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# Migration and work-related health in Europe

– A Literature Review

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SAL TSA – JOINT PROGRAMME  
FOR WORKING LIFE RESEARCH IN EUROPE  
The National Institute for Working Life and The Swedish Trade Unions in Co-operation

SALTSA is a collaboration programme for occupational research in Europe. The National Institute for Working Life in Sweden and the regional trade union organisations SACO (the Swedish Confederation of Professional Associations), LO (the Swedish Trade Union Confederation) and TCO (the Swedish Confederation of Professional Employees) take part in the programme. Many problems and issues relating to working life are common to most European countries, and the purpose of the programme is to pave the way for joint research on these matters from a European perspective.

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## *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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## *Introduction*

While international migration has been a well-established phenomenon globally, the latter part of the twentieth century has witnessed a significant increase in mobility on a global scale, a factor associated with progressive globalization of labour markets. This has created a growing diversity of migrants now resident in Western Europe. European integration has also created a more internationally mobile workforce within the EU. These trends are likely to continue into the coming decades, particularly as demographic changes will compound the already present skills shortages in some key employment sectors. Europe's population is projected to shrink by 110-150 million over the next five decades (Preston, 1999) due to the combination of an ageing population and a declining birth rate, and long-term projections of population growth show that this will result in an active population too small to support welfare systems at their current levels (Salt et al., 1996). This, coupled with declining pay and working conditions in many public sector employment niches, is likely to lead to further skills shortages in coming decades. There has been considerable interest in using controlled immigration to ameliorate these problems, and as a result, migrant workers are likely to become viewed as a potential resource in the future, so it is therefore imperative that some profile of the work-related health status of Europe's migrant population is clarified. This is therefore an increasingly important research gap which will require attention from policy-makers across Europe. This review will attempt to draw together some of the themes and issues related to migrant health and employment which are currently in the literature, and will identify any potential research gaps.

The title carries an implicit assumption that migration necessarily causes work-related health problems. This is often the case, but not always. Sometimes, voluntary migration can bring career opportunities which enhance the general well-being of migrants, particularly the highly skilled. Conversely, involuntary or 'tied' migration can involve a degree of deskilling and downward social mobility, and can be associated with potential health problems, particularly where departure has involved trauma. Clearly, a wide range of people at varying skills levels come under the category of 'migrants', and this review will attempt to incorporate this diversity.

## *Work-related health problems*

There is little literature which deals with the combination of migration and work-related health problems, as most literature is either related to migrant health, or work-related health in general. However, Sweden has taken the lead in this field, as Statistics Sweden has conducted a 20 year survey, which showed that physically demanding, stressful and repetitive employment leads to most health problems among immigrant workers, with musculoskeletal disorders constituting the largest single illness category among those with an immigrant background (Statistics Sweden, 1997; Socialstyrelsen, 1998). In another recent Swedish study, 72% of immigrants reported physically demanding work, compared with 62% of Swedes, and 16% and 10% of immigrants and Swedes respectively reported stressful and repetitive work. As a result, immigrants had sick leave at a level 70% greater than Swedes, with large differences between different ethnic groups, levels being highest among Southern European women. Yugoslavs and Hungarians reported these problems twice as often as Swedes, and women more than men, particularly women from Iran, Chile and Turkey (Socialstyrelsen, 1998). However, a similar study in Norway showed no significant differences in the levels of musculoskeletal disorders between immigrants and Norwegians (Blom and Ramm, 1998).

In Europe, significantly more attention is paid to traditional areas of occupational health, such as technical safety and the effects of chemical, physical and biological hazards in the workplace than to psychosocial aspects of health. Work-related stress therefore has a low priority, and in some cases is regarded as an inherent weakness in the individual, despite emerging evidence that work-related stress is affecting increasing numbers of people globally. In some countries, notably, Sweden, Finland and the Netherlands, psychosocial occupational hazards are acquiring more importance (Kompier and Cooper, 1999). However, cross-national European comparative studies of the quality of working environments have not been carried out to any great extent, with some notable exceptions, including work carried out by the European Foundation for The Improvement of Living and Working Conditions (Paoli, 1997). The ILO also carried out a recent survey of stress in several European countries (Britain, Germany, Finland and Poland), and found that anxiety, burn-out and depression constitute a major health burden both financially and in terms of lost working hours (Osborn, 2000a). Stress is also thought to reduce immunity to other diseases (Ader et al. 1995), though the individual's response to stress, and social support will play an important role (Kiritz and Moos, 1974). Migrants are often at particular risk from stress-related work problems as they generally occupy lower status occupational niches and have the added burden of racism and discrimination to deal with.



## *Migration, citizenship and definitional issues*

To undertake a Europe-wide research programme in the field of migration and employment-related health issues is an ambitious project, not least due to the complexity of definitional issues among EU member states. The EU was established during the post World War 2 period and has recently pursued a policy of economic integration and eased mobility of labour within its boundaries, but this has also been associated with the tightening of Europe's external boundaries to migrants and workers from outside the EU, particularly those from less developed countries. These trends towards economic integration have tended to obscure the complexities of the migration histories of the individual EU member states, and while both migration and economic restructuring have led to changes in the fabric of all Western European nations throughout the post-war period, there are marked differences both in the political measures implemented to control immigration and integrate migrant populations, and in the ways in which the majority populations have reacted to immigration. As a result, the politicisation of the migrant presence, and subsequent racist discourses, vary considerably from nation to nation, resulting in an array of definitional terms used to describe migrants and ethnic minorities. These processes have also created differing national research priorities, depending on which immigration issues have been problematised. This complexity creates problems for truly cross-national comparative research on health and migration, as it is not always possible to find comparable data sources in different countries.

## *A European migration history*

Even the measurement of international migration has become fraught with problems due to its complexity. It has become increasingly difficult to distinguish short and long term migration, while push factors interact with other institutional factors, blurring the distinction between forced and voluntary migration. However, it is possible to determine some clear patterns within this complexity. This section will consider the migration patterns common to Western Europe, and will be used to establish a framework from which individual national case studies will be considered. A useful way of conceptualising the current complexity of migrant populations in Western Europe is demonstrated by White (1993), who has divided post-1950 international migration to Europe into three distinct waves: labour migration, family reunification and post-industrial migration. Although there is considerable overlap in timescale between these waves, and place-specific anomalies exist where different countries are being

compared, they do correspond to a broad pattern, as this model could be applied to any Western European country. The three waves of migrants have experienced rather different social and economic conditions on arrival, and will be discussed in turn.

## **Post World War 2 Labour Migration**

The 1950s and 1960s saw the agglomeration of capital in the core industrial areas of Western Europe, and as a result, this period was characterised by mass migrations of predominantly single males seeking unskilled employment. Castles and Cosack (1973) demonstrated that these migrants played a crucial role in the economic prosperity of the region, and describe labour migration as a structural necessity for the economies of receiving countries at that time. Migrant-receiving societies adopted different policies towards labour migrants, from permanent settlement in Sweden, the UK and the Netherlands, to an essentially exploitative and exclusionary system in West Germany, where the strategy of *Konjunkturpuffer* was explicitly designed to avoid permanent settlement of labour migrants. This rotational system allowed the German government the flexibility of matching immigration to cyclical fluctuations in labour demand, and workers could easily be repatriated during slump periods. The German approach to labour migration was encapsulated in the term *Gastarbeiter* (guest workers), which reflected the perceived impermanence of these migrants, supporting the continuing myth that Germany was not a country of immigration. The German guest worker system also involved careful health screening of potential migrants, a highly selective process to ensure that only the fittest and most able were recruited (Castles and Kosack, 1973). This policy has had long term repercussions for health outcomes among migrant groups in Germany, as demonstrated by continued lower mortality rates among Turkish residents in Germany (Razum et al., 1998).

Economic factors largely explain the occurrence and subsequent demise of mass migrations during this period, but they do not explain the spatial patterns of the flows. King (1995) identifies two major types of sender countries: firstly, former colonies and secondly, countries on Europe's southern and eastern peripheries. Britain actively sought labour migrants from its former colonies, particularly in the West Indies, and many migrants also arrived from India and Pakistan to settle permanently. France received many migrant workers from its former colonies in North Africa and also encouraged permanent settlement, while the Dutch encouraged permanent settlement by the Surinamese. Countries such as Sweden, Germany and Denmark, which had no significant colonial linkages engaged in labour recruitment schemes with countries on Europe's rural periphery, notably Spain, Italy, Greece, Yugoslavia and Finland. As some of

these countries began to see improvements in their own economies, labour migration dried up and sources further afield were sought, such as Turkey, Morocco and Pakistan. Some of the Southern European countries evolved from being countries of substantial net emigration to countries of net immigration within a very short period, both as a result of transformation of their economies and a rapid fall in fertility (King and Rybaczuk, 1993). Italy subsequently filled its emerging labour shortages by tolerating, rather than actively recruiting, migrants from its own former colonies such as Somalia and from other sources such as Bangladesh.

