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ORIGINAL ARTICLE

Reviewing the topic of migration and health as a new national health target for Germany

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Abstract
Objectives To review migration and health as a potential new national health target for Germany.
Methods The theme was evaluated along 13 standardized criteria preset by the Health TargetsNetwork. For each of the criteria an expert opinion based on an extensive (but nonsystematic)review of literature is presented.
Results Migrants differ in many health-related aspects from the majority population in Germany.Despite having some health advantages, their health status, on average, is lower thanthat of non-migrants. They also experience barriers in health care and cannotparticipate in the society on equal terms with the majority population. Differentmeasures to improve the health situation of migrants are available, but their currentimplementation in the health system is limited in several ways. Present data on thehealth of migrants is inadequate and limits migrant-sensitive health reporting.
Conclusion The evaluation of potential health targets based on standardized criteria is a valuabletool for health policy formulation. The present documentation can assist other countriesin evaluating migration and health as a national health target. It may also contribute tosimilar activities at the European level.

Keywords Health targets · migration · health care utilization · health care effectiveness · migrantsensitivedata

Introduction

Setting health targets is a common approach of health systems to coordinate and steer activities of stakeholders, to increase accountability and to support the development

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and prioritization of health policies and strategies. This is particularly important in complex health systems such as that of Germany consisting of several organizations and institutions that are responsible for the provision of health care (Busse and Riesberg 2004).

In many European countries, health targets play an increasingly important role in health policy formulation (Srivastava and McKee 2008). In Germany, health targets emerged in the late 1980s and have been implemented by the 16 federal states to varying degrees and by means of different approaches (Wismar et al. 2008). One such approach involves the Health Targets Network *(Kooperationsverbund gesundheitsziele.de)*. It was founded by the federal Conference of Health Ministers in 1997 and consists of representatives of over 120 stakeholders such as the German Statutory Pension Insurance Scheme and the National Association of Statutory Health Insurance Physicians who all are involved in target identification and target setting. These processes are initiated and coordinated by the Health Targets Network and have been in place since 2000 (Maschewsky-Schneider et al. 2009; Wismar et al. 2008). They follow three steps. First, the Health Targets Network pre-selects a list of several potential health targets. Second, for each of these targets a group of experts is recruited who evaluate the respective health target based on standardized criteria. Third, based on the reports of the different expert groups, the Health Targets Network produces recommendations on which health targets are of high priority and should be pursued as national health targets by stakeholders in the future (Maschewsky-Schneider et al. 2009).

Thirteen standardized criteria (Table 1), which are supposed to ensure a comprehensive evaluation of competing topics, have been developed in a multidisciplinary exercise by the Health Targets Network. The criteria are generic and generally follow a "problem-oriented" perspective. In the past, they have been used to evaluate a range of different health targets that focus on selected diseases, on health promotion and healthy aging and in the change of risk behavior (Maschewsky-Schneider et al. 2009).

As an expert group, we were asked to review the topic of migration and health as a potential new health target to be implemented at the federal level in Germany. Migrants constitute large proportions of the population in many European countries. In Germany, almost 20 % of the population have a migration background (i.e., have migrated themselves or are offspring of immigrants), totaling about 16 million individuals (Statistisches Bundesamt 2013). Migrants in Germany are a very heterogeneous group. Health-related advantages with respect to the German majority population have been described (David et al. 2014), but on average, migrants' health status and access to health care services is poorer than that of the majority population (Razum et al. 2008). Coordinating activities of different institutions in Germany through the implementation of migration and health as a health target could significantly contribute towards an improvement of the health situation of migrants. Documenting this process can help other European countries in their planning steps to define migration and health as a national health target, and may also contribute to further joint European approaches to include migrant health in target setting and other health policy measures.

We evaluated this theme along the 13 criteria preset by the Health Targets Network. In the following, we present a summary of the results and assess the limitation of this approach.

