

# Access to Health Care for Undocumented Migrants in Europe



 PICUM

PLATFORM FOR INTERNATIONAL COOPERATION ON UNDOCUMENTED MIGRANTS

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# Access to Health Care for Undocumented Migrants in Europe



PLATFORM FOR INTERNATIONAL COOPERATION ON UNDOCUMENTED MIGRANTS

**PICUM**, the **Platform for International Cooperation on Undocumented Migrants**, is a non-governmental organization that aims to promote respect for the human rights of undocumented migrants within Europe. PICUM also seeks dialogue with organizations and networks with similar concerns in other parts of the world.

PICUM promotes respect for the basic social rights of undocumented migrants, such as the right to health care, the right to shelter, the right to education and training, the right to a minimum subsistence, the right to family life, the right to moral and physical integrity, the right to legal aid and the right to fair labor conditions.

PICUM's activities are focused in five main areas:

- 1. Monitoring and reporting:** improving the understanding of issues related to the protection of the human rights of undocumented migrants through improved knowledge of problems, policies and practice.
- 2. Capacity-building:** developing the capacities of NGOs and all other actors involved in effectively preventing and addressing discrimination against undocumented migrants.
- 3. Advocacy:** influencing policy makers to include undocumented migrants in social and integration policies on the national and European levels.
- 4. Awareness-raising:** promoting and disseminating the values and practices underlying the protection of the human rights of undocumented migrants among relevant partners and the wider public.
- 5. Global actors on international migration:** developing and contributing to the international dialogue on international migration within the different UN agencies, international organizations, and civil society organizations.

PICUM has nearly 90 affiliated members and 90 ordinary members in approximately 20 countries in Europe and beyond. PICUM's monthly newsletter on issues concerning the human rights of undocumented migrants is produced in seven languages and circulates to PICUM's network of more than 2,400 civil society organizations, individuals and further.

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**Michele LeVoy**

PICUM Director

## Introduction

*“The exclusion of vulnerable groups from health care brings along major risks like individual suffering and exploitation, a risk for public health in general, demand for emergency services which are far more expensive, the creation of backstreet services, ethical dilemmas, problems for the administration and discrimination against the concerned migrants.”*

Wayne Farah, Newham Primary Care Trust

### Undocumented Migrants in Europe

Undocumented migrants are migrants without a residence permit authorizing them to regularly stay in the country of destination. In its work, PICUM encounters two principle types of undocumented migrants:

- (i) People whose arrival in the country of destination has been by a legal route, but who have subsequently found that the substantial cost of their movement cannot be recovered through the very limited work opportunities permitted under the official schemes;
- (ii) People who, though gaining admission by irregular routes, had been led to that point after a long-drawn out process involving a substantial commitment in time and scarce financial resources, but who had not at the onset of their journey necessarily intended ‘illegal’ migration.

While it has been estimated that there may be from 5 to 8 million undocumented migrants in Europe,<sup>1</sup> they largely remain invisible in the eyes of policy makers. This situation puts enormous strain on local actors such as NGOs, health care and educational

professionals, and local authorities, who often work with limited resources to defend undocumented migrants’ fundamental rights, including the right to health care, education and training, fair working conditions, and housing. These local actors are confronted on a daily basis with situations confirming that irregular legal status is an obstacle for a sizeable part of the population in accessing basic social services. Professional groups experience clashes between what their professional ethics tell them to do and the incriminatory discourse regarding undocumented migrants.

### Undocumented Migrants and Health Care

Undocumented migrants in Europe face serious problems in gaining access to health care services. For them, a worsening of their physical and mental health is more likely to occur owing mainly to poor access to health care services and/or the continual fear of being discovered and expelled.

While numerous international instruments in human rights law have been ratified by EU member states and refer to the right of *everyone* to health care as a basic human right (regardless of one’s administrative

<sup>1</sup> The report by the Global Commission on International Migration (GCIM, *Migration in an Interconnected World: New Directions for Action. Report of the Global Commission on International Migration, October 2005*, (Madrid: Médecins du Monde, 2005), p.32. Available online at: <http://www.gcim.org/attachements/gcim-complete-report-2005.pdf>) states that the Organization for Economic Cooperation and Development - OECD has estimated that “between 10 and 15 percent of Europe’s 56 million migrants have irregular status, and that each year around half a million undocumented migrants arrive in the EU.”

status), the laws and practices in many European states deviate from these obligations.<sup>2</sup> It is a fact that a high percentage of undocumented migrants do not access any kind of health care even if they are entitled.

Undocumented migrants mainly seek health care when they are severely ill. Health is commonly not their main concern because all of their energies are often exhausted in acquiring the minimum subsistence necessary for survival.

Many undocumented migrants lack information about their rights to access medical services in the country where they live. On many occasions, they do not seek medical help because they have an enormous fear of being discovered and deported. They easily confuse the levels of administrations and public authorities. They also think that hospitals and health centers will inform the police of their presence.

There are many vulnerable groups of undocumented migrants as regards access to health care, including children, pregnant women and people with severe chronic diseases such as HIV/AIDS.

Besides these common hindrances, there are many other practical obstacles in all countries linked to procedures and administrative conditions, discrimination, language and cultural barriers, medical fees, etc. In addition, practice shows that many undocumented migrants are generally unable to pay medical fees in those countries where they are requested to do so. Those undocumented migrants who do seek health care more frequently favor NGO clinics and hospital emergency units.

Improving access to health care for undocumented migrants is an urgent priority not only since the lack of it is proven to have serious consequences for

undocumented migrants themselves, but also upon public health in general. In fact, the effectiveness of public health policies requires the participation of all residents in health care programmes to protect the well being of all.

### The Human Right to Health Care

Before providing an overview of the situations concerning access to health care for undocumented migrants in the different EU member states examined in this publication, it is necessary to first elaborate on the international human rights standards regarding the right to health care. The situation in each EU member state regarding accessibility to health care services for undocumented migrants should be weighed against this international standard, rather than against other EU member states.

The UN International Covenant on Economic, Social and Cultural Rights provides the most comprehensive clause on the right to health in international human rights law. According to article 12(1), States Parties recognize:

*“the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”*

The content of this provision has been further clarified by the Committee on Economic, Social and Cultural Rights (CESCR), established to monitor the implementation of the convention in its General Comment 14. Accordingly, “States are under the obligation to respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal migrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy...”<sup>3</sup>

<sup>2</sup> PICUM, *Undocumented Migrants Have Rights! An Overview of the International Human Rights Framework*, (Brussels: PICUM, 2007).

<sup>3</sup> UN Economic, Social and Cultural Rights Committee, *General Comment No. 14 (2000). The right to the highest attainable standard of health*, UN Doc.E/C.12/2000/4. August 2000, para. 34. Available online at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>



## The Different Legal Systems in EU Member States

While no EU member state's legislation specifically forbids access to health care for undocumented migrants, access to publicly subsidized health care, either partially or fully, is not entirely guaranteed in Europe. In some countries, all health care (even emergency care) is provided only on a payment basis and treatments are generally unaffordable for undocumented migrants.

The most restrictive member states shield themselves from criticism by asserting that emergency care is never denied to undocumented migrants. However, it is impossible to seriously speak about "accessibility" to health care when undocumented migrants continue to be asked to pay high and unaffordable sums in return, even in situations where their life is at severe risk or when they seek to give birth, as is occurring in some EU member states.

In addition, access to health care is being used as an instrument of immigration control policies and has become increasingly restrictive in recent years. For example, entitlements have been significantly reduced in the UK and France has introduced more conditions to access publicly subsidized health care.

There is a growing tendency in Europe to restrict access to health care for undocumented migrants and to reinforce the link between access to health services and immigration control policies. Such policies not only undermine fundamental human rights but also overburden migrant communities who may already be marginalized and living in precarious situations. "Disputes over immigration status frequently cut across the provision of care and treatment, leaving sick people untreated, supported only by others in the migrant communities who themselves subsist at a minimum wage and minimum social amenity standards."<sup>4</sup>

The applicable laws and procedures are generally complicated and need more publicity. Many relevant actors are unfamiliar with the legislation in force and have difficulties to accurately describe undocumented migrants' entitlements to health care. In addition, it has been observed that having ambiguous laws with a high degree of uncertainty can be politically motivated.

When regulating this issue, EU member states use different concepts and generally do not provide clear-cut definitions. There are many terms in use: emergency care, urgent medical care, essential medical care, immediate care, immediate necessary treatment, medically necessary care, etc. The absence of clear definitions has brought confusion and failures at the level of implementation but has also allowed wide interpretations of the law (as has happened in the Netherlands where the lack of definition of the concept of "medically necessary care" has allowed doctors to increasingly expand health coverage for undocumented migrants).

In some countries, there is no specific legislation on access to health care for undocumented migrants. There are only very indirect laws and regulations applying (e.g. like the obligation imposed by Swedish legislation on county councils to provide immediate care to all persons in need).

## A Difficult Categorization of Countries

PICUM's research and the experience of organizations in its network have shown a wide disparity amongst EU member states concerning legal entitlements of undocumented migrants to health care services.

Given the different systems existing in Europe concerning access to health care for undocumented migrants, the categorization has been very difficult. We have, however, distinguished five different situations:

<sup>4</sup> AIDS and Mobility Europe, *You can speak! How HIV-positive people with an uncertain residence status survive in Europe, September 2006*, (Amsterdam: AIDS and Mobility Publications, 2006), p.2. Available online at: <http://ws5.e-vision.nl/systeem3/images/WG%20IV%20-%20You%20can%20speak.pdf>

- i. Countries where all care is provided only on a payment basis, such as Austria and Sweden. Nonetheless, there are exceptions for particularly vulnerable groups or specific medical conditions: Sweden covers the expenses generated for providing health care to children of rejected asylum seekers, and Austria allows access to treatment of contagious diseases such as tuberculosis free of charge.
- ii. Other countries offer free health care in very limited cases, such as Hungary and Germany. In Germany low level entitlements are overridden by the duty to denounce imposed on public officials dealing with undocumented migrants' health care files. The Social Welfare Office is obliged by law to inform the Foreigners' Office about the presence of a patient in an irregular situation each time they go to a consultation or when health care providers ask for reimbursement of medical costs. Consequently, undocumented migrants refrain from exercising their already limited entitlements.
- iii. A third category is countries with somewhat wider coverage but whose legislation is rather restrictive, ambiguous and with a high degree of uncertainty. Good examples of countries in this situation are the UK and Portugal.
- iv. Other countries, such as France, Belgium and the Netherlands, have put a "parallel" administrative and/or payment system in place concerning health care services for undocumented migrants. However, undocumented migrants are still treated in the mainstream health system.
- v. Finally, Italy and Spain provide the widest health coverage to undocumented migrants. Although there are certain conditions, gaps and failures, the spirit of the law, particularly in Spain, is to provide universal access to health care. Therefore free access to health care is offered to all, including undocumented migrants.