This period was therefore marked by a growing spatial diversity of migrant origins, with particular countries setting up linkages from specific sender countries, thus establishing linkages which have subsequently led to chain migration, and the establishment of certain migrant communities in various countries. Although there are some migrant groups which have settled in a number of different countries, the varying institutional and policy-related factors have differentiated their experiences, and the fact that many of these communities have been established through chain migration gives them particular characteristics which cannot be replicated from place to place. This, in association with place-specific racialisations of minority populations, renders comparative research problematic.

Mass labour migration came to a halt during the early 1970s when a combination of factors rendered it untenable. The 1973 oil crisis precipitated economic recession and unemployment in core countries, rendering labour migrants surplus to requirement, but deeper structural changes were also acting on the economies of receiver countries, changes which were to end mass labour migration permanently. Global economic restructuring was creating a *new international division of labour*, leading to new patterns of international migration. The 1970s saw the emergence of the transnational firm as a unit of production, creating a new global, hierarchical and geographically separated division of labour (Sassen, 1991), which involved the relocation of much unskilled labour demand to new areas within the developing world, and the decline or disappearance of the sectors which had formerly employed labour migrants.

### **Family Reunification**

By the early 1970s, most Western European countries had either implemented immigration controls or terminated labour migration permanently, and in the 'guest worker' countries, it was assumed that labour migrants would return home when they were no longer needed. The reality, however, was very different, and throughout the 1970s, substantial numbers of migrants continued to arrive from countries which had traditionally supplied labour migrants. During the latter part

of the labour migration period, some of the host countries had created legal rights for migrant workers to reunify their families, and many had taken advantage of this. This second wave consisted mainly of family reunification, and was therefore characterised by an entirely different gender and age composition, being composed primarily of 'tied' migrants, the wives and children of former labour migrants. The impact of this chain migration on receiver societies was therefore very different. They formed visibly distinctive communities in most major European cities, congregating mainly in inner city slums and poorer housing areas. This was a result of the occupational ghettoization of the original labour migrants, whose residential locations had been determined largely by the situation of workers' hostels in the poorer areas of cities, or the availability of low cost housing in these same areas. The arrival of families incurred a degree of residential mobility, as better housing was required, but the original areas of settlement continued to be foci for ethnic minorities, attracting both concern and hostility from some of the receiving populations. This period also saw ethnic minorities firmly established on the bottom rung of the social hierarchy, a factor which was to have future implications for their health and well-being, and indeed, many epidemiological studies have failed to recognise the significance of this socio-economic component when using factors such as ethnicity as a variable. This wave made its presence felt in new ways, placing particular demands on public services like health care and education, and at a time of recession and unemployment, migrants were often scapegoated for these wider societal changes (Heisler and Layton Henry, 1993).

Although family reunification peaked during the late 1970s, it is still an ongoing process, as refugees are also entitled to bring in family members. In addition, within some migrant communities, strong ties have been maintained with sender countries and are reinforced through regular visits and marriages within particular social and ethnic networks. These influences are likely to decrease as second and third generation migrants become more westernised and assertive in the face of demands from their more traditional parents. Also, recent trends have been towards a tightening up of family reunification rules throughout Western Europe (Salt 1995), reducing the potential for this migration in the future.

### **Post industrial migration**

By the 1980s, family reunification had been replaced by a third, and more diverse wave of international migrants, characterised by greater emphasis on push factors. This diversity reflects changing social, political and economic conditions globally. In particular, there is more polarisation between wealthy skilled, and poor dispossessed migrants, a factor which reflects deepening structural

economic inequalities at a global scale. There has also been a distinct feminisation of migration flows (King, 1995), which applies mainly to migrants at the lower end of the socio-economic spectrum. Nevertheless, there are still clear patterns related to political and cultural linkages, particularly to colonialism, with even refugee flows mirroring such connections (Lopes, 1991; Dansk Flygtninghjælp, 1997). White (1993) identifies three sub-groups within the post industrial wave: highly skilled workers and business managers migrating within the developed world; refugees and asylum seekers; and clandestine migrants. These sub-groups are diverse and will therefore be discussed individually.

### *Highly skilled migrants*

Migration of highly skilled migrants between key global cities has been explained by Salt (1992) and Findlay et al. (1996) in the context of the *new international division of labour*, where managerial functions have become more centralised in major global cities. Findlay and Garrick (1990) have identified three major channels of skilled worker movement: the internal labour markets of multinational companies; contract work organised by companies to meet skills absent in developing countries; and employment organised by recruitment agencies. Most research has focused on upward mobility within the labour markets of transnational companies (Salt, 1988). These 'executive nomads', primarily from Japan, North America and Western Europe, are predominantly male, face few immigration restrictions, and do not create a visible presence in their host societies, despite the great economic significance of their presence. As such contracts tend to be temporary, migration is usually short-term and circular, and these migrants are rarely included in epidemiological studies.

Very recent trends have witnessed a significant increase in the numbers of highly skilled workers migrating to Western Europe, particularly, an increase in intra-EU migration. A recent survey of the practices of 270 organisations employing expatriates demonstrates that intra-EU migration is increasing in extent, with North American skilled migrants becoming numerically less significant. This growth in expatriate assignments in Western Europe is clearly associated with EU integration, and is projected to continue and to incorporate Eastern European migrants in the future. However, the same survey demonstrates that assignments abroad are increasingly short-term in nature, and it is noted that it is becoming more difficult to attract employees who will accept longer-term assignments abroad. As a result, companies are now relying more on business trips and virtual assignments. The most common reasons cited for failure of foreign assignments are (in order of importance): adaptability problems with partners; children's educational needs; emotional resilience; and partners'

careers. In light of these problems, and the expense of foreign assignments, companies are now trying to find other ways of increasing mobility, mainly in the form of business trips and short-term assignments (PricewaterhouseCoopers, 2000). Recent attention has focused on the lack of research into the experiences of 'tied' migrants in this context, and there is a growing body of evidence to suggest that they suffer a significant degree of stress related to migration, which may impact health.

### *Clandestine migration*

At the other end of the economic spectrum, are forced and illegal migrants. For obvious reasons, the full extent of illegal migration in Western Europe is unknown, but it is clearly a significant factor, and the International Labour Office estimated that in 1991, there were around 2.6 million undocumented non-nationals in Europe (Salt, 1998). Southern Europe experiences relatively high levels of clandestine migration, partially due to ease of entry and proximity of sender countries (King, 1993), but also to the well developed informal labour markets which provide employment niches for illegal workers. Governments have been reluctant to act against this phenomenon as it is tacitly understood that informal labour markets play an important role in their economies (White, 1993). Clandestine migration is less common in Northern Europe, where informal economies are less developed, labour forces more unionised, and comprehensive registration systems prevent black market employment occurring on any significant scale. There is increasing evidence to suggest that illegal migration is organised by underground agencies, who provide employment links with specific employers prior to migration. There are some serious health concerns for illegal migrants, who often do not have access to health care provision, and do not undergo screening processes (such as for tuberculosis) which legal migrants may be entitled to. They are also outwith the legal protection mechanisms for employees in dangerous occupations, and may suffer serious health consequences as a result. There is also growing awareness of the situations of significant numbers of trafficked migrants who are forced into prostitution or bonded labour to pay off their debts, often working in very poor conditions, with associated health risks. Known routes for the illegal trafficking of migrants include networks linking Mali, Senegal, and other Sub-Saharan countries with Spain, via Morocco (IOM, 2000), and 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.

### *Refugees*

Refugees are currently the most substantial source of new migrants to Western Europe, a manifestation of increasing political unrest and disintegration globally, particularly since the mid 1980s. Widgren (1989) identified the 1980s as the beginning of a new period in global refugee migration, marked increasingly by intercontinental movements, the causes of which he partly attributes to the decolonization process in Asia and Africa. Desbarats (1992) notes that prior to this period, Europe's reception of refugees was primarily related to European conflicts and involved modest UNHCR quotas. Robinson (1996) also observes this change in pattern, characterised by a shift from organised and controlled reception of quota refugees to a situation where spontaneous refugees now dominate flows, a pattern enhanced by ease of transport and pre-existing migrant networks. Overall, these changes have led to increasing diversity in refugee migration to Western Europe.

