

WHO, and we hope that these can be built on. We also agree that WHO needs to collaborate with others and that there are circumstances under which rapid processes are needed.<sup>3</sup> However, systematic reviews should be used to inform those processes whenever possible, and when systematic reviews are not available, the evidence that was used and the methods that were used to summarise that evidence should be transparent.

We fully support Julian Elliott and colleagues' second recommendation, that WHO should support the development of capacity within countries through initiatives such as EVIPNet and REACH. We are sceptical about their first, more futuristic, recommendation for two reasons. WHO does not have the capacity to do that, and until countries have the capacity to use systematic reviews appropriately to inform recommendations and policy decisions, a map such as they propose would be of limited value. Moreover, it can be argued that international recommendations are important because they reduce unnecessary duplication of efforts, in addition to providing support to countries with limited capacity. This, of course depends on the guidelines being well informed by the best available evidence, and constructed in a way that they can easily be adapted to specific contexts.<sup>4</sup>

ADO is a member of the WHO Advisory Committee on Health Research. JNL is President of the PAHO/WHO Advisory Committee on Health Research and a member of the Scientific and Technical Advisory Committee of the Alliance for Health Policy and Systems Research, which is co-sponsored by and housed within WHO.

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## Right to health care for vulnerable migrants

Access to health care for vulnerable migrants in the UK is an increasingly important issue, and your Editorial (July 7, p 2)<sup>1</sup> highlights the human rights arguments in support of making these services available. The public health and economic arguments in favour of ensuring access to health care for this group have been documented elsewhere.<sup>2</sup> However, the report from Médecins du Monde's *Project: London*,<sup>3</sup> which indicates that pregnant women in this group are finding it difficult to access care, raises another important question.

Tackling health inequalities is a priority for the UK government, and inequalities have been documented in the area of stillbirths and perinatal mortality. The latest report from the Confidential Enquiry into Maternal and Child Health<sup>4</sup> indicates that women of "black" and Asian ethnicity in the UK have significantly higher rates of stillbirth and neonatal death than women of white ethnicity.

Nearly 60% of the patients seen at *Project: London* were from sub-Saharan Africa and Asia<sup>2</sup> and there is anecdotal evidence that many asylum seekers whose applications have been turned down are African.<sup>5</sup> This finding suggests that denying women in this vulnerable group access to antenatal care might result in a failure to achieve some of the goals set out in the national strategy to tackle health inequalities. In making decisions about access to health care for vulnerable migrants, the potential effect of these decisions on health inequalities should be an important consideration.

I have spoken at workshops advocating access to health care for migrants who are undocumented.

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We welcome your Editorial of July 7,<sup>1</sup> in which you address the problem of access to health care for migrants. The recognition of a right to health irrespective of immigration status is fundamental; however, according to the experience of Médecins Sans Frontières (MSF) in southern Italy, legislation per se is not sufficient to ensure access.

In Italy, MSF supports various health centres dedicated to immigrants, giving special attention to cross-cultural mediation services and outreach activities, including information provision, and awareness-raising. This approach has substantially improved access to health care for undocumented migrants, as shown by data from the Campania region, where 10151 consultations were done in seven health centres supported by MSF in 2006.

Since 1999, undocumented immigrants have had the right to receive care at dedicated health centres under Italian law, without being denounced to immigration authorities. In 2004, we visited and interviewed 770 migrant seasonal farm workers, 51.4% of whom were undocumented and 23.4% asylum-seekers.<sup>2</sup> Overall, 40% had become ill during their first 6 months in Italy and 93% after 19 months; the most common problems were infectious diseases, skin problems,



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intestinal parasites, and mouth, throat, and respiratory infections including tuberculosis. However, 75% of the refugees, 85.3% of asylum-seekers, and 88.6% of illegal immigrants were not benefiting from any health care.