### **The Implementation of the Law at Local and Regional Levels**

PICUM's research has shown that in many countries there is high decentralization of competences from the central government to the regional and local entities. There are also many gaps between what the law says and its implementation. The procedures concerning implementation of the law are often complicated; there are many conditions, sometimes many administrations involved and a lot of bureaucracy.

Many local authorities in charge of implementing the law lack information about undocumented migrants' entitlements and thus may illegally deny or refuse to recognize undocumented migrants' right to access publicly subsidized health care.

On many occasions, the enforceability of rights depends on NGO pressure or mediation. Many problems that occur within the administrative system are solved by NGOs through simple means such as telephone calls. The problem appears to be greater whenever undocumented migrants do not seek the help of NGOs or in those areas where there are very few NGOs working with immigrants (such as in the countryside in many parts of Europe).

Within each country, there are many differences in the implementation and interpretation of the law. Whilst we find local administrators implementing the law very generously, organizing information campaigns or adopting guidelines to achieve uniformity, there are other administrators discriminating or introducing illegal additional requirements to "avoid abuses."

### **Health Care Providers and Hospitals**

It is a constant feature throughout Europe that those health care providers who are more "undocumented migrant friendly" (who are more willing to render service to undocumented migrants) tend to become more overloaded.

When talking about undocumented migrants' entitlements, all interviewed doctors and nurses expressed a different understanding of the term "urgent" when compared to the one established in legislation. For example, these medical professionals strongly stressed the urgency of providing mental health care to undocumented migrants (whereas mental health is not considered "urgent" health care in many countries). Highly concerned about undocumented migrants' health care needs, they are increasingly involved in advocating for undocumented migrants' rights. They are normally listened to by health authorities and they have a great persuasive power.

With regards to hospitals, it is necessary to make some specific considerations. Medical staff generally apply professional codes and duties - it is not common to find doctors and nurses openly denying health care to anyone. However, hospital administrators are the first point of call and free from the binding duty of professional ethics. Administrators may not have so many problems to turn away undocumented migrants at the hospital reception.

The main barriers and problems arising at hospitals are as follows:

- In many cases, undocumented migrants are requested to prove that they can pay before they receive health care. In some countries, hospitals perceive undocumented migrants as synonymous with the loss of income and therefore are reluctant to treat them.
- Other times, hospitals provide health care and send the bills to undocumented migrants afterwards. Since undocumented migrants are sometimes unable to pay, many bills remain unsettled. Some of these bills are sent to NGOs if they had previously contacted the hospital concerning a particular patient.
- There is also a lack of information concerning undocumented migrants' entitlements to health care and confusion about target groups (migrants, undocumented migrants, asylum seekers, etc.) and their entitlements.

- Hospital administrations sometimes wrongly believe that their duty to check entitlements is also a duty to report to immigration authorities.
- There are problems with medical history records, many of which are caused by one of the informal strategies used by undocumented migrants to access health care: the use of insurance cards belonging to family members or friends.
- Also observed is a poor presence of interpreters and cultural mediators in many hospitals.

As with health care providers in general, there is a concentration of undocumented migrants in some "undocumented migrant friendly hospitals" which are mainly private and religious hospitals (sometimes publicly financed, some other times privately financed).

A last observation about hospitals is that in addition to possessing very relevant information about the health care situation concerning undocumented migrants, they also have much information about their living and working conditions but do not implement systematic data collection.

## NGOs

NGOs are another very relevant actor in this field since they also provide direct health care and health care-related assistance to undocumented migrants.

The main services provided by NGOs to undocumented migrants are as follows:

- Advice and help to access mainstream medical services. This is one of the most common activities since most NGOs are interested in making the common law system work rather than organizing a parallel charity-based system for undocumented migrants.
- However, given the gaps and the failures of these systems, many organizations (and this is a phenomenon existing in all countries) also provide direct health care assistance through clinics and

mobile units run by volunteer health care providers. These clinics mainly offer primary health care services but sometimes provide more specialized care such as gynecological or mental health care.

- NGOs also refer patients to health care providers within their networks.
- Providing medicine (primarily received through donations).
- They may also pay bills for care, medicine or tests prescribed to undocumented migrants.
- Finally, some NGOs implement other initiatives concerning undocumented migrants, for example, the provision of a small card containing the patient's medical history and treatments prescribed.

Given the gaps and failures of the health care system, there is enormous pressure on NGOs and charities, particularly in countries where legislation is rather restrictive. These organizations make a tremendous effort to fill the gaps and correct the failures of the state system and on many occasions feel obliged to constantly improvise solutions.

They do this under difficult conditions since they often lack human, technical and financial resources and, in some countries, they face pressure from public authorities given the repressive culture, as is the case in Germany or Austria. In addition, there are a high number of undocumented migrants reliant on them. In some countries their task is essential since NGOs and religious hospitals are the only providers of health care to undocumented migrants.

### **Formal and Informal Networks**

The existing lack or insufficient access to health care for undocumented migrants has very much boosted networking at the local level.

Many relevant actors rely on informal networks. NGOs, hospitals and individual health care providers maintain regular contact by telephone and e-mail. They also organize meetings to exchange information on resolving problems within specific situations or to plan targeted actions to advocate for undocumented migrants' right to access health care. Public administrators and authorities are often involved in these informal networks as well. Even the police will sometimes agree to avoid a particular NGO or hospital.

There are also frequent examples of formal methods of cooperation such as partnerships at the local level involving cooperation of NGOs, health care providers, as well as hospitals and local authorities with responsibility for public health. Most of these partnerships seek to facilitate access to health care at the local level for undocumented migrants in general or for particularly vulnerable groups of undocumented migrants.

### **Improving Access to Health Care: An Urgent Priority**

Improving access to health care for undocumented migrants continues to be an urgent priority in Europe today despite the tremendous efforts made by civil society to fill the gaps and guarantee the minimum respect for human dignity.

Nonetheless there are still many undocumented migrants in Europe who do not access any kind of health care or access it at a very late and dangerous stage.

## Purpose and structure of this report

This report has been the result of a two-year European project co-funded by the Employment and Social Affairs and Equal Opportunities Directorate General of the European Commission. Nineteen partners from the following EU member states participated in the project: Austria, Belgium, France, Germany, Hungary, Italy, the Netherlands, Portugal, Spain, Sweden and United Kingdom.

The main purpose of this publication is to give visibility to various problems associated with the existing lack of or insufficient access to health care for undocumented migrants residing in Europe.

To this aim, we have chosen to present the situation regarding access to health care for undocumented migrants in terms of law and practice through eleven country profiles corresponding to the different member states participating in this study.

Concerning the legal framework, information is provided on:

- i) the general health care system;
- ii) the specific legal entitlements of undocumented migrants to access fully or partially publicly subsidized health care;
- iii) the procedures and financing of the different systems put in place by EU member states to give a response to undocumented migrants' health care needs.

Each country profile also gives an overview of the situation in practice, e.g. the most common problems and obstacles preventing undocumented migrants from accessing health care as well as the role of civil society and local actors in this field.

During the first year of the two-year project, field trips and research interviews were carried out. In the second year, the information was assimilated into report format. Some slight modifications to the legislative framework may have occurred since the research was completed and PICUM has made efforts to include updates where possible. Although the project has now come to a close, readers may contact PICUM to include changes in the various EU member states' legislation examined in the study.

Ultimately, this study seeks to serve as inspiration for new strategies and actions to continue addressing the problems associated with insufficient access to health care for undocumented migrants in Europe. PICUM hopes that the information contained in this publication will be useful in convincing the governments of EU member states to speak more, to do more, and to take on their responsibilities and comply with international human rights obligations instead of continuing to rely upon civil society as an alternative provider of health care for undocumented migrants.

# 1. AUSTRIA

*A severely ill undocumented Chinese man went to the hospital in Vienna and had a serious but successful stomach surgery. Eighteen days after he left the hospital, another undocumented Chinese man came to the same hospital using the identity card of the first one. Since the second man had grave stomach problems, the doctors took him directly to the surgery relying on data from the medical history pertaining to the person mentioned in the identity card presented. During the surgery, the life of the patient was in real danger. He only survived thanks to the doctors realizing on time that the patient did not have the blood group mentioned in the records.*

## » Terms:

*Länder* – states of the Federal Republic of Austria

## GENERAL HEALTH CARE SYSTEM

Austria has a compulsory statutory health insurance system that covers about 95% of the registered population on a mandatory basis and 2% on a voluntary basis.<sup>5</sup> Co-insured family members are subject to a reduced contribution, which in many cases is waived (e.g. for children). The insured have a legal entitlement to social insurance benefits, which are financed predominantly by income-dependent contributions. The financing of the statutory health

insurance system is always based on contributions paid in equal shares by employers and employees, accounting for around 7.5% of salaries in 2005, with limits for maximum contributions.<sup>6</sup>

People who remain uninsured are mainly unemployed nationals and immigrants as well as asylum seekers. In 2003, a study commanded by the Federal Ministry of Health and Women noted that there were around 160,000 uninsured persons in Austria.<sup>7</sup> For them, the state provides health care, medicine

<sup>5</sup> Statutory health insurance is organised according to vocational groups and regional aspects, with some very wide variations in arrangements. Health insurance provides the following benefits: medical aid, medication, hospital care, home nursing and midwives, psychotherapy and clinical-psychological diagnosis, services of the medical-technical professions, mother-child medical card examinations, health examinations and preventive medical check-ups, travel and transport costs, grants for prosthetic materials and auxiliaries, sickness benefits payments in cases of occupational disability through illness, maternity benefits, social accident insurance and the nursing care.