The characteristics of refugees vary considerably, and despite the tendency for host populations to lump together economic migrants and refugees as one undifferentiated 'other', it should be noted that refugee migration to advanced industrial countries is often a selective process which favours skilled and resourced migrants. This has led to a situation where in some countries, such as Sweden and the UK, contrary to popular images, the refugee population is actually more skilled than the native population (pers. com. Ekblad; pers.com. Scottish Refugee Council). The negative reactions to refugees in some receiving countries have been superimposed on pre-existing racisms, leading to problems of labour market discrimination, which intensify the difficulties experienced by many refugees when attempting to re-establish their careers after migration. Refugee deskilling has been noted in a number of countries as a very significant problem, particularly Sweden (pers com Ekblad) and Denmark (Wren, 1999). Clearly, this will add to psychological health problems experienced during the readjustment process after the trauma of persecution and forced flight, but there are also health implications for refugees forced into physically demanding manual work to which they may be unaccustomed.

### **Very recent migration trends**

The above migration pattern has been fairly universal throughout Western Europe, and most countries could be fitted fairly easily into this framework. The model does not, however, account for very recent changes in patterns of migration in Europe, where skills shortages in certain sectors have developed in a number of countries during the latter part of the 1990s (Harding, 2000; Salt, 1998). These shortages, coupled with removal of immigration barriers for EU migrants, have led to increased general mobility within the EU at all skills levels

and among both males and females. The mobility patterns are very variable, but movements are largely temporary in nature, and the International Organisation for Migration (2000) reports that the majority of migrants involved are highly skilled. The extent of this mobility is significant, but is rather less than would be expected, as recent figures show a total of only 5.5 m EU nationals (just 1.6% of total EU population) working in another EU country (Sassen, 2000), and between 1985 and 1995 the numbers have not increased significantly (Eurostat, 1997). The health impacts of these movements constitute an important research gap, however, it is unlikely that this voluntary movement will involve any significant deskilling, as people are likely to migrate in order to enhance their careers.

Similarly, it was predicted that the removal of the Iron Curtain would precipitate mass migration from Eastern to Western Europe. However, these predictions have not manifest (IOM, 2000), partly due to a clear tendency to stay in home countries, but also to more strict immigration controls in the west (Salt, 1998). This is in keeping with a general decline in immigration levels in most Western European countries since 1994. However, some new patterns have emerged during the 1990s, which can be broadly outlined as temporary labour migration flows westwards from: Albania to Italy and Greece; Estonia and Russia to Finland; The Czech Republic, Bulgaria, Poland and Hungary to Austria and Germany. Also notable has been the ethnic migrations from Poland, Romania and the Former Soviet Union to Germany (Salt, 1998).

Germany has been in a unique position during the 1990s, operating a system of bilateral agreements with Eastern European countries, which admits Eastern Europeans on temporary work permits. The majority of the workers involved have been from Poland. This system can broadly be divided into four categories: (1) 'Project-tied' work where German firms may subcontract work to foreign firms, which then supply the workers to work within Germany. (2) Seasonal work for up to 3 months (discussed below). (3) Border commuters – Polish and Czech citizens living within 50km of the German border may work in Germany if German workers cannot be found. (4) Guest workers - Germany has now returned to its earlier 'guest worker' system, but on a more modest scale. Bilateral quota agreements are made with sender countries in Central, Eastern and Southern Europe, with more than 40,000 contract workers registered in Germany during the late 1990s (mostly from Poland). They are restricted to working in certain sectors including agriculture, forestry and hotels (Werner, 1996; Hönekopp, 1997).

This policy is aimed at alleviating German labour shortages, and reducing levels of illegal immigration, but specifically in a way which avoids permanent settlement (Hönekopp, 1997). These programmes are aimed primarily at the unskilled employment sector, with generally with poor working conditions, which may have health repercussions. As this is a relatively recent phenomenon,



little research has been carried out, and as such, this constitutes a relatively important new research gap.

### *Labour tourism*

‘Labour tourism’ is an increasingly common form of temporary migration in Western Europe, primarily involving migrants from Central and Eastern Europe, the CIS and North Africa. These movements do not fit the normal definitional criteria of ‘migration’ due to their short term nature (international migrants are normally defined as those who change their country of residence for one year or more), but is nevertheless significant. This is discussed above in the German context, where specific programmes have been established, but it also occurs in a less formalised way in most other EU countries. Many groups from the regions involved choose to work on 3-6 month contracts (depending on the country) in Western Europe, particularly during the summer months, and primarily in occupational sectors such as agriculture, catering, construction and manufacturing, where wages and working conditions are relatively poor (pers. com. agricultural worker). They may not bring in family members, and are often restricted to working with one designated employer. In addition to Germany, Switzerland also has bilateral agreements with Italy, Spain and Portugal, and France has agreements with Morocco, Poland, Senegal and Tunisia (IOM, 2000). These agreements often reflect prior migration linkages. Although this is primarily short-term migration, there are concerns about the exploitative nature of this type of employment and there may also be health issues involved which should be researched. These may include issues such as, exposure to toxic agricultural substances, or the impacts of hard physical labour. Again, this temporary migration phenomenon and its work-related health repercussions constitute an emerging research gap.

### *European Racisms*

Within Europe, there have been place-specific variations in the above migration processes, and significant differences in time-scales, factors which, combined with differential political processes, have created major variations in the ways in which migrants have been received, their access to political participation and citizenship, and also the ways in which they have been ‘racialized’.

Despite the fact that there have been anti-racism measures implemented in most European countries, racism has been an integral part of Europe’s historical development. It is a fundamental part of the reality of most migrants’ lives, and is likely to significantly hinder their life chances after migration in a number of

ways. While European integration is creating a Europe without internal borders, there has been growing tension around the concepts of 'race', ethnicity and the nation state, to the extent that some nation states are relying on powerful ideologies of nationalism to revive the declining function of the nation state. Recent political trends across Europe should be causing alarm, as the far-right has recently made political gains in a number of countries. The Freedom Party in Austria now holds considerable power after the last election, and paradoxically, soon after the EU imposed sanctions against Austria, one of Europe's fiercest critics of Austria's Freedom Party, the Belgian Prime minister, suddenly had greater cause for concern about events at home. Belgium's anti-immigration party, Vlaams Blok, recently won the largest share of the vote (33%) in local elections in Antwerp (Osborn, 2000b). This trend was mirrored in Norway where, seemingly, the far right Progress Party has become the most popular political force in the country (it polled 35% in a pre-election opinion poll), and its leader may easily become the next prime minister of Norway (Osborn, 2000c). The rise of Neo-Nazism in Germany is also causing concern among Germany's politicians (Staunton, 2000), while the traditionally liberal and tolerant Scandinavian countries, Sweden (Pred, 1997, 1998) and Denmark (Hjarnø, 1991; Schierup, 1993; Wren, 2001) are also demonstrating a disturbing degree of racism. In Britain, there is strong evidence of institutionalised racism within the Crown Prosecution Service (Dyer, 2000) and in the police force (Campbell et al, 1999).

Bovenkerk et al (1990) argue that there are common themes and issues related to racism and labour market discrimination, but these do not sufficiently explain the complexities and variations in the nature of reactions in different countries. Hall (1978) argues that 'racial' distinctions are social constructions, created under the specific conditions of the societies in which they appear. Essentially, 'racial' distinctions are related to the form of social relations at historically specific times, and to the ways in which these relations maintain fundamental inequalities in power. Racism is therefore not a static phenomenon, but one which is renewed and transformed, over time and constituted differently in different places, and for this reason we should not seek universal definitions of racism, but examine place-specific manifestations and their impacts. Migration histories are therefore important factors in the way different racist discourses have evolved within individual nation states in Europe. Place-specific racist discourses have important impacts on immigration and integration policies, both of which are important factors shaping the life-chances and health profiles of potential migrants. These differing contexts and political processes are closely linked with differences in the ways in which nations are imagined as communities (Anderson, 1991), which can either incorporate or exclude migrants. The EU is a recent imposition on

these historically constructed institutional factors, hence the difficulty in finding common ground among European racisms.

The way racism manifests and is resisted, and the way migration is politicised in different nation states has direct ramifications for the way migrants/ethnic minorities are defined, and consequently, for the way data are recorded. Discourses, and the concepts and definitions which they inform, are place-specific to nation states, and not easily transferred across national boundaries. To understand the complexities of definitions and to contextualise their meaning, there needs to be awareness of their specific contexts. Citizenship, and access to it often rests on distinctive understandings of, and historical paths to, nationhood (Brubaker, 1990). These contexts are also important for understanding the nature and impacts of migration, so a brief outline will be given of the migration histories and policy developments in a range of countries.