Table 1 List of criteria developed by the Health Targets Network for the standardized evaluation of potential health targets

Criterion	Definition
Severity in terms of mortality	The health problem causes a high mortality.
Severity in terms of morbidity	The health problem causes a high burden of disease.
Prevalence	The health problems and its risk factors are highly prevalent in the population.
Potential for improvement	The health problem can be adequately addressed.
Economic relevance	The health problem is associated with considerable direct and indirect costs, which can be addressed through appropriate measures.
Ethical aspects	The health target is of high ethical relevance and not associated with ethical concerns.
Equal opportunities	The health target contributes towards mitigating social and health disparities.
Importance as perceived by the population	The health problem is perceived by the population and by politicians to be of high priority.
Measurability	The achievement of the health target is measurable.
Feasibility in terms of measures and instruments	Measures and instruments necessary for the implementation of the health target are available.
Feasibility in terms of stakeholders	Stakeholders are willing to implement measures aiming towards the implementation of the health target.
Opportunities for the participation of the population	The population and particularly those affected by the health problem are able to participate in the implementation of the health target.
Legal framework	The legal basis for measures necessary to implement the health target is available.

Methods

Our group consisted of researchers (the authors of the present article) with a broad expertise in the field of migration and health. Following a kickoff meeting, a report on each of the 13 criteria was prepared by the review group. We conducted a non-systematic, extensive review of peer-reviewed and other literature for all of the predefined criteria, with a geographic focus on Germany, and including English and German language articles and reports. The search was carried out using the databases PubMed and Social Science Citation Index and the search string "(migra* OR ethnic*) AND Germany AND" followed by respective terms for the different criteria such as "mortality", "morbidity" and "access to health care". We focused on articles published over the period 2000–2014. To also identify gray literature such as government reports, we performed a corresponding search of internet publications using the search engine Google Search. The reference lists of identified literature were scanned manually for relevant sources. In addition, literature considered important or relevant by the review group was included where appropriate. Ethical aspects (Criterion 6) were evaluated based on position papers and declarations by the World Health Organization and the United Nations.

All quantitative results provided in the current article are taken from the respective literature cited as reference(s). However, our analysis is to be considered an expert opinion rather than reflecting the result of a systematic review, as no strict search protocol was followed and in several instances examples rather than a full body of evidence were used to support arguments. Also, we did not explicitly set inclusion and exclusion criteria. An external reviewer who was not part of our panel and not otherwise involved in the criteria analysis reviewed our report prior to finalization. The final report served as a document for further decisions by the steering group of the Health Targets Network. A short summary of the decision making process has been published elsewhere (Maschewsky-Schneider et al. 2013).

Results

(1) *Severity in terms of mortality* Causes of death statistics and other data sources show that the pattern of causes of deaths is similar between migrants and the non-migrant majority population residing in Germany. Migrants, however, have a 40 % lower age-standardized overall mortality than the majority population. The same is true for disease-specific mortality with respect to most causes such as deaths from cardiovascular disease and cancer. However, while a constant decline in age-standardized mortality figures can be observed for non-migrants in the last years and decades, the mortality among migrants remains stagnant (Kohls 2011; Razum et al. 2008).

(2) *Severity in terms of morbidity and* (3) *prevalence* Particularly older migrants in Germany experience a higher prevalence of certain communicable and non-communicable diseases. For example, Turkish migrants have higher prevalences of hepatitis B and *Helicobacter pylori* infections. A higher prevalence of *Helicobacter pylori* infections presumably also contributes to higher incidences of gastritis and stomach cancer, which can be observed in this population group (Zeeb et al. 2002). The incidence of other types of cancer such as breast cancer in women or skin cancer in women and men, however, is lower among migrants than among the majority population (Spallek et al. 2009). In terms of work-related morbidity, migrants are at a higher risk of occupational accidents and diseases (Brzoska et al. 2013; Razum et al. 2008) as well as retirement due to disability (Brzoska et al. 2010a). Differences in the rates of retirement due to disability increase with age and are particularly pronounced between older German nationals and individuals of Turkish origin (Brzoska et al. 2013).