Additionally, about one third of the Austrian population pays premiums into a private supplementary insurance policy in addition to their social security contributions. Such complementary insurances may grant the insured person better accommodation in the hospital (single rooms, for example), coverage of the costs of treatment by a doctor who does not have a contract with the particular patient's health insurance, payment of daily benefits in cases of illness, or the assumption of costs for complementary medical treatment procedures. See Bundesministerium für Gesundheit und Frauen (BMGF), *Public Health in Austria*, (Wien: BMGF, 2005), pp. 103-107. Available online at: [http://www.bmgfj.gv.at/cms/site/attachments/8/6/6/CH0083/CMS1051011595227/public\\_health\\_in\\_austria\\_2005\\_internet.pdf](http://www.bmgfj.gv.at/cms/site/attachments/8/6/6/CH0083/CMS1051011595227/public_health_in_austria_2005_internet.pdf)

<sup>6</sup> Große-Tebbe S. and Figueras J. (eds.), *Snapshots of Health Systems – The State of Affairs in 16 Countries in Summer 2004*, (Copenhagen: WHO, 2004), p. 8. Available online at: <http://www.euro.who.int/document/e85400.pdf>

<sup>7</sup> The Austrian government has traditionally stressed that the whole population residing legally in Austria was insured. Nonetheless, in 2003 it published a report conducted by the European Centre for Social Welfare Policy and Research that showed that there were around 160,000 people aged 15 or older living in Austria without any public or private insurance, including foreign students and tourists. See Bundesministerium für Gesundheit und Frauen (BMGF), *Quantitative und qualitative Erfassung und Analyse der nicht-krankenversicherten Personen in Österreich*, (Wien: BMGF, 2004), p. 14. Available online at: <http://www.bmgfj.gv.at/cms/site/detail.htm?thema=CH0083&doc=CMS1083763194914> and International Organisation for Migration (IOM) – National Contact Point Austria within the European Migration Network. *Illegal Immigration in Austria. A Survey of recent Migration Research*. (Wien:IOM, 2005), p.56. Available online at: [http://www.emn.at/modules/typesetool/pnincludes/uploads/FINAL\\_VERSION\\_ENG.pdf](http://www.emn.at/modules/typesetool/pnincludes/uploads/FINAL_VERSION_ENG.pdf)

and compensation in cases of injury or accident at work.<sup>8</sup> As for any social service in Austria, undocumented migrants are generally excluded from these provisions.

The Federal Ministry of Health and Women has the general competence in the field of health policy and the structural planning of the health care system. In addition, this ministry shares responsibility for the protection of general public health, for preventive medical measures including preventive medical treatment of school-age children, public hygiene and vaccinations, monitoring and combating contagious and infectious diseases, for matters of hospitals, nursing homes and public social and welfare establishments.<sup>9</sup>

The nine *Länder* governments deliver public health services and have strong competences to finance and regulate inpatient care.<sup>10</sup> Additionally, important responsibilities are also assumed by social security institutions as self-administered public operations. Access to individual services of the public health care system is governed by social law.<sup>11</sup>

An important contribution to acute medical care is provided by the outpatient clinics of specialized departments in hospitals. More than half of Austria's hospitals are so-called "fund-hospitals" which essentially encompass the acute-illness sector (except accident and emergency hospitals) and are financed through a mix of tax revenues and health insurance contributions via provincial health funds.<sup>12</sup>

## HEALTH CARE FOR UNDOCUMENTED MIGRANTS

### 1. Legal Entitlements to Access Fully or Partially Publicly Subsidized Health Care

Austrian state discourse related to undocumented migrants is marked by a decisive and explicit over-emphasis on repressive policies, instruments and measures. Consequently, there is no public social or health care support for undocumented migrants.<sup>13</sup> Undocumented migrants are not eligible to access the social security system including health, accidental and pension insurance. Since they cannot obtain public health insurance they do not enjoy any legal right to benefit from health care facilities.

The only legislation indirectly applicable is the Austrian law on hospitals and sanatoria, which provides that every hospital should admit and treat injured patients whose health is in serious danger.<sup>14</sup> This law does not exclude anyone on grounds of nationality or residence status and thus leaves the door open for undocumented migrants to access the emergency system in life-threatening situations but they will always have to pay for the expenses. Given the costs, it is most likely that undocumented migrants will not seek health care or will not be able to pay the hospital bills.

<sup>8</sup> This system was introduced by the "Basic Welfare Support Agreement" and entitles access to health care and medicine with some restrictions when compared to the general scheme. The agreement entered into force on 1 May 2004. See Große-Tebbe S. and Figueras J., (2004: 7). Available online at: <http://www.euro.who.int/document/e85400.pdf>. See also IOM, (2005:34). Available online at: [http://www.emn.at/modules/typetool/pnincludes/uploads/FINAL\\_VERSION\\_ENG.pdf](http://www.emn.at/modules/typetool/pnincludes/uploads/FINAL_VERSION_ENG.pdf)

<sup>9</sup> See BMGF, (2005: 19f). Available online at: [http://www.bmgfj.gv.at/cms/site/attachments/8/6/6/CH0083/CMS1051011595227/public\\_health\\_in\\_austria\\_2005\\_internet.pdf](http://www.bmgfj.gv.at/cms/site/attachments/8/6/6/CH0083/CMS1051011595227/public_health_in_austria_2005_internet.pdf)

<sup>10</sup> Ibid.

<sup>11</sup> Ibid., p. 15.

<sup>12</sup> See Große-Tebbe S. and Figueras J., (2004:8). Available online at: <http://www.euro.who.int/document/e85400.pdf>. See also BMGF, (2004: 54)

<sup>13</sup> See IOM, (2005:27) and (2005:29-36). Available online at: [http://www.emn.at/modules/typetool/pnincludes/uploads/FINAL\\_VERSION\\_ENG.pdf](http://www.emn.at/modules/typetool/pnincludes/uploads/FINAL_VERSION_ENG.pdf)

<sup>14</sup> See §§ 22-23 Bundesgesetz über Krankenanstalten- und Kuranstalten (KAKuG) BGBl. Nr. 1/1957, last modified by BGBl. I Nr. 155/2005.

In Austria, there are specific laws regarding infectious diseases such as tuberculosis and HIV/AIDS that require health care providers to inform the competent authorities about all new cases. The provisions are very general and do not make any distinction on grounds of residence status. The Tuberculosis Act of 1968 stipulates that people suffering from infectious tuberculosis have to receive medical treatment and the authorities are obliged to provide subsidized health care.<sup>15</sup> In practice, however, it is very difficult to treat undocumented migrants with tuberculosis since they do not normally have the necessary living conditions for the continuity and success of the treatment.

Concerning HIV/AIDS, the AIDS law obliges doctors to inform patients about their disease and the risk of transmission as well as the precautions to avoid infection of others.<sup>16</sup> The test is free but there is no subsidized access to treatment for undocumented migrants. As a result, some undocumented migrants with HIV/AIDS seek treatment at places like *Aidshilfe* in Vienna.

***Aidshilfe Wien*** offers counseling, anonymous testing and treatment to people with HIV/AIDS. This organization offers anonymous care and undocumented migrants may thus also receive retroviral treatment as well as social and psychological support.

<http://www.aids.at>

## 2. The Situation in Practice

Given their exclusion from the insurance system and from the state-funded scheme for uninsured persons,<sup>17</sup> undocumented migrants are obliged to pay the full cost of treatment when seeking health care in Austria. Since treatments are often very expensive, in most cases undocumented migrants lack the necessary financial means to pay.

Consequently, undocumented migrants only go to hospitals when they have serious diseases that cannot be treated elsewhere. Even the Federal Ministry of Health and Women seems to acknowledge this fact in its report about uninsured persons in Austria. This study also stresses that among the group of uninsured persons, undocumented migrants are one of the most vulnerable due to their fear of being discovered and sent back to their countries of origin.<sup>18</sup>

When ill undocumented migrants cannot find any other alternative than seeking treatment at the hospital, they usually receive unaffordable bills after obtaining the treatment. Many turn to NGOs or family members for help with covering the costs. Family members especially face serious difficulties in paying the incurred medical expenses.

Hospitals are not obliged to register the residence status of a patient and, as the International Organization for Migration (IOM) states, “a patient cannot be forced to give any reliable data. Sometimes, it happens that the hospital cannot find out who actually was medicated.”<sup>19</sup> As Dr. Gerald Ressi of the organization *OMEGA* in Graz reported, “there are many cases where bills remain unpaid.” Therefore,

<sup>15</sup> See §§ 2 and 10 of the Tuberkulosegesetz, BGBl Nr. 127/1968, last modified by Federal Law BGBl. I Nr. 65/2002.

<sup>16</sup> See Aids-Gesetz BGBl Nr 728/1993, last modified by Federal Law BGBl. I Nr. 98/2001.

<sup>17</sup> International Organisation for Migration (IOM) – European Network for Co-operation and Exchanges on Social Exclusion and Health Issues for Migrants. *National Report Austria: Soziale Exklusion und Gesundheit von MigrantInnen in Österreich*. (Wien: Ludwig Boltzmann Institut, 2003), pp.30. See also IOM, (2005:27). Available online at: [http://www.emn.at/modules/typetool/pnincludes/uploads/FINAL\\_VERSION\\_ENG.pdf](http://www.emn.at/modules/typetool/pnincludes/uploads/FINAL_VERSION_ENG.pdf)

<sup>18</sup> BMGF, (2004:90). Available online at: <http://www.bmgfj.gv.at/cms/site/detail.htm?thema=CH0083&doc=CMS1083763194914>

<sup>19</sup> IOM, (2005:27f). Available online at: [http://www.emn.at/modules/typetool/pnincludes/uploads/FINAL\\_VERSION\\_ENG.pdf](http://www.emn.at/modules/typetool/pnincludes/uploads/FINAL_VERSION_ENG.pdf)



the hospital must apply to the District Social Welfare Department to cover the budget losses arising from unpaid bills of uninsured people.<sup>20</sup>

Unpaid bills may also have consequences for the few undocumented migrants who manage to regularize their stay in Austria. “They will get the residence permit together with a big debt towards hospitals that they will probably have to pay for the rest of their lives,” said Gerald Ressi of *OMEGA*.