## **Britain**

Several European countries such as the UK, France and the Netherlands share a common history of colonialism, where the migration of various groups has been closely linked to the process of decolonisation and to specific political ties to the 'mother country'. This process has historically been associated with automatic citizenship rights for early migrants, into nation states which were able to incorporate 'others' with relative ease, while maintaining their political identities as nation states. In this way, the West Indian migrations have been incorporated into contemporary meanings of what constitutes Britishness ('Black British'), particularly as 'British' has always been a composite identity, and is therefore easy to extend to other groups (Bryant, 1997). Surinamese migrants and their offspring have enjoyed similar acceptance as Dutch citizens. These case-specific circumstances are particularly relevant for the UK, where discourses centring around colonialism and 'race' stem from a period of biological racism prevalent during the colonial period. The ideological notion of 'race' has thus become firmly embedded in British political culture (Miles, 1994), despite the fact that theories of biological racism are now recognised as social constructions with no biological or scientific basis (Smith, 1989; Brah, 1993). This term is not used in other European countries, particularly after the atrocities committed during World War 2, but Gilroy (1987) argues that the role of 'race' as a categorisation has an explicitly political role in Britain, as the concept has evolved as a locus for black resistance, as a positive signifier of black identity and of the experience of shared oppression and migration. Smith argues that 'race' can therefore be considered a valid category of analysis, not in an explanatory sense, but due to its role as 'a powerful social myth, with far-reaching human consequences' (Smith, 1989:11).

The association between discourses of 'race' and 'blackness' is clearly evident in Britain. Britain's particular colonial ties have resulted in the term 'black' as a descriptor of particular migrant groups and their offspring, which has now been incorporated into the official census (1991), though this does not allow individuals within ethnic groups to be distinguished as first, second or third generation migrants, or by nationality, but rather, by a common historical origin in another region. However, the use of the term 'black' cannot be universalised throughout Europe, where migrants have different histories and ethnic origins. These terms would, be obsolete in other countries where migrations have originated from regions such as Southern Europe and the Arab world, and where a colonial history is absent. Discourses centring around 'race' and 'blackness' would have little meaning or significance in countries such as Germany, where no significant colonial ties have been involved in the migration process, and where the concept of 'race' is considered an outdated expression of biological racism, bearing uncomfortable associations with fascism and the Nazi regime during the 1930s (Miles, 1994). Similarly, the Nordic countries would be puzzled by this discourse, for the same reasons.

### **France**

France, which also has a history of colonial migration, has been less concerned with any discourse of 'race' and more with culture and religion. The French state has been conceived as an essentially political, and not a specifically cultural entity (Brubaker, 1990), where political unity, and not shared culture constitutes nationhood, which can incorporate 'others' with relative ease. Birth and residence therefore confer rights of citizenship, which is defined expansively, though in an assimilatory capacity (Bovenkerk et al, 1990). Terminology describing new migrants has focused on exclusionary terms such as *immigrés* and *étrangers* and conflict has resulted over the perceived 'unassimilability' of new migrants (Bovenkerk et al, 1990).

### **The Netherlands**

In the Netherlands, the term 'immigrant' has been considered inappropriate and has not been used by the authorities. Discourses were phrased in terms of 'ethnic minorities' at an early stage, partly due to the relatively long history of colonial migration (Bovenkerk et al, 1990; Miles, 1994), but also to the fact that the concept of minority groups has been relatively easy to incorporate into Dutch society due to pre-existing 'pillarization'. Various sections of Dutch society (based on religion) have already established the right to organise and developed their own separate institutions, and Dutch society has already evolved within a

‘living-apart-together’ framework, where differences have become inherent to the national identity (Doomernik, 1995:54). As in France, citizenship rights are based on principle of *jus soli*, and Dutch citizenship is conferred on all who have a Dutch parent, regardless of where they are born, and can be obtained relatively easily after five years residence (Bryant, 1997). Concerns in the Netherlands have focused on the ‘social undesirability’ of migrants (Bovenkerk et al, 1990), and the perceived threat of Islamic fundamentalism (Van Amersfoort, 1993).

## **Germany**

Other European nation states have no colonial histories and therefore no associated post-colonial migrations. Post World War 2 labour migrants were therefore related to other types of linkages. In Germany, these linkages were based on bilateral government agreements, where labour was exported from countries such as Turkey, to fill labour shortages in Germany. The ways in which the German nation has historically been conceived have been very influential in the development of immigration policies. Brubaker (1990) argues that Germany is regarded as a community of descent independent of the state, and that the nation was conceptualised as an organic entity before Germany was unified as a spatial entity. The idea of a German nation is therefore not a political one, but is imagined as a *Volk*-centred ethnocultural unity. Access to German citizenship is therefore based upon biological descent (*jus sanguinis*), which allows ethnic Germans in Eastern Europe (*aussiedler*) automatic citizenship rights, even though they may have no knowledge of the German language and culture, while second and third generation Turkish migrants born and educated in Germany have great difficulty obtaining German citizenship. Germany therefore constitutes a community of descent, not confined by territorial boundaries (Bryant, 1997), a factor reinforced by the myth that Germany is not a country of immigration. The connection ‘foreign workers’ have with Germany is therefore highly ambivalent, with liberal admission policies, and a relatively relaxed asylum policy, but denial of citizenship rights (King, 1995). German integration policies have effectively meant that *gastarbeiter* (a term signifying a temporary stay) and refugees have had to integrate as ‘foreigners’ with diminished status in society. As a result, in ordinary German usage, the exclusionary term *ausländer* (foreigner) is the much-used official definition of long-term residents (including second and third generation migrants) in Germany who are not of German ethnic descent (Rittstieg, 1994). These factors are reflected in official health data categories, which crudely divide the country’s inhabitants into two categories, ‘Germans’ and ‘migrants’. There is minimal breakdown by nationality status, or differentiation by migrant origin.

## Sweden and Denmark

Sweden, Denmark and Norway have no colonial migration ties, though they have indirectly absorbed racist theories from the colonial period in Europe (Salimi, 1991). Post-war labour migration to these countries was primarily from Europe's southern and eastern peripheries, rendering the British discourse of 'race' and 'blackness' redundant. However, even among the Nordic countries, political factors have been quite different. The way migrant workers were viewed in Denmark is a close reflection of the German situation, where a perceived culturally homogenous national identity has provided fertile territory for the development of cultural racism. This has led to the use of terms such as *gæstearbejder* (borrowed directly from German and implying a temporary stay) and *fremmede* (strangers), as descriptors of externalised 'others'. Labour migration was considered a temporary phenomenon, and migrants were never expected to become part of the fabric of the Danish nation. However, in direct contrast to the German situation, Danish citizenship is granted fairly easily after seven years residence.

Swedish policy has been very different, and despite the absence of colonial linkages, early labour migrants were encouraged to settle permanently and become part of Swedish society, a policy prompted by a very active trade union movement. This process was facilitated by easy access to Swedish citizenship, and comprehensive integration policies. Sweden adopted various multicultural policies at a relatively early stage, and the state has been very active in promoting integration and health facilities for migrants.

Both Denmark and Sweden have primarily received migrants (both labour migrants and refugees) from Muslim-majority countries. Immigration has therefore been perceived specifically in religious and cultural terms, and racist discourses have been specifically 'anti-Muslim' (Pred, 1998; Wren, 2001). The relative lateness of labour migration, particularly in Denmark, has resulted in its unfortunate coincidence with economic recession during the 1970s and 1980s. It has been all too easy to associate deteriorating economic conditions with the presence of labour migrants and refugees, whose arrival during the 1980s was facilitated by relatively liberal entry policies. Active refugee dispersal policies during the 1980s in both countries, along with media provocation, brought the refugee issue to the top of the political agenda, resulting in considerable anti-refugee hostility at that time. Refugees were constructed as a 'burden' to society at a time when unemployment levels were very high, and these negative stereotypes have had the unfortunate consequence of fostering fairly severe labour market discrimination, rendering many highly skilled refugees as permanent welfare clients (Schierup, 1993; Wren, 1999).

## *Integration*

Considerable literature exists on integration of immigrants in Europe, but this concept is rather vague, and open to interpretation depending on the country in which it is used (Salt et al., 1996). In the UK the term has evolved from concepts of community, in France and Denmark, from assimilation, and in the Netherlands and Sweden, multiculturalism. It is notable that integration research often focuses on issues of public concern, and these may be issues which are conceptualised from an anti-immigration stance (Salt et al., 1996). During the 1970s and early 1980s, integration research tended to focus on issues such as labour market participation, employment rights, and housing. The focus within the social sciences has now moved towards a more political view of integration, tackling issues such as citizenship rights, political participation and racism. A recent meeting by the *Refugee Employment Working Group* established that among refugees, the key to integration was considered to be employment, which provides economic independence, self esteem, and the ability for refugees to make a contribution to their host societies (Refugee Employment Working Group, 1999), an observation supported by earlier findings (ECRE Task Force, 1999). Given the structural changes in Western European economies related to the increase in informal and marginal employment, Salt et al. (1996) argue that labour market integration is likely to become more problematic in the future. Due to differences in the way integration is conceptualised in different European nation states, and to differing political agendas, there is a distinct lack of truly cross-national work on the topic.