(4) *Potential for improvement* The higher burden of disease among migrants partly results from a variety of factors migrants are exposed to in different phases of their life. For first-generation migrants, they comprise environmental and social factors in the countries of origin, factors associated with the migration process as well as environmental and social conditions in the host country. The latter include poor working conditions, a lower socio-economic status and sometimes a low German language proficiency and low health literacy (Ackermann Rau et al. 2014; Razum et al. 2008; Spallek et al. 2011). Aside from a general improvement of their social situation, the health status of migrants can be improved by reducing barriers that many migrants experience in terms of health care access and health care quality (see criterion 7). Reducing such barriers could, for example, help to better address higher lifetime prevalences of measles infection in migrant children (Robert Koch-Institut 2008) and higher rates of occupational accidents and work-related disability (Brzoska et al. 2013).

(5) *Economic relevance* To the best of our knowledge, no studies have been conducted on the cost effectiveness of policies and interventions that aim to improve the health status of migrants in Germany. Considering the overall higher burden of preventable and treatable diseases among migrants and their large population size in Germany, however, it seems reasonable to assume that an improvement of the health situation of migrants is associated with a substantial economic benefit. Communication difficulties between patients and medical staff may lead to incorrect treatments or unnecessary duplicate examinations, which cause high health care costs (BASS 2009).

(6) *Ethical aspects* In its constitution, the World Health Organization emphasized that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being" which must be provided "without distinction of race, religion, political belief, economic or social condition" (World Health Organization 1948, p. 100). A similar demand has been made by the United Nations in its Universal Declaration of Human Rights (UN General Assembly 1948) and since then has been repeated in several international agreements such as the Ottawa Charta for Health Promotion (World Health Organization 1986). Maintaining and strengthening the health of migrants, consequently, is of high ethical and social responsibility for the health care system of every country.

(7) *Equal opportunities* Many migrants experience barriers in health care which may lead to a lower utilization of primary and secondary preventive services (Keller and Baune 2005; Zeeb et al. 2004) and to a lower utilization and effectiveness of tertiary preventive services such as rehabilitation. The latter, for example, is reflected in a higher risk of disability retirement or in a lower chance to work in full-time positions after rehabilitation (Brzoska et al. 2010b; Brzoska and Razum 2012). Barriers become evident with respect to problems in communication. They result from insufficient information about rehabilitative services, poor German language proficiency or cultural beliefs and expectations not sufficiently accounted for in the health care setting (Brause et al. 2010; Brzoska et al. 2010a), calling for a concept of intercultural opening of the health care system (see criterion 10).

(8) *Importance as perceived by the population* The population in Germany benefits substantially from ethnic, cultural and religious diversity. In the last decades, migrants have not only contributed to social and cultural life but also have become integral pillars of economic prosperity and competitiveness (Lee 2014; Niebuhr 2010). However, not the entire population in Germany is aware of migrants' contribution to the society. Migrants also experience discrimination as a result of prejudice and reservation (Salentin 2008). Aside from reducing barriers to health care among migrants, therefore, discrimination needs to be addressed to allow migrants to participate in the society on equal terms with other population groups.

(9) *Measurability* Some health-related indicators are available that can be used to evaluate the achievement of a health target that deals with the health of migrants. Among other things, they comprise information on self-reported illness in the last 4 weeks and on the prevalence of obesity as provided by the annual German Microcensus (Statistisches Bundesamt 2014). The German Health Interview and Examination Survey for Children and Adolescents, which is commissioned by the Federal Ministry of Health, provides information on vaccination coverage and participation in pediatric check-ups (Kurth et al. 2008). In addition, routine data from social security carriers allow to monitor indicators such as work-related disability (Deutsche Rentenversicherung Bund 2013) as well as occupational accidents and diseases on a continuous basis (Deutsche Gesetzliche Unfallversicherung 2013). In the near future, the prospective German National Cohort will provide valuable information that can be used to answer specific etiological questions regarding the health of migrants (Wichmann et al. 2012). Although these and other high-quality health indicators are available, many of them only allow to define migration status by nationality because information necessary to identify German nationals with a migration background (such as self-defined ethnicity or the birth place of parents) is missing (Schenk et al. 2006; Brzoska et al. 2012). Establishing migration and health as a new federal health target thus must also strive for an improvement in the availability of valid and reliable data sources (Foets 2011).