Even though hospitals may reject an immigrant patient if their medical condition is not considered to be an emergency,<sup>21</sup> in practice, the tendency is for hospitals to treat undocumented migrants despite the potential budget losses, because there are not many cases arising.

### 3. The Role of Civil Society and Local Actors

To cope with the above-mentioned practical obstacles and with the lack of entitlements to public health care for undocumented migrants, some organizations either act as intermediaries, asking for a cancellation or reduction of the fees, or establish lists of individual health care providers willing to assist undocumented migrants free of charge. Examples of these kinds of organizations are *Caritas*, *Diakonie-AMBER MED*, *Asyl in Not*<sup>22</sup>, *Verein Ute Bock*<sup>23</sup> and *Deserteurs- und Flüchtlingsberatung*, all based in Vienna.

The *Deserteurs- und Flüchtlingsberatung* (Counseling for Deserters and Refugees) was founded in 1992 as a support organization for Serbian and Croatian war deserters. Today it offers counseling to all refugees and migrants, mostly with regard to questions concerning residence and asylum. The organization is rooted in the anti-racism movement. An important part of its work consists of referring people, including undocumented migrants, to other facilities and organizations that are able to provide help.

<http://www.deserteursberatung.at>

In addition, some organizations and hospitals like *Diakonie-AMBER MED*, *Caritas* and *Krankenhaus der Barmherzigen Brüder* in Vienna and *OMEGA-CARITAS* in Graz also provide direct medical assistance and medicines to undocumented migrants.

*AMBER-MED* offers health care and medicine for uninsured people in Vienna in cooperation with the *Austrian Red Cross*. Around 800 patients are treated every year by this organization, mostly asylum seekers denied basic care by the state, homeless people and undocumented migrants. *AMBER-MED* is supported by a network of more than 70 doctors and institutions such as laboratories and hospitals that treat patients for free.

<sup>20</sup> Only the losses of the so-called “fund hospitals” are compensated by the District Social Welfare Department.

<sup>21</sup> IOM, (2005:92). Available online at: [http://www.emn.at/modules/typetool/pnincludes/uploads/FINAL\\_VERSION\\_ENG.pdf](http://www.emn.at/modules/typetool/pnincludes/uploads/FINAL_VERSION_ENG.pdf)

<sup>22</sup> *Asyl in Not* (Asylum in Need) is a support committee for people prosecuted for political reasons. For more information, available online at: <http://www.asyl-in-not.org>.

<sup>23</sup> The *Verein Ute Bock* (Association Ute Bock) is a refugee project offering counselling, educational programmes and practical help. More information available online at: <http://www.fraubock.at>.

The *Diakonie Evangelisches Hilfswerk* is the Refugee Service of the Protestant Church in Austria. In 2004, it started the project **AMBER**; an important contact point for undocumented migrants who would not dare to consult a doctor for fear of being arrested. *AMBER-MED* tries to guarantee anonymity and protects the data of all those who seek medical help.

*AMBER-MED*'s main areas of activity are regular and preventive health care, neurological care and psychotherapeutic crisis intervention. They also have a dispensary of drugs. In cases where the organization cannot provide further help to the patients, they are referred to its network of cooperating health care providers that treat undocumented migrants free of charge. The following is one such case:

*A 40-year old undocumented man from Serbia was suffering from Carpal tunnel-syndrome and had lost the use of his right hand due to a strong deformation. He had been undocumented in Austria for a number of years and employed without a work permit. As he did not have health insurance, he sought free medical treatment at AMBER-MED. One of the AMBER-MED surgeons found a private surgical practice where he was able to do the necessary surgery (cutting a sinew). The aftercare as well as physical regeneration was assured by AMBER-MED. Due to the treatment, the man was able to use his hand and to return to work after a short recovery time*

<http://www.amber.diakonie.at/>

*AMBER-MED*, along with other organizations and institutions, such as *Caritas Graz* and *Krankenanstalt des Göttlichen Heilande* (a religious hospital in Vienna), also offer possibilities for anonymous prenatal counseling, gynecological examinations and childbirth for women without insurance coverage.<sup>24</sup>

Since its foundation in 1991, the *Louise Bus-Caritas Mobile Unit* has provided medical assistance to around 5,200 homeless and uninsured people every year. In 1993, *Caritas St. Josef* took over the organization and responsibility of the *Louise Bus* which offers medical assistance five days a week at seven different places in Vienna – places where homeless people can primarily be found. Doctors and unsalaried assistants ensure professional medical care for patients without health insurance. The mobile unit allows contact with people afraid of going to a doctor to deal with their problems and confiding in them.

At times this mobile unit as well as the other organizations providing direct medical assistance to undocumented migrants in Vienna find themselves in situations where the patients require specialized help that only hospitals can provide. In these cases, most refer the patients to the *Krankenhaus der Barmherzigen Brüder*, a private religious hospital where undocumented migrants are treated for free.

This hospital is today one of the most important contact points for undocumented migrants in Vienna. Free medical care is guaranteed to approximately 20,000 to 30,000 uninsured patients every year, of which about 1,000 to 5,000 are hospitalized. Undocumented migrants largely rely on the *Krankenhaus der Barmherzigen Brüder*, which provides all types of inpatient and outpatient care with the sole exception of HIV/AIDS and accident-related treatments.

<sup>24</sup> See IOM, [2005:94]. Available online at: [http://www.emn.at/modules/typetool/pnincludes/uploads/FINAL\\_VERSION\\_ENG.pdf](http://www.emn.at/modules/typetool/pnincludes/uploads/FINAL_VERSION_ENG.pdf)

The *Krankenhaus der Barmherzigen Brüder* (*Hospital of the Brothers of Saint John*) was founded more than 400 years ago, based on Christian principles of charity. A major project of the hospital is the so-called “new hospitality” that includes a mobile unit for deaf people, a separate unit for stationary treatment of detainees as well as a special mobile unit for those without health insurance and unable to pay for treatment, particularly homeless people or undocumented migrants. Through this form of charity, the hospital applies its mission and indiscriminately offers medical treatment to people regardless of their social or national background or religious commitment.

<http://www.barmherzige-brueder.at/>

Medication is provided for some undocumented migrants by the *Pharmaceutical Depot of the Austrian Red Cross* in Vienna. In 2000, this organization provided pharmaceutical support worldwide for an amount exceeding two million Euros. In addition, the *Red Cross Pharmaceutical Depot* offers prescribed medication to uninsured people for free. However, some medicine is not always available since the depot only has a limited quantity at its disposal.

Apart from the initiatives based in Vienna, others exist in different Austrian cities. For instance, in the city of Graz, *Caritas Graz* and the organization *OMEGA* jointly work on the *Marienambulanz*, a mobile unit which provides health care in several points of the city once a week to uninsured homeless people. Undocumented migrants constitute a significant part of this group.

The *Marienambulanz* is a project carried out jointly by *Caritas Graz* and *OMEGA* with the aim of providing primary health care to people without insurance as well as to homeless people in Graz. Undocumented migrants represent a large part of the target group.

In 2004, 5,061 medical treatments were provided.<sup>25</sup> Since 2001, a mobile unit has traveled to different areas in Graz once a week to provide health care. In January 2006, the *Marienambulanz* was granted the legal status of an official outpatient clinic, according to the Hospital Law of the Styrian region.

<http://www.marienambulanz.caritas-graz.at/>

*Omega Gesundheitsstelle* (Omega Health Center) is a non-profit association which aims for the promotion, support and treatment of individuals who are affected by organized forms of violence and gross systematic violations of health and human rights by employing a family-oriented approach.

<http://www.omega-graz.at>

In a country such as Austria where the state takes no action to solve the problems arising from the lack of access to health care for undocumented migrants, the role of civil society organizations and private institutions is crucial to keep these migrants alive. This reality has also been acknowledged by the Ministry of Health.<sup>26</sup>

<sup>25</sup> Ibid.

<sup>26</sup> See BMGF, [2004: 90]. Available online at: <http://www.bmgfj.gv.at/cms/site/detail.htm?thema=CH0083&doc=CMS1083763194914>

In big cities like Vienna, the existence of informal networks and privately funded initiatives allows undocumented migrants to receive most medical treatments free of charge. However, this seems not to be the case in rural areas with less immigrant population.<sup>27</sup> For example, according to *Frauenhaus Tirol* (Tyrol Battered Women's Shelter), there are very few doctors in Tyrol willing to treat people without health insurance.

Many undocumented migrants are uninformed about the possibility of receiving medical treatment and are continually very reluctant to seek health care in any venue, as they fear discovery. As Dr. Pichler from the *Krankenhaus der Barmherzigen Brüder* said, "Here in Austria, undocumented migrants only come to hospital when they are in an extreme situation. Some of them come only to die."

<sup>27</sup> Ibid.

## 2. BELGIUM

*Consuelo was an undocumented woman from Ecuador who had lived in Belgium for seven years. During her stay, she lived in constant fear due to her irregular status and never went to the doctor, even when she started having health problems. She finally decided to go to the hospital when her situation became very serious, and at that point she was diagnosed with cancer. Her treatment was only partially covered by the state through the “urgent medical assistance” scheme. Since she could not afford the remaining cost of the treatment, she returned to her native country of Ecuador, where she died shortly afterwards.*

» **Terms:**

*CPAS/OCMW* (Centre public d'aide sociale/ Openbaar centrum voor maatschappelijk welzijn) - social welfare centre

*INAMI* (*Institut national d'assurance maladie-invalidité*) - National Institute for Health and Disability Insurance

*SPP-IS* (*Service public de programmation de l'intégration sociale*) - Public service for programming and social integration

### GENERAL HEALTH CARE SYSTEM

Belgium has a system of compulsory national health insurance that covers the whole population and has a very broad benefits package. Health care is privately provided. Health insurance is organized through six private non-profit health insurance funds.

Membership is obligatory but there is a freedom to choose between health insurance funds. The health coverage and the social contribution rates levied are the same for all funds. Nonetheless, reimbursement by individual health insurance funds depends on the nature of the service, the legal status of the provider and the status of the insured. There is a distinction between those who receive standard reimbursements and other vulnerable social groups who obtain higher reimbursements.