## *Migration and employment*

Most migrant groups in Western Europe experience social and economic marginalisation, and immigrants and their descendants tend to be over-represented in lower paid and less skilled employment sectors, and in unemployment statistics. It is non-European migrants who suffer the highest levels of unemployment. Ethnic minorities face a difficult labour market situation due to the changing nature of employment in the EU. Industrial employment has declined, the service sector has grown, and the casualisation of labour means that different types of skills are required (Expert Meeting on Refugee Employment, 1999). The relationship between political migration and downward social mobility has been well documented (Al-Rasheed, 1992; pers.com., Ekblad; pers.com. Scottish Refugee Council; Wren, 1999). The findings of the *Refugee Employment Survey 1998*, showed that 70% of respondents believed refugees

suffered downward social mobility. Often, political migration is perceived as temporary, reducing the impetus to invest in long-term career and economic possibilities, but many refugees who do invest effort in re-establishing their careers are thwarted by non-recognition of their qualifications, and face extreme difficulty. Deskilling has become almost inherent to being a skilled political migrant in Western Europe.

In Italy, a recent study demonstrated the extent to which skilled refugees are forced, along with other immigrants, into low paid, and potentially physically demanding illegal employment (European Network on Integration of Refugees, 1998), a situation mirrored in other Southern European countries, where refugees are not entitled to welfare benefits (ECRE Task Force, 1999). However, there is significant evidence that the situation in Denmark and Sweden is particularly severe, an argument supported by the fact that these countries have the highest levels of ethnic minority unemployment in Europe (Hjarnø, 1991; Schierup, 1992; Pred, 1998; Ekberg and Ohlson, 2000). The language barrier is particularly problematic in these countries, as it takes many years to become fluent in a completely new language. Often, during this period of learning new language skills, new developments within particular professions can result in a further deskilling process. However, studies among first and second generation migrants which control for factors such as language proficiency and place of residence suggest that labour market discrimination is a major contributory factor (Just Jeppesen, 1989; Ekberg, 1997; Knocke, 2000). Similarly, refugees themselves regarded discrimination to be a major barrier to employment at a recent meeting of the Refugee Employment Working Group (Refugee Employment Working Group, 1999; Expert Meeting on Refugee Employment, 1999).

Contrary to popular conceptions, political migrants are often highly skilled (Al-Rasheed, 1992; Busby et al, 1998; Knocke, 2000). Al-Rasheed (1992) argues that many Iraqi political migrants are lawyers, journalists, artists and writers, the type of occupations where it is possible to express political opinions. It is this expression which has subsequently led to their flight. The skills acquired in these professions are often ill-adapted to a life in exile, as they are not easily transferable. However, Berlin et al, (1997) note the disproportionate number of doctors among refugees, and the wasted human potential involved in their deskilling and welfare dependency. Refugees have in the past made important contributions to medicine and science in Britain (CRE, 1996), and clearly, it makes moral and economic sense to use their skills more effectively. Refugee doctors, and other professionals have suffered from the negative and destructive stereotyping in the media in many countries, but could potentially be viewed as a valuable resource. It costs about £200,000 to train a doctor in Britain (Medical Workforce Standing Advisory Committee, 1997), while refugee doctors can retrain for much less. This is particularly important at a time where many



countries are experiencing a skills shortage, and future indications suggest a continuing shortage of doctors during the next decade.

The implications of deskilling among refugees include low levels of labour market participation and welfare dependency, which can create long-term social exclusion and poverty, factors generally associated with poor mental and physical health. This is in addition to prior experiences of trauma and loss, which affect many refugees. It has been argued by representatives at refugee councils in Britain, that a useful approach to tackling refugee welfare would be the integration of employment retraining and health care provision within the same programmes. They observed that often, poor mental health constituted a significant barrier to effective retraining and employment, despite targeted measures within the retraining area.

### *Ethnicity and health research*

Much health research has focused on health differences among different immigrant or ethnic groups. The category of 'ethnicity' is increasingly being used in health research, particularly in Britain, but mainly as a descriptive variable. Comparative research on the prevalence of particular diseases among specific ethnic groups in Britain has tended to emphasise the health differences in a discriminatory way, demonstrated by the focus on negative health characteristics of ethnic minorities (Littlewood and Lipsedge, 1989; Sheldon and Parker, 1992). This is a trend which goes hand in hand with discourses which problematise ethnic minorities in most European countries (Grillo, 1985; Salimi 1991; Jackson and Penrose, 1993; Wren, 1999). Littlewood and Lipsedge (1989) further argue that there are few studies of positive characteristics of minority ethnic groups, such as low rates of suicide and alcoholism among West Indians in Britain. Mental Health research has been particularly problematic, where higher rates of mental illness are frequently reported among minority ethnic groups (Littlewood and Lipsedge, 1981, 1989). A range of studies examining the relationships between mental illness and ethnic origin have produced highly contradictory findings, suggesting that there may be some conceptual flaws in the way such studies are carried out.

Before examining these studies it would be useful to consider an emerging debate around the use of ethnicity as a category in epidemiological research. Bhopal and Senior (1994) identify some very specific fundamental problems with the use of ethnicity as an epidemiological variable, not least that there are no agreed criteria by which ethnicity is measured as there are with other variables such as social class. They argue that ethnic boundaries are fluid and in a constant state of reworking, a situation demonstrated by proposed changes in the 2001

British census classifications. This effectively renders the use of this category less than scientific. Moreover, they are concerned about lack of clarity of the purpose of using the ethnicity category. This is important when first second and third generation migrants are all recorded as members of the same ethnic group. They also express concerns over perceived ethnocentricity in formulation of research topics and the use and interpretation of data, primarily the use of the 'white' population as a standard by which to measure others. This results in emphasis on diseases more prevalent among minority ethnic groups, while ignoring diseases prevalent among all ethnic groups which also kill many among the ethnic minorities. Sheldon and Parker (1992) also express concern over the relatively poor consistency in terminology, and believe that explanation for variations in health outcomes may lie in the values of researcher rather than any genetic or environmental factors. They therefore recommend great thought and care in the use of such categories, as an unquestioning approach to their use can reinforce pre-existing discriminatory stereotypes. This is particularly important where cross-national research is to be undertaken using categories which vary from country to country.

### **Socio-economic links to health**

There has been much discussion about links between low socio-economic status and disease, but it is generally agreed that a strong causal link exists (Townsend et al., 1988; Macintyre, 1986). These findings are corroborated by: findings in a Glasgow study of South Asians (Ecob and Williams, 1991); a Bristol black and ethnic minority health survey (Fenton et al., 1995); and a Swedish study of the relationship between socio-economic status and suicide (FerradaNoli and Asberg, 1997). As minority ethnic groups are over-represented in semi and unskilled occupational groups Fenton et al (1995) argue that it is to be expected that their health would be poorer. Health differences between ethnic groups are therefore likely to be very closely related to relative social disadvantage rather than factors inherent to ethnicity. This trend is not directly related to any specific occupational hazards, but to general poverty and disadvantage. However, it should also be noted that in general, the relative social disadvantage suffered by the ethnic minorities renders them more likely to work in hazardous occupations, which increases susceptibility to specific occupational hazards involving pollutants or accidents (Lee and Wrench, 1980). For these reasons, the use of ethnicity as an epidemiological variable independent from its social context may appear to reveal causal factors which are not relevant. It is therefore argued that health researchers should try to understand these limitations and formulate their research within its socio-economic context, rather than using ethnicity as a free-

standing variable (Sheldon and Parker, 1992; Bhopal and Senior, 1994; Fenton et al., 1995; Navarro, 1989).

