Commentaries

Joint EU Resettlement Programme: the health of refugee and humanitarian arrivals

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On 2 September 2009, the European Commission proposed the establishment of a Joint EU Resettlement Programme. The aim of the programme, led by an EU-wide Resettlement Expert Group, is to expand EU resettlement of refugees and humanitarian entrants, already determined by the United Nations High Commissioner for Refugees (UNHCR), to be in genuine need of international protection.

In 2010, UNHCR estimates that around 747,000 persons worldwide are in need of resettlement. This number is increasing without corresponding growth in the number of available resettlement places. Further, host countries in the developing world, with limited resources, are overburdened and simply cannot integrate large numbers of refugees into their own expanding populace. The Joint EU Resettlement Programme therefore progresses the EU’s ‘greater solidarity’ to third countries that are overloaded, while improving coordination of EU external policies and credibility in international affairs more generally.

The USA, Canada and Australia are the three major resettlement nations. Of the 65,850 refugees resettled worldwide in 2008, just 6.2% (4,378) were resettled in 10 EU countries—France, the Netherlands, the UK, Sweden, Finland, Denmark, Portugal, Czech Republic, Romania and Ireland. Other Member States have provided resettlement on an ad hoc basis (Germany, Luxembourg, Italy and Belgium). The Joint EU Resettlement Programme’s establishment will overcome piecemeal, separate initiatives and build intra-EU resettlement policy and planning where there is consultation and coordination. A consistent approach will set common annual priorities on resettlement, although Member States will remain free to decide whether they want to resettle at all, and if so, how many individuals. A collective EU approach will enhance resource and cost-effectiveness, as participating Member States may seek financial assistance through the European Refugee Fund.

Resettlement is viewed by UNHCR as ‘the last resort’; the individual can no longer return to his or her country of origin nor remain securely in the country of exile. Those prioritized for resettlement by UNHCR are the most vulnerable, including survivors of violence and torture, women and girls at risk, children (such as unaccompanied minors) and persons with medical needs. Many of the aforementioned have lived for years in squalid, overcrowded refugee camps, without proper shelter, nutrition, health care and sanitation. Unsurprisingly, refugee and humanitarian arrivals thus frequently present with complex health needs, which may include infectious and parasitic diseases, psychological and behavioural problems, poor dental health, under-immunization, under-managed chronic conditions, delayed growth and development in children, as well as other injuries caused by war, conflict or torture.

The International Organisation for Migration, in collaboration with receiving third States and UNHCR, is involved in pre-departure medical testing. However, refugee health physicians in current countries of resettlement are concerned since pre-departure screening fails to adequately detect disease and chronic health conditions in new arrivals. Many of these conditions are often unfamiliar to non-specialist health care practitioners in resettlement countries (e.g. schistosomiasis and malaria), as they may not be endemic in the host state. Poor health status on arrival, complicated by ongoing undiagnosed or misdiagnosed health conditions, will undermine the individual’s and their community’s ability to effectively integrate in their new homeland and face the many challenges in establishing new lives—education, transport, employment, social services, culture and language. Health is and will be the key determinant of the ability of vulnerable groups to benefit from a broader set of rights or entitlements. Indeed, if the EU is to take heed of UNHCR’s belief that ‘resettlement can only provide a durable solution if it enables individuals and their community’s ability to effectively integrate in their new homeland and face the many challenges in establishing new lives—education, transport, employment, social services, culture and language. Health is and will be the key determinant of the ability of vulnerable groups to benefit from a broader set of rights or entitlements.

As the new EU-wide Resettlement Expert Group works with the European Asylum Support Office (EASO), which will provide a structural framework for carrying out practical resettlement cooperation activities, the health of new arrivals must be at the fore of EU resettlement policy and planning activities. Solid policy which ensures access to proper post-arrival health assessment in Member States should be prioritized, as must health infrastructure development, health practitioner training and resource development. As sound policy and planning is driven by an evidential basis and knowledge-led practices, it is recommended that EASO teams with public health academics and social scientists and integrates data gathering practices from the outset. This approach aligns with UNHCR’s strategic use of resettlement to maximize benefits not only for the new arrivals, but also for the broader EU community and the international protection regime in general. Best practice must also include monitoring and evaluation of health care initiatives, and integral to this is the consultation with medical and allied health practitioners, settlement support workers and importantly, people of a refugee background.
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Conflicts of interest: To err on the side of caution, I am a member of the Refugee Council of Australia and previously managed the Queensland Integrated Refugee Community Health Clinic (QIRCH), Brisbane Australia (now known as Refugee Health Queensland).

References


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Given the rapid integration of EU Member States and current debate on patient mobility in the EU, one would expect a significant amount of intra-European medical travel. The available data, however, reveals relatively low cross-border healthcare throughout EU history. In 2006, the Observatoire Social Européen in Brussels found that the overall numbers of medical travel in Europe remained ‘minor’. Medical travel seemed the result of specific circumstances such as waiting times or national bioethical legislations, and were endemic to certain areas and contexts such as tourist areas and border regions.1 Later, in 2008, the European Commission stated that cross-border healthcare was responsible for (only) 1% of public expenditure on healthcare2 involving an expenditure of US$13.5 billion (Forbes, 2009).3

In Germany, a survey by one of the largest health insurances, ‘Techniker Krankenkasse’, with over 7 million insured, found that its members were actually quite mobile but only 2–5% of those needed healthcare, and whose costs represented <0.5% of their overall expenditure.4 According to ‘Zorgverzekeraars Nederland’, the sector organization representing the Dutch providers of healthcare, 1% of medical care for the Dutch takes place abroad ‘consciously’. Medical travel out of the Netherlands increased between 2001 and 2005 but has stagnated ever since.5

Mr Westerwoudt, spokesperson of Centraal Ziekenfonds (‘CZ’), third largest Dutch health insurance with over 3 million insured, was also quoted recently as saying ‘Medical travel is dead’ and ‘Financial crisis or not, we never really believed in it’. In addition, whatever medical travel still happens, happens in border areas. ‘CZ’ states that 90% of Dutch medical travellers go to border areas in Belgium (8000 people per year) and Germany (2000 people per year). According to ‘CZ’, these