Patients in Belgium participate in health care financing via co-payments, for which the patient pays a certain fixed amount of the cost of a service, with the third-party payer covering the balance of the amount; and via co-insurance, for which the patient pays a certain fixed proportion of the cost of a

service and the third-party payer covers the remaining proportion.

Private health insurance remains very small in terms of market volume but has increased as compulsory insurance coverage has been reduced.

The Belgian health system is organized on two levels: federal and regional. The federal government regulates and supervises all sectors of the social security system, including health insurance. However, responsibility for almost all preventive care and health promotion has been transferred to the communities and regions.

The federal government is responsible for regulating and financing the compulsory health insurance; determining accreditation criteria; funding hospitals and so-called heavy medical care units; legislation covering different professional qualifications; and registration of pharmaceuticals and their price control. The regional governments are responsible for health promotion; maternity and child health services; different aspects of elderly care; the implementation of hospital accreditation standards; and the financing of hospital investment.<sup>28</sup>

<sup>28</sup> Große-Tebbe S. and Figueras J., (2004:11-14). Available online at: <http://www.euro.who.int/document/e85400.pdf>  
See also “Belgium: Health System Review”, in *Health Systems Review Vol.9 No.2, 2007*. Available online at: <http://www.euro.who.int/document/e90059.pdf>,

## HEALTH CARE FOR UNDOCUMENTED MIGRANTS

### 1. Legal Entitlements to Access Fully or Partially Publicly Subsidized Health Care

Since undocumented migrants cannot officially work, they do not have access to the social security system. There are however some exceptions. Undocumented migrants can get insured if one of the following conditions is met:

- i) their parents, children or spouses are entitled to health insurance;
- ii) they were once documented and had a declared job (paying all social contributions), but at a certain moment lost their legal status, while the employer kept on paying the contributions (in these cases the employee will continue to be insured for a while, since there is a run-off of several years);
- iii) they had previously held health insurance but have lost their legal status;
- iv) they are studying at a recognized school for higher education.<sup>29</sup>

The most recent case approved was that of unaccompanied minors (documented and undocumented), who since January 2007 have been entitled to receive health insurance in Belgium.<sup>30</sup>

For the remaining situations, undocumented migrants have the right to access “urgent medical assistance” free of charge.<sup>31</sup>

The Royal Decree regulating “urgent medical assistance” does not provide a concrete definition of this concept, however it clearly states that:

- i) the assistance provided should be exclusively of a medical nature;
- ii) the “urgent” character must be certified by a doctor;
- iii) health care provided can be preventive and curative;
- iv) the medical help given can be both mobile or provided in a health centre;
- v) the assistance cannot consist of financial help, housing or any other provision of service in kind.<sup>32</sup>

The terminology used has brought on confusion. The word “urgent” gives the impression that only accurate or emergency cases are taken into account. However, the concept is much broader and encompasses a wide variety of care provisions, such as medical examinations, operations, childbirth, physiotherapy, medications, tests and exams, etc. The only exceptions are medical materials such as dental prosthesis, wheelchairs, etc., as well as some types of medicine.

<sup>29</sup> PICUM, *Health Care for Undocumented Migrants – Germany, Belgium, the Netherlands and United Kingdom*, (Brussels: PICUM, 2001), pp.22. Available online at: <http://www.picum.org/Publications/Sample%20pages%20Health%20care.pdf>.

<sup>30</sup> See National Health Law of 13 December 2006 (*Loi du 13 Décembre 2006 portant dispositions diverses en matière de santé*). Although the law stipulates that insurance for separated children would come into force on 1 January 2007, according to the organisation *Medimmigrant*, it will effectively only apply from 1 January 2008. See *Medimmigrant, La loi du 13 décembre 2006 portant dispositions diverses en matière de santé*, (Brussels: Medimmigrant, 2006d). Available online at: <http://www.medimmigrant.be/mm.legislation.fr.htm>

<sup>31</sup> See Organic Law on Social Welfare Centers (*Loi organique des Centres Publics d'Action Sociale*) of 8 July 1976 and Royal Decree of 12 December 1996 on state medical assistance (*arrêté royal relative à l'aide médicale urgente, M.B. du 31.12.1006*).

<sup>32</sup> See Article 1 of Royal Decree of 12 December 1996.

In an official document, the administration explains that urgent medical care even includes “assistance that it is necessary to avoid a health situation that is dangerous for a person or his/her circle.”<sup>33</sup> As reported by *Médecins Sans Frontières (MSF)*, “the ‘urgent’ character must not be interpreted as a matter of life or death. It is rather a notion intending to protect physical and mental integrity. Therefore, a person who is ‘simply’ ill has the right to access health care.”<sup>34</sup>

The government has never adopted provisions that clearly specify those medical services that undocumented migrants are entitled to under this scheme. It is left to the health care provider to decide on a case by case basis what is to be considered “urgent.”

The concept of “urgent medical assistance” applying to undocumented migrants has been largely confounded with the concept of “emergency care” which is the care required immediately in case of an accident or a sudden illness. This type of care, which is defined very restrictively, is regulated by a different law and is granted free of charge to everyone, including undocumented migrants.<sup>35</sup>

Apart from this, undocumented migrants can, at least in theory, also get private health insurance that gives full reimbursement of medical costs. However, since these premiums are always very expensive, few undocumented migrants can afford this kind of insurance.<sup>36</sup>

## 2. The Procedure and Financing of the System

The authorities managing the procedure – the social welfare centers (*CPAS/OCMW*) – have a high degree of autonomy in the implementation of the applicable legislation, to such an extent that there exists no sole procedure to receive “urgent medical assistance” but many different ones.

Most commonly, undocumented migrants first go to the *CPAS/OCMW* in the municipality where they live. The *CPAS/OCMW* then initiates a social inquiry for verifying if the applicant is residing irregularly in their local area and if they are in a precarious economic situation. The *CPAS/OCMW* has to make a decision in thirty days as to whether to agree on paying medical assistance.<sup>37</sup> They will also specify if the validity of the document is just for one consultation or for a longer but determined period of time.

If the decision is positive, the applicant can visit a health care provider recognized by both the National Institute for Health and Disability Insurance (*INAMI - Institut national d'assurance maladie-invalidité*) and the respective *CPAS/OCMW*. The doctor will then examine the patient and send the bill to the *CPAS/OCMW* together with an “urgent medical assistance certificate.”

The *CPAS/OCMW* will pay the health care provider and be reimbursed by the state. Only if the social welfare office receives this certificate attesting the urgent character of a particular provision of health

<sup>33</sup> “Même l’aide nécessaire pour éviter une situation médicale dangereuse pour une personne ou son entourage relève de l’aide médicale urgente.” See *Circulaire* of 20 May 1997 clarifying the Royal Order on urgent medical assistance.

<sup>34</sup> Médecins Sans Frontières. *Accès aux soins en Belgique: Rapport d’activité 2005*, (Bruxelles: MSF, 2006), p. 19

<sup>35</sup> See Act on urgent medical assistance of 8 July 1964 (*Loi relative à l’aide médicale urgente du 8 Juillet 1964*).

<sup>36</sup> PICUM (2001), p.22. Available online at: <http://www.picum.org>

<sup>37</sup> This decision can be challenged before the labour court (*Tribunal de travail*).

care, will the social welfare centre be reimbursed by the *SPP-IS – Service public de programmation de l'Intégration sociale*. The reimbursement procedure is a lengthy process, often lasting up to nine months.

The amount for reimbursement will always relate to a fixed list established by the *INAMI*. Nonetheless, the *CPAS/OCMW* is always free to go beyond and assume the extra cost for those care services not comprised within this list.

The procedure is different in cases where undocumented migrants need immediate medical assistance. In these circumstances, undocumented migrants bypass the social welfare center and go directly to the hospital. It is then the responsibility of the health care provider in the hospital to complete an inquiry and issue the “urgent medical assistance certificate” which will be sent to the respective *CPAS/OCMW*, which in most cases located in the hospital area. Very frequently however, the social welfare centers request an additional social inquiry to ensure that the house visit is completed.<sup>38</sup>

The *CPAS/OCMW* must oversee that “urgent medical assistance” is available and accessible to undocumented migrants. To this aim, it must facilitate the first consultation and the access to medicine as well as monitor the whole procedure. Many *CPAS/OCMW* also make urgent medical care agreements with particular care providers and hospitals (usually public hospitals) to make access to health care easier for undocumented migrants.

Finally, the law guarantees that any information which appears on medical certificates will be treated confidentially and will not be used for any purpose other than repayment. Members of the (para) medical profession are bound by a duty of professional confidentiality.<sup>39</sup>

### 3. The Situation in Practice

The existence of a parallel administrative system with a highly complex and long procedure determines that in many cases the right to access health care is not effectively guaranteed. In addition, there are many differences between the provisions of the law and the situation in practice due to the lack of awareness regarding entitlements and about how the system works.

There are difficulties in determining the competent *CPAS/OCMW*, particularly when undocumented migrants do not have a fixed address. In addition, administrators are often overworked and social workers do not always have a sound knowledge of the “urgent medical assistance” scheme. This has consequences on the quality of the social inquiry undertaken.<sup>40</sup>

While in principle they are obliged to do so, many *CPAS/OCMW* refuse to reimburse costs made in a private hospital. This can lead to problems if people are taken to a private hospital by an ambulance after an accident. In addition, sometimes undocumented migrants are simply not well informed and go to a private hospital instead of a public one approved by the *CPAS/OCMW*.

<sup>38</sup> For more information about the application procedure for the “urgent medical assistance certificate”, Medimmigrant, *Manuel Aide Médicale Urgente pour personnes en séjour illégal. Manuel pour des collaborateurs de CPAS et prestataires de soins*. (Brussels: Medimmigrant, 2006a), pp.4. Available online at: <http://www.medimmigrant.be/mm.publications.fr.htm> and Medimmigrant, *Urgent Medical Care for Illegal Residents*, (Brussels: Medimmigrant, 2006c). Available online at: <http://www.medimmigrant.be/mm.publications.fr.htm>

<sup>39</sup> See Article 4 of Royal Order of 12 December 1996.