## *Migration and health*

Studies examining the health of non-western immigrants in Europe have showed varied results. Comprehensive surveys examining the living conditions (including health) of immigrants were carried out in Denmark, Sweden and Norway in 1996, but produced contradictory results. Contrary to expected findings, the Norwegian survey found that the prevalence of chronic disease was higher among Norwegians than among immigrants (Blom, 1999), however, it was found that when immigrants first became ill, they were affected more severely than Norwegians, and that the illness had greater impact on their levels of activity (Blom and Ramm, 1998). Age was also much more important, as immigrants were found to be more prone to illness as they grew older, specifically those above the age of 45 (Blom and Ramm, 1998; Blom, 1998). This may have longer term policy implications, as the present cohort of immigrants ages. However, age on arrival appeared to be the most significant factor, the older migrants were on arrival, the greater the risk of long-term illness (Blom and Ramm, 1998). This study confirms an earlier health study based in Oslo, where it was demonstrated that selected refugee and immigrant groups do not have poorer health than Norwegians (Hagen et al., 1994). Though the study does identify specific groups (Turks, Iranians and Chileans) as having poorer reported health problems than the native population, the Sri Lankans and Somalis in the survey had much better health (Blom, 1998). Within this picture, there are variations, such as higher levels of mental health problems among immigrants, and significant differences in health between male and female immigrants, differences which do not exist in the Norwegian population (Blom and Ramm, 1998; Blom, 1998). If, as this survey suggests, age is a significant factor, then Norway, along with other European countries, will face a major public health issue later this century when the numbers of elderly among ethnic minority groups will increase (Rait, Burns and Chew, 1996). The aged have specific health needs, and when coupled with racism and socio-economic disadvantage, this will pose a 'triple challenge' to health care providers (Norman, 1985).

These results are somewhat contradictory with Swedish studies, which show that non-western immigrants have poorer health than the Swedish population (Leiniö, 1995; Socialstyrelsen, 1998). The 1996 study (comparing the health of ten immigrant groups) found the largest number of health problems among Finns and Yugoslavs (former labour migrants) and then Chileans and Iranians, who also had greater health problems than Swedes (Socialstyrelsen, 1995). Contrary

to the Norwegian study, age-related health is not significantly different between immigrants and Swedes (Ekblad et al., 1999). As in Norway, the study showed that immigrants suffer more from mental health problems than Swedes (Socialstyrelsen, 1998). In addition, Swedish register data shows that immigrants have more sick leave than Swedes (Kindlund, 1996).

Similar research in Denmark showed that immigrants' health was not significantly different from that of Danes (Viby Mogensen, 2000). However, within this broad picture, again, there are significant differences in the health profiles of the immigrant and the Danish populations. Immigrants suffer higher rates of infectious diseases, while Danes suffer higher levels of psychiatric illnesses and cancer. Immigrants have higher rates of hospitalisation for medical complaints in general, suggesting that use of the criterion of self-perceived health in the survey may have resulted in an underestimation of the significance of health problems among the immigrant population (Ingerslev, 2000).

Unfortunately, these studies have not been directly linked to socio-economic status, so it is not possible to determine the role that poverty and disadvantage may have played in generating differential health outcomes. However, it is interesting to note that in two Scandinavian countries (Denmark and Norway), where comprehensive welfare provision has reduced social inequalities over half a century, the health profiles of one of the most disadvantaged groups in their societies does not differ significantly from the rest of society. This may in fact support the hypothesis that there is a strong relationship between socio-economic factors and health, and it is the absence of severe poverty which has led to the absence of significant differences in health outcomes. As this is not the case in Sweden, a more likely alternative hypothesis could be that self-reported illness rates and use of health services are lower among immigrants, masking a significantly poorer health profile.

### **Migration and mental health**

As stated, much of the literature on minority health problems (particularly in Britain) has concentrated on specific health problems which affect minority groups, such as tuberculosis, nutritional deficiency diseases, sickle cell or psychiatric problems, and rarely on the more common causes of mortality among minority ethnic groups (Sheldon and Parker, 1992; Smaje, 1995; Fenton et al, 1995). However, perhaps the most contentious and hotly debated issue has been in the field of psychiatry in Britain. The role of scientific racism in psychiatry in the past, not only in Britain, but throughout Europe, has been well established, and Fernando (1988) argues that this influence persists to the present day.

Various studies show higher levels of mental illness among migrant communities than among native-born, or among the same communities in their

countries of origin, and most studies also indicate higher levels of stress among first-generation migrants. However, surveys intended to clarify the mental health profiles of minority ethnic groups have shown highly contradictory findings. Littlewood and Lipsedge (1981) found rates of schizophrenia among Afro-Caribbeans resident in Britain three times higher than among the British-born population, while an extended study of schizophrenia among this group showed very high levels among both first and second generation migrants (Harrison et al, 1988). Thomas et al (1993) found that second-generation Afro-Caribbeans were nine times more likely than the white population to be diagnosed as schizophrenic. Ineichen (1989) also reports high rates of schizophrenia among South Asians in Britain. Cochrane and Bal (1989) also found a higher incidence psychosis among blacks with origins in the Caribbean, but, significantly, Cochrane (1977) found *lower* rates of psychiatric admissions for Indians and Pakistanis than for whites when age and gender adjustments were made. King et al, (1994) found higher levels of mental health problems among all ethnic minority groups, and argue that the current focus on Afro-Caribbeans is misleading. However, the most substantial population-based study of mental illness among ethnic minorities in Britain to date shows, that contrary to earlier findings, the Afro-Caribbean population suffer similar rates of psychosis to whites, and that adults of South Asian (Bangladeshi) origin suffer *lower* rates of depression. First generation South Asian migrants have relatively good mental health, while that of the second generation is poorer, the inverse being the case for Afro-Caribbeans. Also, surprisingly, South Asian migrants with *poor* knowledge of English suffered *lower* rates of mental illness, while those with a good knowledge of English suffered similar rates to the white population (Berthoud and Nazroo, 1997). However, this may be related to their first or second generation status, or age at migration (Berthoud and Nazroo, 1997). These striking anomalies demonstrate some of the problems of generalising by ethnic group.

Although the links between mental illness and ethnicity constitute contested terrain, there is a consistently high recorded incidence of schizophrenia among Afro-Caribbeans in Britain which runs through most of the studies. King et al (1994) discuss consistent finding in several countries where migrants in any group are found to be more susceptible to mental illness, a trend which corresponds with higher levels of mental illness among the foreign-born population in Norway (Blom and Ramm, 1998; Blom, 1998), and in Sweden (Socialstyrelsen, 1998; Sundquist et al., 2000). Swedish women have been found to suffer more than men, particularly if they have no family networks in Sweden (Socialstyrelsen, 1998). Ineichen (1989) regards it unlikely that there is one single cause, but argues that multiple interacting causes are more likely. Some have argued in favour of a genetic link, and others that people at risk of mental

illness are more likely to migrate (Berthoud and Nazroo, 1997; Carpenter and Brockington, 1980), but most arguments view the socio-economic context as most significant (Smaje, 1995). Westwood (1994) argues that rates of schizophrenia are generally higher in inner cities where ethnic minority groups tend to be concentrated, indicating a strong link between poor mental health and socio-economic disadvantage. Other relevant factors to consider are that second generation British-born Afro-Caribbeans have now reached young adulthood, when schizophrenia most commonly manifests, which may account for an apparent excess.

Recent attention has turned to racism as an explanatory factor (Littlewood and Lipsedge, 1988), as it has been established that Afro-Caribbeans in general, face a much higher risk of involuntary hospitalisation than the white population (Littlewood and Lipsedge, 1989; Ineichen, 1986; Davies et al., 1996). It is also known that Afro-Caribbeans have a greater chance than whites of being diagnosed as schizophrenic, despite presenting the same symptoms as white patients (Sheldon and Parker, 1992; King et al, 1994). There has recently been a significant shift in discourse initiated by black and Asian psychiatrists (Westwood, 1994), towards recognition of these factors. Sheldon and Parker (1992) argue that racism should be incorporated as a risk factor in mental illness rather than ethnicity, as it constitutes an important element in the causal process. However, Lewis et al. (1990) argue that this factor alone cannot explain the over diagnosis of schizophrenia. Clearly, however, as it is very difficult to define the precise interrelationships between race, culture, ethnicity, social class and migration, the methodologies of epidemiological studies can be highly problematic and may affect results. These factors should certainly be borne in mind when analysing results.

Racism can be relevant both in the diagnosis of mental illness but also in its role as a pathogenic stressor which may precipitate mental illness (Fernando, 1986). Mirdal (1984) and Ekblad et al. (1999) argue that the migration experience itself can act as a stressor, with negative health consequences for some groups, particularly refugees, who may have moved under traumatic conditions. Ekblad et al. (1999) describe migration as a psycho-social crisis with major psychological repercussions for many migrants and their families. Further, migration can lead to deep loneliness (Westwood, 1994), and additional stressors of racism and cultural change can contribute to negative mental health outcomes. However, these factors do not fully account for the apparently high levels of illness among second generation migrants.

