Using longitudinal analysis, it has been possible to identify changing trends throughout the 1990s in some key policy areas, including research into the relationship between health changes and unemployment, and between labour market training and education.

EHPS: European Household Panel Survey
Conducted since 1994, the format and aims are very similar to the BHPS, though the questions differ slightly.

GHS: General Household Survey
Sample size: 10,000 households, 15,000 adults.
The GHS is an annual continuous survey established in 1971, providing the opportunity to examine relationships between population, housing, health, employment and education. The GHS does not provide continuous data about individuals, but provides more general information about changing social trends in British society.

IPS: International Passenger Survey
Sample size: 250,000 per year (of which less than 1% are migrants).
Established in 1964, The IPS is the most utilised source of data on immigration and emigration, and the only source of detailed data on people entering and leaving the UK. The small sample size means that any figures can only be estimates with very large standard errors. Further, the growth in passenger traffic has reduced the sampling fraction over time. The definition of immigrant in the IPS is based on a declared *intention* to stay for more than one year, so the IPS excludes asylum seekers and visitors who overstay.

Overall, the quality of data in Britain is relatively good, though the possibilities of linking migration, employment and health are limited to some rather crude health indicators. With the exception of the LS (with the census, NHSCR and cancer registries), British data sources are not integrated, and different data sources should therefore be considered separately. In terms of cross-national comparison, the data present a major problem, as Britain is the only country in the study to adopt ethnicity as a statistical category. In some respects, this is an advantage, as second generation migrants can be easily identified due to the inclusion of 'country of birth' and 'immigration date' in the census. It is therefore possible to determine the migration status of individuals, which is not feasible where nationality is used as the sole indicator (as in some other European countries). However, this makes cross-national comparisons more complex, but not impossible. One major advantage of British data sources is that access is free to academics working within the country, providing they register with the Office of National Statistics (ONS).

Germany

The data sources outlined below are largely independent, and cannot be linked, with the exception of the census, which is supplemented with address details from the population registers, and the microcensus, which is supplemented with details of vital events such as births, deaths, marriages, divorces and naturalisations, and with migration statistics.

Census (and census of occupation)
The census is normally conducted at 10 yearly intervals, though there have been breaks in this pattern (1950, 1961, 1970, 1987). The census of occupation is carried out at the same time as the census and is the only data source which provides information on all economically active people. However, this is carried out by firm, and information about individuals is not available.

Microcensus
Sample size: 1%

The microcensus has been combined with the Labour Force Survey in one simplified questionnaire, providing a fairly comprehensive data set. The microcensus is carried out annually in a simplified form, and every third year, health variables are included, providing a good source of data where migration, employment and health can be combined (the table shows the variables available every third year). Unfortunately, the microcensus cannot be linked with the main census.

CRF: Central Register of Foreigners
Maintained since 1953, this register records all immigration to Germany, and details of all residents who do not hold German citizenship. It has not been possible to outline all of the variables contained in the register due to lack of information, but a broad outline of the basic variables is provided in the database. As access to citizenship in Germany is very tightly controlled and many second generation migrants are denied German citizenship, this register contains data about individuals who would be unlikely to be classified as 'foreigners' in most other European countries. This is likely to boost the numbers of so-called 'foreigners', giving an exaggerated statistical account of Germany's immigrant population for purposes of international comparison.

MS: Migration Statistics
Continuous population registration results in recording of all migrations within Germany, and immigration to, and emigration from, Germany.

Overall, the census and the microcensus constitute good quality data sources which link migration, employment and health. Unfortunately, these sources cannot be linked together. The census has the advantage of covering the whole population, but only at ten-yearly intervals, while the microcensus is conducted more regularly, but only includes a 1% sample of the population.

Netherlands

Basic data about fertility, mortality, marriage and migration is held in population registers in the municipalities. This system involves the continuous recording and linkage of selected information about individuals. Population registers are compiled from lists of residents and regularly supplemented with information about birth, death, adoption, marriage, divorce and migration. The municipalities are responsible for providing the central statistical office with data necessary to compile national statistics. These statistics are supplemented by surveys where necessary, but most data sources are not linked. A large number of other registers exist, such as, hospital registration and accident registration, but most of these registers cannot be linked and are not held at Statistics Netherlands. Surveys provide the best sources of data for migration, employment and health, but are only representative samples. The most significant source of data is the *Health Interview Survey* (HIS), a major health survey.