<sup>40</sup> See Médecins Sans Frontières, [2006: 19]



Some other problems arise from the fact that the term “urgent” is not defined. Local actors, in particular local authorities, complain about the ambiguity of the concept used within legislation. “It is crucial to clarify the term ‘urgent medical assistance’ and achieve greater convergence among the different *CPAS/OCMW*. Access to health care not only depends on the law but also on the internal organization and policy of the respective *CPAS*,” said Sophie Magnée of the Brussels-Capital Social Welfare Center.

Furthermore, health care providers are often confused regarding this process (a serious concern given that they are responsible for deciding the urgency of a particular situation), as are undocumented migrants themselves who have the tendency to think their entitlements are limited to very urgent cases or to care provided in the emergency units of the hospitals. Addressing this problem, *Medimigrant* issued a recommendation that the government should start by deleting the word “urgent” from the expression “urgent medical assistance.” In their opinion, this will avoid a lot of misunderstanding.

The procedure to access health care is lengthy and consists of numerous steps. Belgian organizations deny that these circumstances may have unfortunate consequences upon undocumented migrants’ health status.

It takes a long time for the social welfare centers to gather all the information they need to decide whether to refund costs for the care provided. In the meantime, the medical expenses remain outstanding. This is particularly problematic in cases where the patient has an urgent need to visit a doctor. As *Médecins Sans Frontières* has reported, certain social workers at the *CPAS/OCMW* choose to send undocumented migrants directly to the emergency unit: “They know well that the administrative

procedure and the social inquiry will take too long. This example shows that the current procedure is not in accordance with patients’ needs, needs that are often quite urgent.”<sup>41</sup>

In practice, many undocumented migrants in need of medical assistance first go to the doctor without the previous agreement of the *CPAS/OCMW*. The problem arising in these kinds of situations is that the cost of the first consultation is usually paid by the patient since the doctor is often not one of the health care providers recognized by the competent social welfare center.

There are many health care providers in Belgium who are not aware of the existence of a law on “urgent medical assistance” or do not understand the meaning of the concept used by the legislation. Others are unwilling to cooperate and follow the administrative procedure due to their own ideological reasons or because they fear that they will not be reimbursed or that if they are reimbursed, it will be too late.

Certain *CPAS/OCMW* have made agreements with specific general practitioners. Most NGOs look at this practice very positively as it is an efficient way to solve the problem: facilitating access to health care for undocumented migrants as well as making doctors feel more confident about the reimbursement of medical costs.

There are many differences in the implementation and interpretation of the law given the high degree of autonomy that the respective authorities (*CPAS/OCMW*) have to manage the procedure. The result is that accessibility to health care largely differs from municipality to municipality. In Brussels alone, there are nineteen municipalities, each with their own requirements and procedures. Whilst some are rather restrictive and ask for a lot of documentation, others are willing to agree more easily.

<sup>41</sup> *Ibid.*, p. 17.

Some *CPAS/OCMW* in Brussels (e.g. Brussels Capital and Molenbeek municipalities) have developed a good practice that has gained government recognition.<sup>42</sup> It consists of providing undocumented migrants with a “medical card” which secures their treatment or receipt of medicine for a certain period depending on their specific health care needs, thus saving the undocumented migrant from passing through the whole procedure each time they become ill or require more medication. Nonetheless, there are still many municipalities that continue providing agreements on a case by case basis.

Even if this practice is very positive and appreciated by NGOs, undocumented migrants are forced to go through the procedure again and again, especially if they have severe chronic diseases. “To be able to continue my long-term treatment, I have to go every three months to the general practitioner and ask him to send the ‘urgent medical assistance certificate’ to the *CPAS/OCMW*. It is always a matter of back and forwards. That is painful for somebody who is seriously ill. There is excessive bureaucracy. They play with the patients, they play with us,” explained Juan Manuel, a Colombian undocumented migrant who has been living in Belgium for five years.

Undocumented migrants face serious difficulties with the social administration in Belgium. However, this is not the only problem arising. Undocumented migrants are often fearful of visiting a social welfare center because they think that the immigration authorities will be informed about their irregular presence in Belgium. This constitutes a growing problem in the current context of increasing repression.<sup>43</sup> Undocumented migrants are particularly sensitive about establishing contact with the *CPAS/OCMW* because the social worker normally completes a house visit as a part of the social investigation. In this sense, *Medimmigrant* thinks that

social workers should regularly reassure undocumented migrants that no link to the immigration authorities exists.

In reality, many undocumented migrants do not know about the existence of this right or are badly informed about it. Rejected asylum seekers seem to be the most informed group when compared to recent arrivals or those who have never legally resided in Belgium.<sup>44</sup>

As a result, undocumented migrants use various informal strategies to try to obtain medical assistance, such as borrowing documents from family members or friends who are documented; paying the full cost of medical services by themselves (which often leads to the accumulation of debts) or with the help of others like religious communities; negotiating with doctors about the cost of health care; and going to organizations delivering medical assistance free of charge.

#### 4. The Role of Civil Society and Local Actors

Given the fact that undocumented migrants’ access to health care is still very limited and that there are many practical obstacles preventing them from accessing medical treatment, organizations such as *Médecins Sans Frontières (MSF)* and *Médecins du Monde*<sup>45</sup> provide free health care to ill undocumented migrants.

*MSF*’s “Access to Health Care” project seeks to facilitate access to health care, in particular primary care. This organization provides social, health and psychological assistance in Brussels and Antwerp to vulnerable populations including undocumented migrants. Firstly, the social department collects necessary data in order to give advice for accessing social services. After that, a doctor examines the

<sup>42</sup> See *Circulaire* of the Ministry of Social Integration of 14 July 2005.

<sup>43</sup> See *Médecins Sans Frontières*, (2006 : 20)

<sup>44</sup> See PICUM, *Book of Solidarity: Providing assistance to undocumented migrants in Belgium, Germany, the Netherlands and the UK*. Vol. 01, 2002, [Brussels: PICUM, 2002], pp. 21-22.

<sup>45</sup> <http://www.medecinsdumonde.be>

patient, takes the necessary measures according to their health status and if necessary, refers them to a psychologist.

Many undocumented migrants go to *MSF* for an initial consultation, especially if they live in an area where the municipality asks for an “urgent medical assistance certificate” issued by a doctor before starting the procedure.

***Médecins Sans Frontières (MSF)*** is an international humanitarian aid organization which provides emergency medical assistance to populations in danger in more than 70 countries. In Belgium, *MSF* focuses on improving access to health care for the disadvantaged and most vulnerable populations. They provide information about the health system as well as direct medical assistance through two clinics located in Brussels and Antwerp.

In 2005 alone, *MSF* provided 8,140 consultations. Up to 80% of the patients treated were undocumented migrants and asylum seekers.

<http://www.msf.be>

*Medimmigrant*, an organization based in Brussels, provides information to undocumented migrants about their rights and the procedure to access “urgent medical assistance” in Belgium. *Medimmigrant* also acts as an intermediary between the patient and the *CPAS/OCMW* and refers migrants to particular health care providers or other organizations if necessary.

During contact hours, *Medimmigrant* answers questions regarding access to health care as well as about residence permits for medical reasons. Given that their assistance is mainly provided via telephone, appointments are exceptional, e.g. when the case is very complex or there are language barriers, etc.

*Medimmigrant* also has a fund to pay the first consultation or medicine in exceptional circumstances, e.g. if the procedure is failing or during the time that the social welfare office is deciding whether or not to provide medical services free of charge.

The organization ***Medimmigrant*** seeks to ensure the right to health care for undocumented migrants and people with a precarious residence status embedded in the legislation and have it concretely implemented by social services and other public institutions.

Besides providing information about entitlements to access health care, *Medimmigrant* actively mediates to speed up the procedure to access health care. Their assistance is specifically addressed to residents or organizations located in the Brussels Capital Region.

*Medimmigrant* also works at the structural level. To this aim, it takes part in numerous platforms and initiatives at the national level and makes regular recommendations to the government in the field of access to health care with the aim of achieving better implementation of the law as well as raising awareness amongst the different stakeholders. Part of this work also focuses on residence permits for medical reasons. This organization is committed to uphold the right to stay and the right to social services for people who are unable to return to their country of origin as a result of their illness. It also lobbies for the establishment of a European medical database with information covering the accessibility and availability of necessary treatments and medicine in the countries of origin.

<http://www.medimmigrant.be>

Belgian organizations also carry out significant advocacy work. They witness barriers in accessing health care and make frequent recommendations to the government in relation to the procedure to grant “urgent medical care” in Belgium.

Some of their main proposals concern the clarification of legislation, the simplification of the administrative procedure, uniformity in the implementation of the law by the different *CPAS/OCMW* and the organization of official information campaigns to give more publicity to the rights of undocumented migrants and to fill in the existing lack of information among undocumented migrants, health care providers and public administrations.

Three concrete suggestions made by Belgian organizations to the social welfare centers are:

- i) to allow undocumented migrants go directly to the doctor whenever they get ill rather than to the *CPAS/OCMW*;
- ii) to provide patients with “medical cards” (a practice that is already in place in some municipalities) allowing them to access health care and medicine for a determined period of time;<sup>46</sup>
- iii) to conclude agreements with specific health care providers to facilitate access for undocumented migrants as well as to avoid problems of reimbursements of medical costs.<sup>47</sup>

There are other claims concerning, for example, the inclusion of undocumented migrants in official prevention campaigns e.g. for breast cancer, tooth decay, etc.

As a result of a strong advocacy campaign led by the organization *Medimmigrant*, the government agreed on recognizing the entitlements of unaccompanied minors (documented and undocumented) to health insurance in Belgium. This having been achieved, their claim is now focused on extending health insurance to all undocumented children since, as they state, the “urgent medical assistance” scheme is insufficient for undocumented children. Allowing them to have health insurance will facilitate access to health care and will not entail an extra cost for the government.<sup>48</sup>

The response that the Belgian system has given to undocumented migrants’ health care needs is generally conceived positively by the relevant actors since it offers relatively wide coverage. However, the extremely complicated procedure causes a lot of problems in practice. Introducing appropriate reforms will help to fill the existing gap between law and practice and will offer a greater protection to undocumented migrants’ right to health care.