(10) *Feasibility in terms of measures* Different measures are available that aim to improve the health status of migrants such as interpreters and health mediators (sometimes also referred to as health navigators) to address problems in communication between patients and health providers. Furthermore, non-German language material and the implementation of low-threshold health services aim to address migrants' barriers to health care utilization (Razum et al. 2008; Razum and Spallek 2014). Some health care institutions also provide cross-cultural training for their staff to better address their patients' diversity in terms of cultural and religious needs (Beauftragte der Bundesregierung für Migration' Flüchtlinge und Integration 2010). For the integration of migrants in health care services (e.g., psychiatry, pediatric care, care for the disabled), standardized training programs for qualification and human resources development were developed and successfully implemented (Hegemann and Salman 2010). Another and more holistic approach towards the diversity of health care users is diversity management (Gordin 2011). Although these and similar approaches are applied in clinical practice in various combinations and to varying extents, they are usually not evaluated in terms of their cost and outcome effectiveness as well as with regard to acceptance and satisfaction in the target group. Aside from improving the health care for migrants it is also essential to target other factors that affect their health status such as poor working and living conditions (Razum et al. 2008; Razum and Spallek 2014).

(11) *Feasibility in terms of stakeholders* Institutions of the health care system are responsible to provide adequate health services for the entire population of which migrants

are a substantial part. Many institutions accept this responsibility and offer services tailored to the needs of migrants (see, for example, Beauftragte der Bundesregierung für Migration‘ Flüchtlinge und Integration 2013). Currently, their approaches to migrant-sensitive care still have many limitations (see criterion 7) and concerted action is necessary to improve health care for migrants sustainably. Similarly, through illustrating the potential economic benefits of a healthy migrant workforce, employers must be motivated to improve the working conditions of migrants.

(12) *Opportunities for the participation of the population* The community of migrants must be actively involved into the implementation of the health target. This can be facilitated through numerous migrant organizations operating on the federal, state and regional level (Beauftragte der Bundesregierung für Migration‘ Flüchtlinge und Integration 2011; MASSKS 1999). They comprise, among other things, sports associations, labor unions, cultural centers and political associations. To promote their participation, their legal rights, e.g., in terms of possibilities to take part in localelections, also need to be strengthened. With regard to self-help potentials, one important supportive approach is to train transcultural health mediators, such as in the “MiMi-With Migrants for Migrants” program (Salman and Weyers 2010).

(13) *Legal framework* The majority of migrants shares equal entitlements to use health services with all other population groups, due to the compulsory health insurance scheme in Germany (Razum et al. 2008). Using this perspective, the implementation of migration and health as a health target therefore is, in principle, not different from implementing targets aiming to improve the health of other population groups. Asylum seekers and refugees are entitled to basic health care for the time of their stay in Germany. Little is known about the health care situation of undocumented migrants in Germany (Woodward et al. 2013). Although they are entitled to receive free emergency health care, they risk attracting the attention of public authorities when they approach health care institutions (Björngren Cuadra 2013; Razum et al. 2008). Measures implemented to improve the health care of migrants should also strive to improve health care access for these population groups. In particular, it is necessary to implement laws preventing health and social care institutions from notifying authorities about undocumented migrants among their clients. In addition, the health target should be instrumental in establishing the legal basis needed to finance available measures—such as the employment of interpreters and health mediators or trainings in cross-cultural competence—sustainably and comprehensively (Junge and Schwarze 2013; Purnell et al. 2011).

Discussion

Our criteria analysis provided a comprehensive overview of issues related to migration and health in Germany, and highlighted numerous topics warranting health policy and practice to be directed towards this theme. Notably we were able to provide scientific evidence of particular health risks as well as some health advantages of migrants in Germany. However, a key feature of our investigation into migration and health was the ongoing lack of comparable and specific data on many issues that were deemed relevant in the context of target setting. Therefore, we hope that a substantive focus on migration and health as a health target can also push the development of migrant-sensitive health reporting, same as health target setting in the past has spurred the development of regional- and local-level health information systems (Horch and Ziese 2005; Wismar et al. 2008).