HIS: Health Interview Survey
Sample size: 15,000.
The most comprehensive data source linking migration, employment and health, HIS has been conducted by Statistics Netherlands since 1981, and aims to give a complete picture of health trends among the Dutch population. From 1981 to 1996 the survey was conducted among a random sample of residential addresses. Since 1997, the survey has

become one module within a larger survey *The Permanent Survey on Living Conditions (POLS)*. The variables highlighted are those available from 1981, but since 1997, the survey can be linked with POLS, and variables included in POLS are also highlighted.
While this is an extremely useful data source, the non-response rate is often as high as 40%, raising questions regarding its representativeness. To compensate for this problem, a calculated weighting scheme is applied to maintain representativeness. Interviews are conducted face-to-face .

Labour Force Survey
Sample size: 8,000 households per month.
In 1999 the design of the LFS changed to make it more comprehensive. This means that new variables have been available only since 1999, resulting in discontinuity of data.

Overall, The Netherlands provides fairly good data sources, with there possibilities to link migration, employment and health, however, comparability with other countries is problematic, as surveys are only representative samples and do not cover the whole population, and there do not appear to be any comprehensive data sources with full national coverage.

France

Census
Conducted at ten-yearly intervals, the last census was in 1999. The aim of linking migration, employment and health is not possible using the French census as no health variables are included.

Labour Force Survey
Sample size unavailable, and further details unavailable.

Overall, the coverage of French data sources is relatively poor, but it should be remembered that this may not be the full picture. It has been extremely difficult to obtain any basic information from statistics holders in France, and researchers are urged to consider these problems before including France in any study using statistical data.

Italy

Census
Conducted at ten yearly intervals, the last census was held in 1991. Again, the data coverage appears to be relatively poor, with no real potential to link migration, employment and health variables, as health is not included in the census. However, this again is another case where it has been very difficult to extract basic information from statistics holders. As above, this is a factor which should be considered before embarking on any statistics-based research in Italy. It would be advisable for this task to be carried out by Italian researchers.

The Italian Trade Unions will present a Report about Immigration and the Labour Market in November 2000, and Caritas, with the Ministry of Health, will present another Report about Immigration and Health in December. The Trade Unions and Ministry of Health

have a database that could be interesting to consult, but there are bureaucratic obstacles for its use by non-Italians.

As with the French data, there is no possibility of linking migration, employment and health using the census, and overall, the Italian data are difficult to access and unsuited to the purposes of the propose project.

Meta-database conclusions

Clearly, there are limited opportunities for cross-national research using the above data sources. While some countries such as Sweden, possess high quality data sources which could potentially provide comprehensive coverage of the topic under investigation, other countries such as France and Italy do not have data sources which offer any potential for these linkages to be made. It would be possible to provide some basic coverage of the topic using the rather crude variables in the Labour Force Survey if France and Italy were excluded, and this would provide at least a partial picture of the situation. By Swedish standards, this would be a very poor representation of the situation given the potential offered by their comprehensive data sources. The problems related to cross-national research can therefore be outlined as follows:

- There is no possibility to link data on migration, employment and health in some of the countries included in the study.
- While most countries (with the exception of the Netherlands) provide full coverage in their data sources, some of this only occurs at ten-yearly intervals, and census years vary by country.
- Some relatively good surveys exist, but these are based on samples, and do not give full national coverage. This can be problematic where minority ethnic groups are concerned, as their response rates are often lower.
- Some countries integrate their data sources using personal identification numbers, while others do not.
- Accessibility to data varies by country. Some countries levy very high charges for data access, while others provide it free of charge to academics working within the countries concerned.

Conclusion

The findings of the feasibility study have demonstrated the need for research in the area of migration and work-related health, particularly in light of the expected increase in mobility in Europe during the coming decades. While labour markets for the highly skilled are becoming more international in operation, research shows that skilled migrants face the potential added burden of migration-related stress, sometimes on top of already stressful occupations. A new and growing trend of labour shortages in some unskilled sectors has led to a general increase in international movements of low-skilled labour migrants in Europe, a trend which potentially has work-related health implications for the migrants. Future research could potentially focus on these groups, though at this stage, there is no clear spatial or temporal pattern to this trend, and sender countries appear to vary considerably by region. Many of these migrants are also on short-term work visas, and are rarely accompanied by their families. However, the problems faced by forced migrants attempting to adapt to the European labour market are clearly more urgent than for any

migrant group, particularly as there is often no option to return if the problems cannot be resolved. Considering the current and projected future labour shortages in Europe, and the skills profile of the refugee population (refugees as a group are in general are more skilled than their host populations), policy measures could be directed towards more fruitful retraining programmes, focusing on mental and physical health as a vital component, to prevent the current situation, where well-developed skills are being wasted through the deskilling process. The social exclusion and marginalisation experienced by many refugees could potentially be reduced with some coherent and appropriate policy interventions, particularly if implemented at EU level.