The way mental health problems are treated by western psychiatrists can also be problematic. Due to the absence of relevant cross-cultural psychiatric care in many places, sufferers are provided with medication which merely masks the problems without dealing with the underlying issues. This is a particular problem

for dispersed refugees in the UK, where adequate cross-cultural health care is not provided (pers. com. Scottish Refugee Council). Alternatively, treatment may be in the form of psychoanalysis, which, anthropologists argue, is imbued with core western, middle class cultural values (Kleinman, 1988), focusing on the individual, and not on the societal or community context in which people live. More traditional forms healing tend to focus more on the social context of the sufferer, demonstrating the differences between western egocentric culture and non-western socio-centric cultures (Helman, 2000). These factors demonstrate the value of viewing disease and illness in a much more holistic sense than is currently the case within western medicine, which tends to classify disease by categories or regions of the body. As somatization demonstrates, there may be strong linkages between mental and physical symptoms, indeed Chinese medicine (and other alternative health systems used in the west) regards somatic complaints as the primary illness problem, even in the presence of obvious physiological symptoms (Kleinman, 1980). For these reasons, it is essential that migrant communities have access to cross-cultural health care, if their needs are to be catered for adequately. Such services are fairly well-developed within Denmark and Sweden, but clearly inadequate in other European countries. Similarly, the categorisation of specific diseases in health surveys ignores the complexity of their often culture-bound manifestations, and for these reasons, crude health data sets may give a distorted or unrepresentative health profile of some migrant groups.

### **Refugees and health**

Littlewood and Lipsedge (1989) offer no clear explanation for differential rates of mental illness between ethnic groups, but refugees clearly suffer higher rates of mental illness, while lower rates are observed among migrant groups such as South Asians in Britain, perhaps due to family and social networks. Similarly, in Sweden, refugees suffer from poorer general health than Swedes (Sundquist, 1995; Sundquist et al, 1998). A recent study in Italy showed that typically, refugees did not suffer significant health problems prior to flight, and that it was only *after* migration that a drastic decline in health was experienced. The most common health problems were psychological, followed by stomach problems (closely related to anxiety and stress) (European Network on Integration of Refugees, 1998). Migration can be considered as a major traumatic event, and where migration is long-distance, many assumptions about the world are no longer valid after migration (Helman, 2000). Where migration is involuntary, communication and language problems, coupled with racism and unemployment can create *cultural bereavement* (Eisenbruch, 1988), which carries similar

symptoms to grief. In this sense, migration can be considered pathogenic (Bayard-Burfield et al., 2000):

“We must never forget that for the refugee, exile is like a small death which cancels out his previous life. The experience of mourning, which is in itself a demanding process, becomes difficult when one is alone and the outlook is all too shadowy and uncertain.” (European Network on the Integration of Refugees, 1998)

#### *Post traumatic stress disorder*

A new and urgent health problem Post Traumatic Stress Disorder (PTSD), has been highlighted by (Ekblad et al., 1999), and is particularly prevalent among refugees, many of whom suffer from PTSD after war, victimisation and torture (Apitzsch and Ramoskruggiero, 1994). Recent epidemiological studies have revealed that the psychiatric morbidity associated with mass violence in civilian and refugee populations is elevated when compared with non-traumatised communities (deGirolamo and McFarlane, 1996). According to Jablensky et al. (1994), the most common symptoms and signs that appear in refugees across different cultures include: anxiety disorders (i.e. high levels of fear, tension, irritability and panic), depressive disorders (i.e. sadness, withdrawal, apathy, guilt, and irritability), suicidal feelings and attempts, anger, aggression and violent behaviour (which often finds expression in acts of spouse and child abuse), drug and alcohol abuse. The psychiatric diagnosis most frequently identified in most cultures is post traumatic stress disorder (PTSD) (Jaranson, Forbes-Martin and Ekblad, 2001). However, despite an increase in knowledge about the mental health problems and methods of intervention, the magnitude of the problems are not known. The international literature (Breslau et al, 1998) have identified several demographic risk factors for development of PTSD. Lifetime prevalence rates of PTSD are twice as high for women as for men (10.4% vs 5%) and women are four times more likely to develop PTSD when exposed to the same trauma. This is consistent in a Swedish study (SOU, 1998). Breslau et al (1999) found that the higher risk for PTSD in women is primarily due to a special vulnerability to assault and violence and which may be more threatening and injurious to women, most perpetrators being men and therefore performing greater strength physically. Gender differences in response to treatment have not been studied systematically (Foa, Keane and Friedman, 2000). Recent epidemiological evidence indicates that PTSD can be identified across cultures, but it occurs in only a minority of persons exposed to mass conflict, with prevalence rates varying between 4 and 20 % (Silove, 1999) Silove et al. (2000), in a review of risk factors for PTSD, showed that a history of prior



exposure to trauma or to chronic environmental stress is an extremely potent risk factor for PTSD, particular if it is experienced at a young age.

Social factors may also influence risk such as a history of family instability, while good social support is associated with lower levels of symptoms. Lower levels of education and income and being divorced or widowed are also risk factors for PTSD. Breslau et al (1998) have shown that several demographic factors influence the risk of trauma exposure, besides gender including age and socio-economic status as well as ethnicity. Prospective studies reveal that psychological distress usually declines with time in the host country (Ekblad, Belkic and Eriksson, 1996).

The condition appears to be increasing in frequency as low-intensity wars which are more likely to affect civilians, become more common. The recognition and successful treatment of PTSD is crucially important, as it can act as a significant barrier to successful retraining and employment, particularly in the early stages of refugee resettlement. Relevant therapy can be of great value to sufferers in their attempts to regain autonomy and control over their lives.

### *Work-related accidents*

International studies have shown that ethnicity is a significant risk factor for work-related accidents, and Ekblad et al. (1999) report that in Sweden, immigrants are generally over-represented in accident statistics. It is likely that socio-economic factors are more important, given the fact that accident-related deaths are significantly more common among unskilled workers than among middle and high range service sector workers, and that immigrants are generally over-represented in unskilled occupations. Contrary to much of the literature on work-related health problems, a recent study in Norway showed no significant differences in the levels of accidents between immigrants and native Norwegians (Blom and Ramm, 1998, Blom, 1998). Some studies of work-related accidents have been criticised for their lack of attention to confounding factors such a age, skill, and experience, and the fact that ethnic minorities are often concentrated in more risky occupations. It has also been demonstrated in Britain that accident statistics can be distorted by low usage rates of occupational health services (Lee and Wrench, 1980). This type of work-related health issue is relatively easy for researchers to approach, assuming that confounding variables such as socio-economic status are considered fully. Data sources are unambiguous and easily available from occupational health services.

## *Access to health care*

Unequal access to health care has been suggested as one of the major determinants of immigrant health outcomes. It has been argued that in Britain, health services are not always culturally sensitive and do not provide satisfactory levels of care for some minority groups (Smaje and LeGand, 1997; Curtis and Lawson, 2000), a criticism which has been echoed in other European countries. For this, and other reasons, it has been noted that some minority groups do not utilise health care facilities to the same extent as the majority population (Löfvander, 1997; Bollini and Siem, 1995). While this may result in poorer health outcomes, there may be other methods of promoting health among minority ethnic groups. Johnson (1998) argues that migrant and refugee groups often develop their own social networks and alternative health care provision. Western medicine cannot be considered as a universal health care model when even significant numbers of Europeans consult various types of alternative practitioners on a regular basis, and migrant communities in particular, often have well established alternatives. Phaobtong (1992) discusses the important role of indigenous Buddhist healers for South East Asian refugees in the United States, and it is likely that similar functions carried out by other 'community healers' are underestimated. For these reasons, it is not always appropriate to view health care data as accurate indicators of ill-health among minority groups. However, where such alternatives are absent, particularly among forced migrants who are not part of settled ethnic communities, or who have been dispersed away from urban centres where relevant support facilities are found, unequal access to health care can have serious health repercussions.

## *Residential concentration and health*

Smaje (1995b) argues that despite the obvious concentration of housing disadvantage, ethnic concentration may have beneficial health effects, as it allows more community integration, which can partially offset material disadvantage. Although Ecob and Williams (1991) reported poorer health in areas of high density South Asian settlement in Glasgow, the international literature generally shows an inverse, independent relationship between ethnic residential concentration and mental illness (Smaje, 1995b). There are various reasons for this including: protection from the stressors of racism and discrimination (Smaje, 1995b); social support (Dressler, 1988); political mobilisation; and enhanced material opportunities. Community integration is associated with health and well-being generally, as demonstrated by Beckert and Lønnoth (1987) in Denmark. These factors are particularly relevant for refugees,

who are often compulsorily dispersed. In some cases, support services may be provided (as in Denmark and Sweden), although often, these cannot adequately replace the function of informal ethnic networks. In other cases (such as the UK), support services for dispersed refugees are minimal, resulting in secondary migration to more central areas (Robinson and Hale, 1989; Bright and Ahmed, 2001).