The preset and standardized criteria provided for some additional difficulty, as their perspective is problem- or disease-oriented and not theme- or population-oriented, as would be helpful when assessing a broad theme such as that of migration and health. Similar to other expert groups who had worked on theme- or population-oriented topics in the past (Maschewsky-Schneider et al. 2009), we dealt with this situation by interpreting several of the criteria in a way appropriate to our topic. Nevertheless, the fit of our arguments and data to the different criteria was sometimes difficult to maintain.

The process of the criteria analysis for the setting of health targets cannot be equated to the setting of medical guidelines, where evidence is systematically assessed and recommendations for care formulated based on the overall body of evidence (Kirch 2008). Criteria assessments as implemented by the Health Targets Network usually reflect the judgment of an expert panel, with the conclusion that the actual composition of the group also influences the outcome of the exercise. In our case, public health scientists as well as experts from practice and with a personal migration background were involved in the work, supporting a broad perspective in the joint report. However, it is clear that our analysis does not qualify as a systematic review. Nevertheless, we are confident that essential evidence relevant for the process of target setting was included in the criteria analysis.

Experiences from European countries with the setting, implementation and evaluation of health targets were published in a 2008 European Health Observatory Report (Wismar et al. 2008). With regard to the target setting process, different approaches have been employed, and clearly epidemiological evidence alone does not suffice to formulate health targets. Criteria-based approaches such as the one used by the Health Targets Network *(Kooperationsverbund*

gesundheitsziele.de) allow for a systematic and comparable way of selecting targets from a set of candidate topics. Alternative strategies include, for example, selection based on political relevance, or the (complete or selective) adoption of international health targets (Wismar et al. 2008).

During the subsequent steps of the target setting process, the topic of migration and health was not selected as a new health target by the steering committee of the Health Targets Network. The steering committee reviewing the different proposed topics particularly acknowledged the potential for improving the health situation of migrants and for strengthening equal opportunities. However, it found it difficult to narrow down the health target to particular steps that need to be taken. Furthermore, the measurability of the health target was questioned. The steering committee rather recommended to include migration as a cross-cutting theme that should be taken up during the implementation of all existing and new health targets (Maschewsky-Schneider et al. 2013). There are pros and cons of such an approach: issues related to migration and ethnicity are relevant in almost all areas of health policy and practice, and may best be tackled through an integrative approach across all populations and clinical health topics. While we agree with this argument, there is a risk that the topic receives insufficient attention when limited to a cross-sectional issue. Therefore, in addition to promoting general awareness towards the needs of migrants in the formulation of health targets, concerted action is necessary to improve the health of this population group sustainably. This could be accomplished through a separate and nationally agreed target, which could better focus assessments and activities related to migration and health. This includes a stronger call for better data collection across the health system. As regards the selection process of health targets, it must be considered that population-based targets such as migration and health are holistic and require different approaches than problem- or disease-oriented targets. The current selection process in which both types of health targets compete against each other, therefore, needs to be reassessed. As an expert group we will actively follow the currently planned integration of migration and health into the national health targets. Notably, we will help to ensure that appropriate attention is paid to the issue during upcoming health target evaluations.

Policy makers must consider that an international perspective in public health is of increasing importance (McMichael and Beaglehole 2009). While nationally agreed health targets implemented on different levels are important to coordinate activities of stakeholders, targets agreed upon and set at the European level are necessary to address challenges in health care that are faced by European health systems in the 21st century. In terms of the health of migrants, these challenges result from increased mobility both within Europe as well as between European and non-European countries. Experiences with health target setting on the national level can guide the target setting process on the European level.