<sup>46</sup> For more information about this practice, see *Medimmigrant*, (2006a: 9-14). Available online at: <http://www.medimmigrant.be/DMH%20voor%20MZVW%20handleiding%20voor%20OCMWmedewerkers%20en%20zorgverstrekkers%20basispakket%20FR.pdf>

<sup>47</sup> *Ibid.*, pp. 15-16.

<sup>48</sup> *Medimmigrant*, *Health Insurance for People without a legal residence permit*, (Brussels: *Medimmigrant*, 2006b) Available online at: <http://www.medimmigrant.be/ziekteverzekering.eng.web.pdf>

## 3. FRANCE

*The undocumented second wife of an immigrant (in cases of polygamy in France, only the first wife is legally considered the wife of the husband) became ill and went to the hospital with the social security card of the first wife who had died. Many other undocumented women are not aware about their rights to access publicly subsidized health care. Sometimes, particularly when they are pregnant, they go to doctors who charge them disproportionate fees.<sup>49</sup>*

### » Terms:

*AME (Aide Médicale de l'Etat)* - State Medical Assistance

*AMER (Aide Médicale d'Etat Renovée)* - Renewed State Medical Assistance

*Caisses primaires d'assurance maladie des travailleurs salariés* - National Fund of Medical Insurance for Employed Workers

*CMU (couverture maladie universelle)* - Universal Health Coverage Act

*CSS (centers de sécurité sociale de quartier)* - neighborhood social security centers

*PASS (Permanences d'Accès aux Soins de Santé)* - health care center offices

*VHI* - voluntary health insurance

### GENERAL HEALTH CARE SYSTEM

The French health care system is based on a national social insurance system complemented by elements of tax-based financing and complementary voluntary health insurance (VHI).

An important reform took place in the form of the Universal Health Coverage Act (CMU). Passed in 1999 and entered into force in 2000, this act established universal health coverage, opening up the right to statutory health insurance coverage on the basis of residence in France.

The Universal Health Coverage Act contains other provisions which represent a major development in the French social security system. In addition to basic health coverage (*régime de base*), those with incomes below a certain level are entitled to free coverage with the complementary *couverture maladie universelle (CMU)*.

There are three main schemes within the statutory health insurance system. The “general scheme” covers employees in commerce and industry and their families as well as *CMU* beneficiaries (about

84% of the population). The “agricultural scheme” (MSA) covers farmers and their families (7.2% of the population). The scheme for “non-agricultural self-employed people” (CANAM) covers 5% of the population. The system also includes a number of other special schemes, also provided on a work related basis.

Competences in the field of health policy and regulation of the health care system are shared between the state (parliament, government and various ministries), the statutory health insurance funds and, to a lesser extent, local communities, particularly at the department level. The state sets the ceiling for health insurance spending, approves a report on health and social security trends and finally, amends benefits and regulation.

The French health system is gradually decentralizing from the national to regional level. At the same time, power has shifted from the health insurance funds to the state.

The French health system is known for its high level of freedom for physicians and choice for patients, plurality in the provision of health services, easy

<sup>49</sup> Fassin D., Carde E., Ferré N. and Musso-Dimitrijevic S., *Un traitement inégal. Les discriminations dans l'accès aux soins*. (Paris: Université Paris, 2001), p. 122.

access to health care for most people and, except for some cases in certain parts of the country, the absence of waiting lists for treatment. In recent years, a number of reforms have transformed its original characteristics by increasing parliament's role, replacing employees' wage-based contributions with a contribution (tax) based on total income and basing universal coverage on residence rather than on employment.<sup>50</sup>

## HEALTH CARE FOR UNDOCUMENTED MIGRANTS

### 1. Legal Entitlements to Access Fully or Partially Publicly Subsidized Health Care

Free access to health care for the poorest groups of society irrespective of administrative status was guaranteed in France until 1999, when the Universal Health Coverage Act (*CMU*) removed entitlements for those without regular residence.<sup>51</sup>

A new parallel administrative system created specifically for undocumented migrants was however put in place. The system, called "State Medical Assistance" (*Aide Médicale de l'Etat - AME*), allows undocumented migrants and their dependants to access publicly subsidized health care upon compliance of certain conditions.

The *AME* entitles undocumented migrants who have been residing in France for more than three months and are below a certain economic threshold (576.13 EUR for one-person households in 2007) to access all kinds of health care free of charge (including abortion). However, there are limitations to the amounts covered on the official reimbursement scheme, preventing access to dental prosthesis and corrective lenses for example impossible.<sup>52</sup> Undocumented migrants do not have to make co-payments although there has been an attempt by the French Parliament to reduce *AME* coverage from 100% to 75%.<sup>53</sup>

For undocumented migrants who do not comply with these conditions, only emergency care is covered by the state with the exception of children who are entitled to access all kind of health care free of charge regardless of their eligibility for *AME*.

According to the applicable legislation, "emergency care" (*soins d'urgence*) means not only care in life-threatening situations but also treatment of contagious diseases (necessary to eliminate a risk for public health), all types of health care for children, maternity care and abortion for medical reasons. The treatment of chronic diseases is excluded.<sup>54</sup>

In addition, all undocumented migrants also have access to public centers providing screening of sexually transmitted diseases and HIV/AIDS, family

<sup>50</sup> Große-Tebbe S. and Figueras J., [2004:21-23]. Available online at <http://www.euro.who.int/document/e85400.pdf> and Sandier S., Paris V. and Polton D., *Health care systems in transition – France 2004*. Available online at: <http://www.euro.who.int/document/e83126.pdf>

<sup>51</sup> Article 3 of the Universal Health Coverage Act (Loi n°99-641 du 27 juillet 1999. Loi portant la création d'une couverture maladie universelle, Journal Officiel de la République Française of 28 juillet 1999).

<sup>52</sup> For full details of the *AME* see COMÈDE, *Migrants/étrangers en situation précaire: Prise en charge medico-psychosociale*, (Paris : Comède, 2005), p. 211-216.

<sup>53</sup> Article 31-1 of the *Loi n° 2002-1576* of 30 December 2002, *Journal Officiel de la République Française* of 31 December 2002, p. 22070. The *AME* reform requires its beneficiaries to pay the '*forfait hospitalier*' in case of hospitalisation and the '*ticket modérateur*' for out-patient consultation. The reform is however not in place yet since the implementing regulation (*décret*) has not yet been published due largely to great opposition by NGOs, health care providers, trade unions and academics. For more information, see Da Lomba S., "Fundamental social rights for irregular migrants: the right to health care in France and England", in Bogusz B., Cholewinski R., Cygan A. and Szysszczak E., (eds.) *Irregular Migration and Human Rights: Theoretical, European and International Perspectives*, (Leiden: Martinus Nijhoff Publishers, 2004), pp. 370-371. Concerning the general legal framework, see Act No 92-722 of 22 July 1992 as amended, which created a right to the *AME* and Article L251-1 of the Code of Social Action and Families (Code de l'Action Sociale et des Familles).

<sup>54</sup> See Articles L 254-1 and L254-2 of the Code of Social Action and Families; See also *Circulaire DHOS/DSS/DGAS n°141 du 16 mars 2005 relative à la prise en charge des soins urgents délivrés à des étrangers résidant en France de manière irrégulière et non bénéficiaires de l'Aide médicale de l'Etat*.

planning, vaccinations and screening and treatment of tuberculosis. None of these centers require any kind of identification to provide services.<sup>55</sup>

Undocumented migrants who have been living in France for at least three years are also eligible for “home medical assistance” (*assistance médicale à domicile*). This allows them to consult general practitioners free of charge. Nonetheless, this right is undermined by difficulties in supplying evidence of a three-year continuous residence in France.<sup>56</sup>

Finally, it is important to mention the specific situation of migrants who lost their status of documented residency. If, during the period of regular stay in France, they were affiliated to social security under the compulsory scheme, they have the right to keep their health insurance for four more years. The complementary *CMU* will be enjoyed during the first year of irregular stay and the *AME* will be the complementary scheme applying for the remaining years.<sup>57</sup>

## 2. The Procedure and the Financing of the System

Undocumented migrants can obtain the *AME* before they get ill, therefore they do not need a medical certificate to get the *AME*.

To this aim, they have to fill in an official form and submit it to one of the entities established under law (most commonly the *centers de sécurité sociale de quartier - CSS* but also hospitals and some NGOs).<sup>58</sup> The files are then transmitted to the public body which holds responsibility for managing the *AME* at departmental level: the *Caisses primaires d'assurance maladie des travailleurs salariés*.<sup>59</sup>

There are several requirements that they have to comply with in order to get the *AME*. They must provide:

- a) an identification document of the applicants and their dependents such as passport, ID card, birth certificate, expired resident permits, etc;<sup>60</sup>
- b) an address; if they do not have any, they have to provide the address of an approved public institution or organization;

<sup>55</sup> CIDAG (Center d'Information et de Dépistage Anonyme Gratuit), IST (Infections Sexuellement Transmissibles), Centers de Vaccination, PMI (Protection Maternelle et Infantile), CDO (Consultations Dépistage et Orientations), CLAT (centers de lutte anti-tuberculeuse). For more information see COMÈDE, *La guide de Comède 2006*, (Paris 2006). Available at <http://www.comede.org>.

<sup>56</sup> See Article 38-1(4) of *Loi Pasqua* of 1993 (*Loi n° 93-1027* of 24 August 1993 *relative à la maîtrise de l'immigration et aux conditions d'entrée et de séjour des étrangers en France*, *Journal Officiel de la République Française* of 29 August 1993 and Article L 111-2 of Code of Social Action and Families; See also Da Lomba S., “Fundamental social rights for irregular migrants”, p. 369 ; See also Fassin D., Carde E., Ferré N., and Musso-Dimitrijevic S., *Un traitement inégal. Les discriminations dans l'accès aux soins*, p. 58.

<sup>57</sup> Groupe d'Information et de Soutien des Immigrés Accés à l'Espace Privé (GISTI), *Sans-papiers mais pas sans droits*. June 2006. Available online at: <http://www.gisti.org/doc/publications/2006/sans-papiers/index.html>

<sup>58</sup> See Article L252-1 of Code of Social Action and Families.