## *Illness and Culture*

Unequal utilisation of health care can also be based on cultural perceptions of illness. If medical practitioners are not culturally sensitive, then their treatments will be of limited value, and their usage rates by some ethnic groups may be low. Where patients and health professionals have very different cultural backgrounds, there can be major problems not only with the diagnosis and treatment of illness, but also the subsequent classification of disease in health records, particularly where mental illness is concerned. Cultural factors can determine the ways in which mental illness is diagnosed and treated, and social definitions of 'normality' and 'abnormality' can vary considerably by culture. Helman (2000) therefore argues that 'normal' behaviour should be a more fluid concept. Similarly, pain is not culture free, and the ways in which people respond to pain and the degree to which they report it to health professionals can be influenced by their social and cultural backgrounds. In some cultures, open displays of emotional distress are not encouraged, and emotional problems can be expressed in the somatic and physical language of distress, manifesting in physical symptoms such as vague aches and pains or breathlessness (Helman, 2000). Some cultures, such as the Chinese, define such somatic complaints as the primary illness problem, even in the presence of obvious physiological symptoms (Kleinman, 1980). It is also questionable whether the particular psychoses present in western society are universal and trans-cultural, as they may be shaped by cultural pressures and conditioning. These are issues which complicate both the classification of disease, and its treatment.

### **Cross cultural psychiatry**

There are three major approaches to the perception of mental illness across cultures:

- A biological approach
- A social labelling approach
- A combined approach

### *Biological approach*

This relies on diagnostic categories which are based on the western psychiatric model, and rests on the assumption that mental disorders can be universalised across cultures because they have a biological basis. Disorders such as schizophrenia are therefore fixed by biology, but secondary features such as delusions may be influenced by cultural factors. This approach has been criticised for being ethnocentric, giving primacy to western models.

### *Social labelling approach*

This perspective sees mental illness as a myth, and does not acknowledge that there are always clear biological symptoms. It is society which defines deviant behaviour, so mental illness can only be defined relative to the society in which it is found, and therefore cannot be said to have a universal existence. Definition of mental illness is thus culture-specific and cannot be universalised across cultures. This perspective therefore regards mental illness as a social construction, which only exists by virtue of the society which defines it.

### *Combined approach*

This perspectives includes elements of both of the above. It acknowledges certain universal manifestations of abnormal behaviour which can be found throughout the world, but asserts that these manifestations are given different labels in different cultures.

Clearly then, diagnosis of mental illness can vary significantly by culture, and this should be taken into consideration when dealing with migration and mental illness. However, even western psychiatry is not internally consistent in the way it diagnoses mental illness, and diagnoses may vary considerably between and within countries. For this reason, cross-national comparisons should be interpreted with caution. Kendell (1975) argues that diagnosis is a very subjective process, which is also open to individual doctors' social, ethnic, religious and cultural backgrounds. Political and moral factors may also be involved in defining so-called deviant behaviour. In a study of mental illness among immigrants in the UK, Littlewood and Lipsedge (1989) suggest that psychiatry, which often misinterprets the religious and other behaviour of Afro-Caribbean patients, can sometimes be used as a form of social control, resulting in the high diagnosis rate discussed earlier.

### *Somatization*

Somatization should also be considered when researching migration and mental health. Somatization is a process where psychological disorders are patterned into a language of distress, that is, a set of physical symptoms, which are often culturally determined. This is particularly relevant with illnesses such as depression, where sufferers may complain of a variety of diffuse physical symptoms such as tiredness, headaches, vague aches and pains, or dizziness. Kleinman (1980) argues that different cultures and social classes have different symptoms of depression, which is more frequently expressed as physical pain among lower socio-economic groups, and as psychological symptoms among middle class professionals. Further, Hussein and Gomersall (1978) have demonstrated how depression among Asian immigrants in the UK often manifests in somatic form.

### *Cultural somatization*

Somatization manifests among some specific cultural groups through the selection of specific organs, which become the focus of symptoms. The organ selected often has some sort of symbolic significance for the ethnic group, and through somatization, they embody some of the values central to their culture (Csordas, 1990). This process is dependent on various factors such as language, concepts of health and illness and culturally sanctioned illness behaviour (Mumford, 1993). Cultural somatization can be linked with wider, culture-bound psychological disorders, where some illnesses may be unique to specific groups or culture areas. Often, the symptoms may have wider social or moral significance, and even perceived links with supernatural forces. As Helman (2000:186) argues, often they constitute a method of resolving social conflicts in a specific 'culturally patterned' way. Helman quotes various examples including voodoo in the Caribbean and amok (violent attacks) affecting Malaysian males. Culturally specific disorders also exist in western societies, including anorexia nervosa, exhibitionism or agoraphobia (Littlewood and Lipsedge, 1989). All are culture-bound because they embody some core western cultural themes. More recent syndromes which have emerged include: road rage, workaholism and myalgic encephalopathy (ME). Many of these illnesses have proven physical bases, but nevertheless embody strong social metaphors and are seen as product of perverse aspects of the societies in which they appear. Culture-bound disorders must therefore be viewed within the wider social, political and gender context within which they occur.

## *Methodological problems*

The literature has identified many issues which could potentially complicate cross-national research in work-related health problems:

### **Mobility**

Increasing levels of mobility create problems for thorough epidemiological research. Problems exist both in terms of spatial and temporal differences, which are not easy to represent accurately within data sources. Longitudinal studies can partially overcome some of these issues, but some health problems may have evolved before migration, others may exist as a result of work after migration, perhaps even with multiple exposure. Migration itself may also contribute to ill-health. These are difficult methodological issues which must be dealt with in any study of migration-related health problems. Schærström (1999) also highlights how, in addition to the complications of high mobility levels, long disease latency periods and environmental change further complicate the picture. He has attempted to deal with this complexity in a doctoral thesis which uses time-geography as a methodological framework (Schærström, 1996).

### **Diagnostic anomalies**

Helman (2000) highlights the problem of discrepancies in medical diagnoses between European countries, an issue demonstrated by Van Os et al. (1993), who found very significant differences in the incidence of schizophrenia in France and Britain, which they believe can be attributed to diagnostic biases. Another larger study based on observations in five European countries found major differences in the diagnostic rates for a range of diseases, though it was not clear whether this reflected a greater incidence of this disease in some countries, or differences in diagnosis (O'Brien, 1984).

### **Classification of disease**

The use of statistical data to classify diseases into categories can often be misleading. A holistic view of health would consider the interconnected nature of the human body, and the linkages between different classifications of illness. Stress and trauma can lead to associated physical symptoms, which are often dependent on the physical and genetic make-up of the individual. Most medical practitioners would recognise the links between eg anxiety and stomach problems, or stress and musculoskeletal problems among IT workers. The disease classifications used in statistical data sources can often miss these interconnections.

## **Culturally dependent views of illness**

As discussed earlier in this review, the way a specific cultural group perceives particular illnesses may affect not only the ways symptoms appear, but also how they are perceived by the sufferer. This has ramifications for health care utilisation rates among different ethnic groups.

## *Conclusion*

As demonstrated in this review, migration and work-related health constitutes an important research gap, and while there is abundant literature on the links between migration and health, and between employment and health, there is very little literature which combines all three aspects. With the potential future expansion of the EU, labour migration is likely to increase significantly, and migration-related health impacts will therefore be of greater significance. While the feasibility study identified problems of data incompatibility for cross-national analysis, even within European countries, it is difficult to combine all three aspects using statistical data sources. It is therefore recommended that future research in this area should rely on more qualitative methods. This would allow data to be tailored to the specific combination of factors which are to be linked, but would also allow the incorporation of more fluid concepts of health and disease, which is extremely important when examining health profiles of individuals who may have different cultural perspectives on ill-health.

Within the review, the following research gaps have been identified as areas for future research:

- Migration of the highly skilled has received some attention, however, the situation of tied migrants in this context is rather more precarious. Often there are stresses associated with being a tied migrant, which could potentially affect mental health. This is an important research gap, particularly if companies are to function effectively within a global labour market in the future.
- The situation of illegal migrants has attracted considerable concern, particularly as many work in dangerous and unregulated workplaces and have no access to health services.
- Deskilling among refugees has been highlighted as a major concern throughout Europe, and should be a major focus of any future project.

- Short-term temporary labour migration, primarily from Central and Eastern Europe has been growing in extent throughout the 1990s. Many workers are working under exploitative conditions reminiscent of the post World War 2 'guest worker' phase. With the potential for the EU to incorporate Eastern European countries in the coming decades, the health implications seem particularly urgent to investigate.
- The extent to which work-related accidents are more common among immigrants is contested terrain. It is suggested that there is a strong link between socio-economic factors and accident levels, and this alone can explain an apparent excess among migrants.



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