References

Ackermann Rau S, Sakarya S, Abel T (2014) When to see a doctor for common health problems: distribution patterns of functional health literacy across migrant populations in Switzerland. Int J Public Health. doi:10.1007/s00038-014-0583-5 (online ahead of print)

BASS (2009) Kosten und Nutzen des interkulturellen Übersetzens im Gesundheitswesen (Vorstudie). Büro für Arbeit und sozialpolitische Studien, Bern

Beauftragte der Bundesregierung für Migration‘ Flüchtlinge und Integration (2010) 8. Bericht der Beauftragten der Bundesregierung für Migration, Flüchtlinge und Integration über die Lage der Ausländerinnen und Ausländer in Deutschland. Beauftragte der Bundesregierung für Migration, Flüchtlinge und Integration, Berlin

Beauftragte der Bundesregierung für Migration‘ Flüchtlinge und Integration (2011) Migranten(dach)organisationen in Deutschland. Beauftragte der Bundesregierung für Migration, Flüchtlinge und Integration, Berlin

Beauftragte der Bundesregierung für Migration‘ Flüchtlinge und Integration (2013) Das kultursensible Krankenhaus. Ansätze zur interkulturellen Öffnung. Beauftragte der Bundesregierung für Migration, Flüchtlinge und Integration, Berlin

Björngren Cuadra C (2013) Right of access to health care for undocumented migrants in EU: a comparative study of national policies. Eur J Public Health 22:267–271

Brause M, Reutin B, Schott T, Yilmaz-Aslan Y (2010) Migration und gesundheitliche Ungleichheit in der Rehabilitation. Abschlussbericht. Universität Bielefeld, Bielefeld

Brzoska P, Razum O (2012) Das Risiko einer Erwerbsminderung nach Abschluss der medizinischen Rehabilitation. Ein Vergleich von Rehabilitanden deutscher und ausländischer Staatsangehörigkeit im Längsschnitt. Präsentation auf der 7. Jahrestagung der Deutschen Gesellschaft für Epidemiologie, Regensburg, 26–29. September, 2012

Brzoska P, Voigtländer S, Reutin B, Yilmaz-Aslan Y, Barz I, Starikow K, Reiss K, Dröge A, Hinz J, Exner A, Striedelmeyer L, Krupa E, Spallek J, Berg-Beckhoff G, Schott T, Razum O (2010a) Rehabilitative Versorgung und gesundheitsbedingte Frühberentung von Personen mit Migrationshintergrund in Deutschland. Forschungsbericht 402. Bundesministerium für Arbeit und Soziales, Berlin

Brzoska P, Voigtländer S, Spallek J, Razum O (2010b) Utilization and effectiveness of medical rehabilitation in foreign nationals residing in Germany. Eur J Epidemiol 25:651–660

Brzoska P, Voigtländer S, Spallek J, Razum O (2012) Die Nutzung von Routinedaten in der rehabilitationswissenschaftlichen Versorgungsforschung bei Menschen mit Migrationshintergrund: Möglichkeiten und Grenzen. Gesundheitswesen 74:371–378

Brzoska P, Voigtländer S, Spallek J, Razum O (2013) Arbeitsunfälle, Berufskrankheiten und Erwerbsminderung bei Menschen mit Migrationshintergrund. In: Schott T, Razum O (eds) Migration und gesundheitliche Ungleichheit in der Rehabilitation. Beltz Juventa, Weinheim, pp 49–61

Busse R, Riesberg A (2004) Health care systems in transition. European Observatory on Health Care Systems, Copenhagen

David M, Borde T, Brenne S, Ramsauer B, Henrich W, Breckenkamp J, Razum O (2014) Comparison of perinatal data of immigrant women of Turkish origin and German women—results of a prospective study in Berlin. Geburtshilfe Frauenheilkd 74:441–448

Deutsche Gesetzliche Unfallversicherung (2013) DGUV Statistics 2012. Figures and long-term trends. Deutsche Gesetzliche Unfallversicherung e.V., Berlin