Based on the findings of the feasibility study, the following areas could be recommended as possible research areas:

- The extent and health implications of deskilling and unemployment among refugees in selected countries. This would include the interaction of factors such as labour market discrimination, trauma and depression, and the role of mental health problems as a barrier to employment.
- The impacts of different types of integration policies and their outcomes for refugees
- An assessment of the situation of second generation migrants in the labour market.
- An examination of the extent and nature of occupational accidents and health disorders among migrants employed in dangerous and physically demanding occupations.
- An examination of work-related stress among skilled migrants, and the experiences of 'tied' migrants.
- Health problems among illegal migrants.
- Work tourism from Eastern Europe and associated health problems.

The migration and work-related health research gap is matched by a gap in relevant data sources in some countries. There are few integrated data sources outside Scandinavia, where it is possible to make linkages between migration, employment and health at anything other than a very crude level. While it would be possible to conduct detailed national studies in Sweden and Denmark using register data, and possibly in Germany and the Netherlands using survey data (this would provide samples only), the lack of integrated data sources in other countries such as France and Italy renders cross-national research including a wide range of countries extremely problematic. The Labour Force Survey is the only data source which offers any potential for some basic cross-national comparisons, but only at a very crude level.

In light of the above situation, other possibilities for data capture have been explored. A viable alternative to using existing data sources is to create new ones which will serve the purposes required. It is therefore recommended that a mixed method approach, as outlined below, should be considered for a longer term project:

Stage 1
The implementation of a questionnaire survey in selected countries. This strategy would have a dual function, firstly to create a dataset which could address the above issues through quantitative analysis of overall trends, but secondly, also to provide a platform for recruiting subjects for more in-depth qualitative interview research. The Immigrant Survey implemented in Sweden, Denmark and Norway has demonstrated how a well- structured questionnaire can be created, and this could serve as a basic model for a new questionnaire. This approach would ensure cross-national and temporal comparability, while also

enabling entirely appropriate and relevant data sources to be created. This would not provide full coverage and would only serve as a representative sample, but it would create uniformity in the data, and represents the most viable option given the current circumstances. This process would provide a new and entirely valid data source which would effectively provide the basis for new knowledge to be acquired in the field of migration and employment-related health.

Stage 2
Stage 1 would be followed by a series of in-depth interviews with migrants from a range of different migrant categories. This methodology would serve to identify the causal mechanisms involved in processes such as deskilling, and would also clarify some of the trends identified using quantitative data. The interviews would also clarify place-specific, and occupation-specific health trends and their associated causal mechanisms. In-depth interviews have been recognised within the social sciences as an important method which can reveal the underlying causal mechanisms associated with social trends, mechanisms which are difficult to identify using quantitative data alone.

Appendix

Refugee support programmes under way in Scotlamd

1. 'Equal': EU funding opportunity soon to be in place. This is to be implemented across the EU. Community initiative concerning transnational co-operation to promote new means of combating all forms of discrimination and inequalities in the labour market.
2. Leonardo da Vinci project – development of European concepts for the use of qualifications and competence of migrants for their vocational training. Contact, Pamela Clayton (University of Glasgow, Adult and Continuing Education Department).
3. 'Breathing Space' project (see below).
4. 'Men in Mind': Ethnic minority men and skills. Offers needs assessment and counselling. Linked to Skillnet.
5. 'Linknet' mentoring project (Black mentors for black mentees) Access to employment and training – will be on-line from October
6. Glasgow Healthy Cities partnership to promote education and health. Will include refugees.
7. RETAS (Refugee Education and Training Advisory Service). This is part of a nation-wide project based in London which aims to provide pathways into employment for refugees, and is linked to the World University Service.
8. City of Edinburgh social inclusion project.
9. The Good Health Project: Aimed at helping to address mental and physical health needs of asylum seekers and refugees in Scotland. Part of a European-funded consortium project involving other refugee councils in Britain.

Refugee projects in London

1. Access to employment for refugee doctors – contact Deng Yai, Refugee Council.

2. 'Refugees into work'. A project which follows successful trainees, who are assigned a mentor who helps in search for employment. Help given includes: language support, job search skills and interview skills (Refugee Council).
3. The Refugee Training Partnership (RTP). A 5 year programme set up to increase training and employment opportunities for refugees in inner London. Brings together a wide number of agencies.
4. Refugee Outreach Team, Lambeth, Southwark and Lewisham, London. This project is located within the health authority of one of the poorest areas of London, which also has many refugees. The project aims to facilitate the use of health services by refugees, and to raise awareness of the health care needs of refugees among health providers.
5. Stepping Stones into the 'new deal'. A programme designed to inform refugees about the 'New Deal' – a government programme for the unemployed. Workers are appointed in the areas with highest unemployment levels and promote access to training and work.