Immigrants are too often unaware of their rights, and changing the law does not automatically lead to improved access. In our experience, major determinants of access to health care for vulnerable migrants are appropriate legislation, strong political commitment, adequate cultural mediation, and proactive outreach programmes.

We declare that we have no conflict of interest.

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In your Editorial,<sup>1</sup> you call on the UK government to learn from other EU countries in order not to deny migrants, irrespective of their legal status, access to health care. We welcome such a progressive, inclusive health policy, which should be embedded in the constitution.

A Dutch state report concluded that fears surrounding medical “tourism” are unfounded.<sup>2</sup> In the Netherlands, as well as in several other EU countries, migrants have limited access to health care, and sometimes no access at all without the assistance of civil-society and non-governmental organisations.<sup>3</sup> The UN Special Rapporteur on the right to health, in his 2006 address to the Swedish government,<sup>4</sup> concluded that Swedish health policy regarding

asylum seekers and undocumented migrants is inconsistent with international human rights law.

UN treaties and EU instruments on human rights relevant to undocumented migrants have been summarised in an excellent overview,<sup>5</sup> and the results of a study by the Platform for International Cooperation on Undocumented Migrants (PICUM) in 12 EU countries on access to health care for undocumented migrants will be launched this month. Preliminary results show a serious difference between de jure and de facto access in most countries. We urge all EU country governments to acknowledge explicitly their responsibility for the health care of each person residing on their soil and to guarantee these individuals’ rights to necessary health care. If such responsibilities are not accepted, serious human rights violations will continue, and further harm will be done to vulnerable people who not only have a right to health but to social inclusion. Governments, and not only in the EU,

should respect, protect, and fulfil these rights. Last but not least there should be progressive realisation and never retrogression as is the case in the UK.

We declare that we have no conflict of interest.

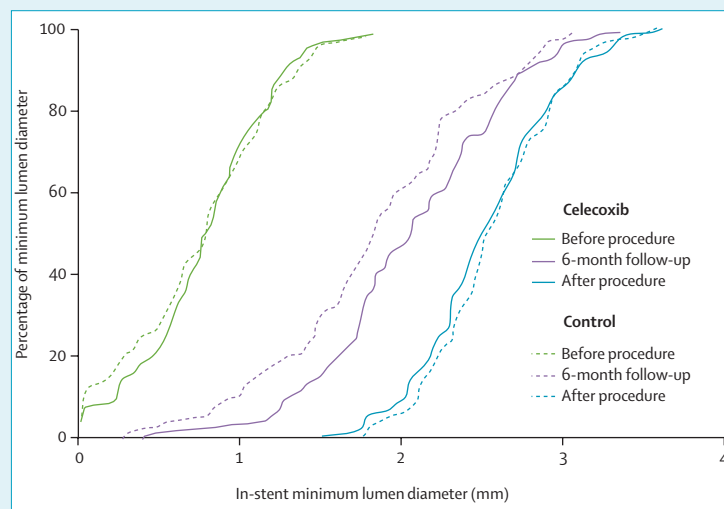
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- 5 Platform for International Cooperation on Undocumented Migrants. Undocumented migrants have rights! Brussels: PICUM, 2007. <http://www.picum.org/> (accessed Aug 15, 2007).

## Department of Error

Bon-Kwon Koo, Yong-Seok Kim, Kyung-Woo Park, et al. Effect of celecoxib on restenosis after coronary angioplasty with a Taxus stent (COREA-TAXUS trial): an open-label randomised controlled study. *Lancet* 2007; **270**: 567–74—In this Article (Aug 18), there was an error in figure 2 (p 571). The correct version is shown below.



**Figure 2: Minimum lumen diameter before the procedure, after the procedure, and at 6-month follow-up**

In-stent minimum lumen diameter as measured by quantitative coronary angiography showed significant changes over time in each group ( $p < 0.0001$ ) and these serial changes were significantly different between the celecoxib and control groups ( $p = 0.001$ ).