Deutsche Rentenversicherung Bund (2013) Statistik der Deutschen Rentenversicherung Rentenzugang des Jahres 2012 einschließlich Rentenwegfall, Rentenänderung/Änderung des Teilrentenanteils in der deutschen gesetzlichen Rentenversicherung. Deutsche Rentenversicherung Bund, Berlin

Foets M (2011) Improving the quality of research into the health of migrant and ethnic groups. Int J Public Health 56:455–456

Gordin J (2011) Diversity in Healthcare. In: Borowski N (ed) Organizational Behaviour in Health Care. Jones & Bartlett, Sudbury, pp 15–40

Hegemann T, Salman R (2010) Interkulturelle Qualifizierung und Personalentwicklung - Förderung interkultureller Kompetenz in psychiatrischen Versorgungseinrichtungen. In: Hegemann T, Salman R (eds) Handbuch Transkulturelle Psychiatrie. Psychiatrie Verlag, Bonn, pp 242–258

Horch K, Ziese T (2005) Das Zusammenspiel von Gesundheitsberichterstattung und Gesundheitszielen. In: Gesellschaft für Versicherungswissenschaft und -gestaltung e.V.(GVG) (ed) Gesundheitsziele.de: Impulse, Wirkungen und Erfahrungen. Akademische Verlagsgesellschaft, Berlin, pp 245–250

Junge F, Schwarze A (2013) Sprach-und Integrationsmittlung: Ein praxisbewährtes Instrument zum Umgang mit sprachlicher und kultureller Vielfalt (nicht nur) im Krankenhaus. In: Bouncken RB, Pfannstiel MA, Reuschl AJ (eds) Dienstleistungsmanagement im Krankenhaus I. Prozesse, Produktivität und Diversität. Springer Gabler, Wiesbaden, pp 367–382

Keller A, Baune B (2005) Impact of social factors on health status and help seeking behavior among migrants and Germans. J Public Health 13:22–29

Kirch W (2008) Encyclopedia of Public Health. Springer, Dordrecht

Koch-Institut Robert (2008) Kinder- und Jugendgesundheitssurvey (KiGGS) 2003–2006: Kinder und Jugendliche mit Migrationshintergrund in Deutschland. Robert Koch-Institut, Berlin

Kohls M (2011) Morbidität und Mortalität von Migranten in Deutschland. Bundesamt für Migration und Flüchtlinge, Nürnberg

Kurth BM, Kamtsiuris P, Holling H, Schlaud M, Dolle R, Ellert U, Kahl H, Knopf H, Lange M, Mensink G, Neuhauser H, Rosario A, Scheidt-Nave C, Schenk L, Schlack R, Stolzenberg H, Thamm M, Thierfelder W, Wolf U (2008) The challenge of comprehensively mapping children's health in a nation-wide health survey: design of the German KiGGS-Study. BMC Public Health 8:196

Lee N (2014) Migrant and ethnic diversity, cities and innovation: firm effects or city effects? J Econ Geogr. doi:10.1093/jeg/lbu032

Maschewsky-Schneider U, Klärs G, Ryl L, Sewöster D, Starker A, Saß AC (2009) gesundheitsziele.de. Bundesgesundheitsbla 52:764–774

Maschewsky-Schneider U, Gocke M, Hölscher U, Kolip P, Kuhn A, Sewöster D, Zeeb H (2013) Gesundheitsziele.de. Die Auswahl eines neuen Gesundheitsziels für Deutschland. Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz 56:1329–1334

MASSKS (1999) Selbstorganisationen von Migrantinnen und Migranten in NRW. Wissenschaftliche Bestandsaufnahme. Ministerium für Arbeit, Soziales und Stadtentwicklung, Kultur und Sport des Landes Nordrhein-Westfalen, Düsseldorf

McMichael A, Beaglehole R (2009) The global context of public health. In: Beaglehole R, Bonita R (eds) Global public health: a new era. Oxford University Press, New York, pp 1–22

Niebuhr A (2010) Migration and innovation: does cultural diversity matter for regional R&D activity? Pap Reg Sci 89:563–585

