strain and all three physical working conditions predicted disability pensions. So did socio-economic position, general health and common mental disorders. After simultaneously adjusting for all studied variables heavy physical exertion (HR 1.7, 1.2–2.3), low socio-economic position (HR 1.8, 1.1–2.9), common mental disorders (HR 1.6, 1.2–2.1) and poor self-rated health (HR 6.9, 4.8–9.8) still predicted disability pensions.

Conclusions

Besides general and mental ill-health, physically heavy work and low socio-economic position contribute to early exit from work through disability pension. Among the work environment factors reducing physical exertion in particular would support employees maintaining work ability until their normal retirement age.

Disability pensioning: the gender divide may be explained by occupation, income, mental distress and health

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Background

We wanted to test the hypothesis that gender divide in disability pensioning may be explained by differences in health, mental distress, occupation or income.

Methods

In the Oslo Health Study in year 2000–01 of all inhabitants aged 40, 45 and 59–60 years, 11 072 (48.7%) attended. Former analyses of both attendees and non-attendees have shown that associations between social characteristics and social security benefits, chronic disease and lifestyle were unbiased. Survey data were linked to data from the National Insurance Administration and Statistics Norway for 10 421 participants, and 9195 participants were eligible for disability pension at the end of 2000. Occupation, general health and mental distress were self-reported while income was from official statistics.

Results

In the next 4 years, 5.4% of our eligible sample got a disability pension. Age-adjusted rate of disability pension for women was 41% higher than for men. Self-reported health was important for pensioning, and seemed to reduce the female overweight, and so did a test of mental distress. After adjusting also for nine occupational groups and working conditions, the female overweight was reduced to insignificant 13%, and including income 3 years before pensioning, there was no gender divide (OR = 1.03; 95% CI 0.76–1.39 for women compared to men).

Conclusion

A high rate of disability pension among females in Oslo, Norway, is explained by women having poorer self-reported health and more mental distress than men, earning less and having jobs with much strain and lack of control.

Work–family interference and long-term sickness absence: a longitudinal cohort study

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Background

Alongside work environment factors, interference between work and domestic life has been brought forward as important in explaining long-term sickness absence, particularly for women. The aim was to investigate the association between work to family interference (WFI), family to work interference (FWI) and long-term sickness absence for women and men in different family and work-related settings.

Methods

The study population is a random sample of gainfully employed individuals in ages 25–50 years in Sweden ($n = 2867$). Telephone interview data were collected during spring 2004 including questions about family-, work- and health-related factors. The outcome measure is at least one spell of long-term sickness absence >14 days during 2005 based on social insurance register data linked with personal social security number. Associations were analysed with logistic regression.

Results

WFI is more common than FWI and more often reported by women. The overall effects of WFI and FWI were weak. However, for women WFI was associated with long-term sickness absence among those having the main responsibility for housework and family. For men, an association was found for those with higher socio-economic status or permanent employment.

Conclusions

These findings suggest that WFI is associated with long-term sickness absence, but in a gender and situation-specific manner. Hence, for women extensive family responsibilities and for men extensive work responsibilities hampers work and family balance among the employed. Furthermore, the study indicates that both objective and subjective measures should be accounted for in studies aiming at explaining the relation between WFI and double workload vis-à-vis long-term sickness absence.

H.1. Workshop: Ethics and migrant health: right to health care for undocumented migrants in Europe

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One of the consequences of migration policies regarding labour migration and migration for political reasons is the refusal of a number of migrants that are not fitting into the rules and the national or European policy. Political turmoil in various parts in the global world and a huge economical gap between the members of the European Union and the countries beyond the neighbourhood countries, keep generating numbers of economical and political migrants. The creation of a common European asylum area and stricter national immigration policies result in increasing numbers of illegal or undocumented 'sans-papiers' (UDM). The right to health care for UDM varies between countries of Europe and health care providers in cities are confronted with the need for health care in these patients and the local policy. Health care providers are daily confronted with ethical questions in this matter.

The workshop will compare national policies in various countries, present local practices and coping strategies and

case studies. All presentations will be discussed using an ethical framework based on Martha Nussbaum's Frontiers of Justice, addressing how we can extend justice and dignified life conditions to all citizens of the world. This theory encompasses concepts of cooperation and care, thus providing justice to (previously) disregarded groups.