Current projects and organisations in Europe which address employment and/or health issues among migrants in Europe

ECRE Task Force contact details
Coordinating Secretariat
Koen De Mesmaeker / Sara Gaunt
OverlegCentrum voor Integratie Vluchtelingen
Gaucherstraat 164
B-1030 Brussels
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Tel:++32 2 274 00 29/36
Email: *koen@refugeenet.org* *sara@refugeenet.org*

Employment
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British Refugee Council
3 Bondway
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Tel: ++44 171 820 31 06/05
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Education
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Email: corrine@wusuk.org gertrud@wusuk.org

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Consiglio Italiano Per I Rifugiati
Via del Velabro 5A

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Tel: ++39 06 69 200 114
Email: progetti@cironlus.it

Housing
Sander Mateman
Vluchtelingen Werk Nederland
PO Box 2894
1000 CW Amsterdam
Netherlands
Tel: ++31 20 346 72 00
Email: SMateman@vluchtelingenwerk.nl

Community and Culture
Anna Charapi
Greek Council for Refugees
25 Solomou Street
106 82 Athens
Greece
Tel: ++30 1 380 25 08
Email: charapi@gcr.gr

Vocational Training
Yaële Aferiat
France Terre d'Asile
25 rue Ganneron
75018 Paris
France
Tel: ++31 1 53 04 39 99
Email: ftda@refugeenet.org

Other related projects or organisations

The Health of Londoners' Project
Directorate of Public Health
East London and The City Health Authority
Aneurin Bevan House
81-91 Commercial Road
London E1 1RD
United Kingdom
One branch of this project has been to develop health assessment for black and minority ethnic groups.

Skills Match

Midlands Refugee Council
5th floor, Smithfield House
Digbeth
Birmingham B5 6BS
United Kingdom
An employment project aimed at improving the employment prospects of skilled refugees through establishing work placements. This is mostly done through individual mentoring using contacts within the 'minority' sections of professional organisations. There is also a working alliance with a local Positive Action training organisation involving interviewing techniques and accreditation of earlier qualifications.

European Foundation for the Improvement of Living and Working Conditions
Wyattville Road
Loughlinstown
Dublin
Ireland
www.eurofound.ie
The European Foundation for the Improvement of Living and Working Conditions is an autonomous body established by the EU in 1975. Its aim is to contribute to the planning and establishment of better working and living conditions through action designed to increase and disseminate knowledge likely to assist this development.

Institut für Migrationsforschung und Interkulturelle Studien (IMIS)
Universität Osnabrück
Neuer Graben 19/21
D – 49069 Osnabrück
Germany
imis@uni-osnabrueck.de
The Institute has conducted research on both health and employment issues among migrants at different times.

Die Beauftragte der Bundesregierung für Ausländerfragen
11017 Berlin
Germany
www.bundesauslaenderbeauftragte.de

This organisation co-ordinates researchers working in the area of migration, and has regular workshops on the topic.
Diakonisches Werk
Pirckheimerstrasse 6
90408 Nüremberg
Germany
This organisation helps refugees to access health services and offers therapy and psychological support for traumatised refugees.

Department of Public Health and Caring Sciences
Uppsala Science Park
SE-751 85 Uppsala
Sweden

Contact: Ingrid Anderzen ingrid.anderzen@socmed.uu.se
This organisation is involved with the health care needs of highly skilled migrants working in the area.

Pharos Foundation for Refugee Health Care
Herenstraat 35
NL-3584 cs Utrecht
Netherlands
This foundation was established in 1993 and aims to promote the mental and social well-being of refugees and improving their access to health care. It has a number of projects running concurrently running in both the health and employment retraining area, and promotes retraining for professionals working in the refugee area.

EMPLOOI
Prins Henrikkade 48
1012 AC Amsterdam
Netherlands
A mentoring scheme using the skills and contacts of former Dutch businessmen, who work on a voluntary basis. The aim is to help refugees who are ready for work, to find suitable employment.

Project SAM SAM, CLP, Paris. This is a transnational project also running in the Netherlands and Spain. It uses mediators to facilitate access to employment for refugees and other disadvantaged groups. The project is co-ordinated by CLP (Comité de Liason pour la promotion des migrants et publics en difficultés d'insertion).

Enfab-Abruzzo, Italian Trade Union.
In co-operation with French and German partners, this trade union has training activities addressing immigrants' and ethnic minorities' specific needs, which combine employment retraining and health services.

Indvandrerprojekter
Nørregade 36, 3 sal
1165 Copenhagen K
Denmark.

An organisation which has been running for 12 years and focuses on special initiatives for migrants and refugees in the field of training and employment. There is a special emphasis on self-employment and starting up new businesses. The projects attempt to build on pre-existing skills, both formal and informal.