Purnell L, Davidhizar RE, Giger JN, Strickland OL, Fishman D, Allison DM (2011) A guide to developing a culturally competent organization. J Transcult Nurs 22:7–14

Razum O, Spallek J (2014) Addressing health-related interventions to immigrants: migrant-specific or diversity-sensitive? Int J Public Health. doi:10.1007/s00038-014-0584-4 (online ahead of print)

Razum O, Zeeb H, Meesmann U, Schenk L, Bredehorst M, Brzoska P, Dercks T, Glodny S, Menkhaus B, Salman R, Saß A-C, Ulrich R (2008) Migration und Gesundheit. Robert Koch-Institut, Berlin

Salentin K (2008) Diskriminierungserfahrungen ethnischer Minderheiten in der Bundesrepublik. In: Groenemeyer A, Wieseler S (eds) Soziologie sozialer Probleme und sozialer Kontrolle: Realitäten, Repräsentationen und Politik. VS Verlag für Sozialwissenschaften, Wiesbaden, pp 515–526

Salman R, Weyers S (2010) MiMi Project-With Migrants for Migrants. In: Koller, Theadora (Hg). Poverty and social exclusion in the WHO European Region: health systems respond. Venedig, Rome: WHO Europe. In: Koller T (ed) Poverty and social exclusion in the WHO European Region: health systems respond. World Health Organization Europe, Venice, pp 52–63

Schenk L, Bau AM, Borde T, Butler J, Lampert T, Neuhauser H, Razum O, Weilandt C (2006) Mindestindikatorensatz zur Erfassung des Migrationsstatus. Empfehlungen für die epidemiologische Praxis. Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz 49:853–860

Spallek J, Arnold M, Hentschel S, Razum O (2009) Cancer incidence rate ratios of Turkish immigrants in Hamburg, Germany: a registry based study. Cancer Epidemiol 33:413–418

Spallek J, Zeeb H, Razum O (2011) What do we have to know from migrants' past exposures to understand their health status? A life course approach. Emerg Themes Epidemiol 8:6

Srivastava D, McKee M (2008) The emergence of health targets: some basic principles. In: Wismar M, McKee M, Ernst K, Srivastava D, Busse R (eds) Health targets in Europe. Learning from experience. European Observatory on Health Systems and Policies, Copenhagen, pp 9–22

Statistisches Bundesamt (2013) Bevölkerung und Erwerbstätigkeit. Bevölkerung mit Migrationshintergrund. Ergebnisse des Mikrozensus 2012 (Fachserie 1 Reihe 2.2). Statistisches Bundesamt, Wiesbaden

Statistisches Bundesamt (2014) Microcensus. Statistisches Bundesamt, Wiesbaden

UN General Assembly (1948) UN General Assembly, Universal Declaration of Human Rights, 10 December 1948, 217 A (III). United Nations

Wichmann HE, Kaaks R, Hoffmann W, Jöckel KH, Greiser KH, Linseisen J (2012) Die Nationale Kohorte. Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz 55:781–789

Wismar M, Philippi B, Klus H (2008) Germany: targets in a federal system. In: Wismar M, McKee M, Ernst K, Srivastava D, Busse R (eds) Health targets in Europe. Learning from experience. European Observatory on Health Systems and Policies, Copenhagen, pp 123–135

Woodward A, Howard N, Wolffers I (2013) Health and access to care for undocumented migrants living in the European Union: a scoping review. Health Policy Plan. doi:10.1093/heapol/czt061 (online ahead of print)

World Health Organization (1948) Constitution of the World Health Organization. Off Rec World Health Organ 2:100–109

World Health Organization (1986) The Ottawa charter for health promotion. World Health Organization, Geneva

Zeeb H, Razum O, Blettner M, Stegmaier C (2002) Transition in cancer patterns among Turks residing in Germany. Eur J Cancer 38:705–711

Zeeb H, Baune BT, Vollmer W, Cremer D, Krämer A (2004) Gesundheitliche Lage und Gesundheitsversorgung von erwachsenen Migranten – ein Survey bei der Schuleingangsuntersuchung. Gesundheitswesen 66:76–84