Access to healthcare for female UDM in the Netherlands

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Background

Dutch health policy states formally that UDM have access to all necessary medical care, but as UDM are not allowed to get health insurance, healthcare institutions are reluctant to offer help. General practitioners, midwives and pharmaceutics get reimbursed for the costs UDM cannot pay; hospitals and nursery homes do not. Female undocumented immigrants experience many health problems. Our purpose was to identify obstacles these women experience in accessing health care.

Design and methods

Information about the use of health care services and encountered barriers was obtained through semi structured interviews with 100 undocumented women in the Netherlands.

Results

Only 39% of the women received medical care for their health problems. Contacts with hospital care were fewer (25% ever) in comparison with legal migrant women (58% last year).

Only 57% of the women had a regular GP, and even less (21%) undocumented women who were not supported by Dutch (voluntary) aid organizations. Many women reported incidents with payment. Most obstacles were established by the women themselves: fear and shame and not knowing their rights nor the way to get help.

Conclusion/lessons

Financial obstacles put up by health care policy are not the most important barrier for getting access to health care facilities. Strong efforts should be made to inform women about their rights and about the Dutch healthcare system, especially those women who have no support from Dutch volunteers.

Insights into NowHereLand: policies and practices of health care for undocumented migrants in EU countries

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Undocumented migrants (UDM), estimated to cover up to 15% of all migrants in the EU, are a complex challenge for European public health systems. Health policy and health care organizations have to deal with contradictory aims and criteria from public health, professional ethics, human rights, security and law enforcement policies. This leads to the need of a 'management of paradox'.

The project 'Health Care in NowHereLand' (running time 2008–10) aims at identifying practices of health care for UDM in the EU within the complex interplay of existing policies on one side and needs of people on the other side.

The presentation discusses indicators to describe such contextualized practice; e.g. legal and financial conditions under which organizations act, written policies and informal practices, individual coping strategies, etc. Selected case studies are presented to illustrate this complex interplay of policies and practice and the strategies of health care organizations to manage the paradox requirements.

Undocumented migrants' access to healthcare in France, Switzerland and the United Kingdom: how national policies shape local interactions

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This study is a comparative research on access to healthcare for undocumented migrants (UDM) in France, Switzerland and the United Kingdom. We carried out interviews with health professionals, NGOs and migrants in the three countries (choosing one city in each country). We are interested in both national policies and the way they are implemented in local health institutions.

Our hypothesis is that contemporary evolutions in both health and migration policies as well as longer term path dependence affect the situation of these migrants as regards access to healthcare.

The three countries differ largely in their healthcare offer for UDM: France has implemented a comprehensive access system based on the state-supported UDM-targeted 'Aide Médicale de l'Etat.' In the United Kingdom, the last few years have witnessed a shrinkage of *de facto* access, new regulations explicitly charging 'overseas patients' for most of secondary care. Switzerland has no specific UDM-targeted policy, research showing that local compromises make up for the situation of most UDM who lack health insurance.

We are interested in both legal and effective access and in the way these developments affect the doctor–patient relation. Thus, among the three countries, the United Kingdom stood out as the place where this relationship was particularly challenged by new regulations inducing health professionals to go beyond their medical role and become interested in some legal aspects of their patient's situation. In France, the provision allowing for UDM integration in public healthcare facilities allows healthcare workers to maintain a professional stance, which they claim is no different from the relationship with documented patients. In Switzerland, health professionals insist on the subjective dimension of their relationship with their patients and tend to describe their action as a humanitarian act of good will rather than as a right of the patient.

Health care for undocumented migrants in Europe: an ethical framework

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One of the main questions in our world is: how can we extend justice and dignified life conditions to all citizens of the world? This question is urgent when considering the situation of undocumented migrants (UDM) in Europe. In this workshop, we will address an ethical framework for dealing with this question. We will use the 'capabilities approach', developed by Martha Nussbaum, that expands liberal political theory in order to encompass concepts of cooperation and care, thus providing justice to previously disregarded groups. Nussbaum introduces her 'capabilities approach' by discussing 10 essential capabilities—'life', 'bodily health', 'bodily integrity', 'senses/imagination/thought', 'emotions', 'practical reason', 'affiliation', 'other species', 'play' and 'control over one's environment'. These capabilities give us a framework for an ethical evaluation of healthcare provisions for UDM in Europe. This ethical framework emphasizes the relevance of dignity for all individuals regardless of their abilities. Nussbaum's theory enhances an understanding of international justice by demonstrating that the duties of wealthy nations and multinational corporations are fundamental to justice in a global society. 'Care for the underprivileged' comes into focus and is theoretically expanded.