<sup>59</sup> According to the law, the decisions are made by the government representative in the department, who can delegate this power to the director of the *caisse primaire d'assurance maladie des travailleurs salariés*. See Article L252-3 of the Code of Social Action and Families.

<sup>60</sup> For details, see Article 4(1) of the *Décret n° 2005-860* of 28 July 2005 *relative aux modalités d'admission des demandes d'aide médicale de l'Etat* and Article 2(2) of *Circulaire DGAS/DSS/DHOS/2005/407* of 27 September 2005 *relative à l'aide médicale de l'Etat*.

- c) evidence that they have been residing in France for more than three months showing documents such as expired visas, asylum rejection notifications, hotel bills, school registrations, electricity bills, gas bills, telephone bills in the name of the applicant or of the host. It is also possible to submit a document signed by a health care provider or by a knowledgeable organization;<sup>61</sup>
- d) information and identification of their dependants;
- e) information about their economic resources during the previous twelve months to prove that they are under the economic threshold set by the law on the basis of the number of persons in the household (598.23 EUR/month for a one-person household in 2007). If this is not possible for them, the law provides the possibility of making a sworn declaration (*déclaration sur l'honneur*), but this is rather rare in practice.

The *AME* is initially granted for one year but can be renewed and has to be shown every time undocumented migrants seek care, tests or medicine.<sup>62</sup> Once renewed, some *caisses primaires* use the term *AMER* (*Aide Médicale d'Etat Renouvelée*).

When giving medical assistance to undocumented migrants in possession of the *AME* certificate, health care providers have to specify in the files or bills that the services have been rendered to a beneficiary of the *AME* and that no payment has been requested. The cost incurred for providing health services under this scheme are finally covered by the state.<sup>63</sup>

To cover expenses incurred by hospitals for providing inpatient and outpatient emergency care to undocumented migrants not eligible for the *AME*, a special fund was created in 2004: the "*fonds de soins d'urgence*." This fund is paid on a case by case basis by the state to hospitals and is managed by the national *caisse nationale d'assurance maladie* and the departmental *caisses primaires d'assurance maladie*. Hospitals have to prove that the patients do not have any other coverage and inform about the emergency character of the care provided.<sup>64</sup>

Access to emergency care for undocumented migrants is organized through the "health care center offices" (*Permanences d'Accès aux Soins de Santé - PASS*) that are in charge of providing medical and social support to underprivileged persons and thus facilitate their access to health care in public hospitals. Nonetheless, it is still rather difficult to find these kinds of units in most public hospitals.<sup>65</sup> In addition, there are great differences among hospitals as regards the existence and organization of this service for socially excluded patients.

### 3. The Situation in Practice

A high percentage of undocumented migrants residing in France who are in principle entitled to *AME* do not receive it for various reasons.

In 2005, the report of the observatory on access to health care of *Médecins du Monde France* revealed that 93.7% of undocumented migrants assisted in

<sup>61</sup> See *Loi de finances rectificative pour 2003* (n° 2003-1312) of 30 December 2003; See also Article 4(2) of the *Décret n° 2005-860*.

<sup>62</sup> Article L252-3 of the Code of Social Action and Families.

<sup>63</sup> Article L253-2 of the Code of Social Action and Families and Article 44 of the Decree No. 2005-859 of 28 July 2005 on state medical assistance (*Décret n° 2005-859 du 28 juillet 2005 relatif à l'aide médicale de l'Etat*, J.O. n° 175 du 29 juillet 2005, p. 12353).

<sup>64</sup> See *Circulaire DHOS/DSS/DGAS n°141 du 16 mars 2005*.

<sup>65</sup> See Fight Against Exclusion Act of 29 July 1998 (*Loi n° 98-657 du 2 juillet 1998 d'orientation relative à la lutte contre les exclusions*) and *Circulaire DH/AF 1/DGS/SP 2/DAS/RV 3 n° 98-736* of 17 December 1998 *relative à la mission de lutte contre l'exclusion sociale des établissements de santé participant au service public hospitalier et à l'accès aux soins des personnes les plus démunies*.



their *CASO* centers (*Centers d'accueil, de soins et d'orientation*) throughout France in 2005 were potentially entitled to the *AME* but did not have their rights recognized.<sup>66</sup> In this regard, Didier Maille, of the organization *Comède*, estimates that "90% of undocumented migrants do not have the right to *AME* recognized. 10% have the rights but they do not work in practice."

As happens in other countries, there are also many differences of implementation and interpretation among cities and local agencies within the same city. "In small cities, the lack of knowledge is remarkable and the law is interpreted much more restrictively. Some agents even go beyond the law," said Didier Maille, of the organization *Comède*.

The biggest difficulties encountered in practice by undocumented migrants come from the complexity of the system, its requirements and the lack of awareness about undocumented migrants' entitlements among different actors: health care providers, health administrations, social workers and undocumented migrants themselves.

To obtain the *AME*, undocumented migrants have to present a valid identification document. In many cases, this requirement constitutes an obstacle. "Before, the applicant declaration was enough. Today, sworn declarations concerning this requirement are very rare and are only accepted when organizations like *Médecins Sans Frontières (MSF)* make them. It is not the same when undocumented migrants go alone," explains Samuel Hanryon of *MSF*. "Now there are also cases where agents commit abuses, for example, by sending undocumented migrants

to the consulate to ask for a passport. Sometimes, this entails big problems particularly when undocumented migrants do not have contacts with the consulate or when they do not have the money to pay the fees to obtain a new passport."

Applying for the *AME* also requires providing an administrative address which entails a significant barrier for many undocumented migrants. According to the above-mentioned report by *Médecins du Monde*, the situation is worsening every year. In 2005, the number of migrants with precarious administrative status in need of an administrative address was twice higher than that of other residents.<sup>67</sup>

There are also many difficulties facing undocumented migrants needing to prove their residence in France for more than three months. Given their poor housing conditions, it is not always easy for undocumented migrants to provide electricity, gas, or other bills that are required by the regulations. Although some *caisses primaires* expressed that they are quite flexible as regards this and other conditions, there have also been cases where health administrations went too far imposing conditions contrary to the applicable legislation.

The organizations *GISTI* and *Médecins du Monde* have informed that some *caisses primaires* were requesting undocumented migrants to prove their presence in France for each of the three months of residence. Some applicants were unable to do so. To avoid these incidents, the national fund *Caisse Nationale d'Assurance Maladie* reminded in 2005 that the *caisses primaires* should not request one document for each month that precedes the request.<sup>68</sup>

<sup>66</sup> Médecins du Monde, *Rapport 2005 de l'Observatoire de l'Accès aux Soins de la Mission France de Médecins du Monde* (Paris: MDM, 2006), p. 34. Available at : [http://www.medecinsdumonde.org/thematiques/l\\_observatoire\\_de\\_l\\_acces\\_aux\\_soins](http://www.medecinsdumonde.org/thematiques/l_observatoire_de_l_acces_aux_soins).

<sup>67</sup> *Ibid.*, pp. 37-39.

<sup>68</sup> Circulaire du ministère de la santé et de l'emploi du 27 septembre 2005. See *GISTI, Sans-papiers mais pas sans droits*, p. 11. Available online at: <http://www.gisti.org/doc/publications/2006/sans-papiers/index.html>

Similarly, there have been cases in which undocumented migrants were asked to inform about the economic resources of their hosts, something that is illegal, according to the organization *GISTI*.<sup>69</sup>

Although there are cases of direct refusals, many denials by public administrations are informal and therefore hidden (*refus cachés*). Undocumented migrants arrive to the administration desk to start the procedure for the *AME*. There, administrators ask them to bring further documents. Undocumented migrants end up leaving and public officials do not keep their files. In practice, since many undocumented migrants do not come back, it is as if they had never applied for the *AME*. "This way of refusal is unwritten, thus it is very difficult to bring a claim against this decision using the complainant mechanisms provided by administrative law," explains Samuel Hanryon of *MSF*.

Health care professionals and pharmacies may also deny treatment or medicine to undocumented migrants. A survey conducted in 2005 by *Médecins du Monde* revealed that 37% of 725 general practitioners interviewed in ten French cities refused to provide health services to beneficiaries of *AME*.<sup>70</sup> In the opinion of the *Observatoire du droit de la santé des étrangers (ODSE)*, "these discriminatory practices are justified neither by the risk of late reimbursement nor by the freedom that general practitioners have to choose their patients. All doctors, general practitioners and specialists are bound by medical

professional ethics and by public health considerations. Therefore, they must always provide medical help to everyone regardless of their nationality, economic situation or administrative status."<sup>71</sup>

There are many aspects of the *Aide Médical d'Etat* that are still failing and have to be solved. The National Human Rights Commission (*Commission nationale consultative des droits de l'homme*) has acknowledged this and recommended that "it is necessary to bring to an end all the difficulties associated with the granting of the *AME* in order to avoid the failure of the system of health protection and prevention that would be unacceptable from a humanitarian as well as from an efficiency perspective."<sup>72</sup>

There are also problems with the mechanisms created to facilitate access to hospitals for the most marginalized groups, including undocumented migrants who do not have the *AME* recognized. As reported by the organization *Comède*, in most public hospitals "it is still impossible to know where the *Permanence d'Accès aux Soins de Santé (PASS)* is located. It is also difficult to find a staff member able to explain what *PASS* means."<sup>73</sup>

*Comède* also denounces violations of the law in an attempt to avoid the risks associated with the so-called "health tourism" in which some hospitals give instructions to their *PASS* to reject foreigners who have been living in France for less than three months.<sup>74</sup>

<sup>69</sup> Ibid.

<sup>70</sup> *Médecins du Monde* (2006 :47).

<sup>71</sup> ODSE, *Halte aux refus de soins contre les plus démunis! L'ODSE saisit la HALDE*. Available online at : <http://www.actupparis.org/article2799.html>

<sup>72</sup> Assemblée Plénière de la Commission Nationale Consultative des Droits de l'Homme, *Avis sur la préservation de la santé, l'accès aux soins et les droits de l'homme*. January 2006, p.4. Available online at: <http://acatparis5.free.fr/telechargement/CNCDHsante.pdf>

<sup>73</sup> COMÈDE, *Acces aux Soins, Acces aux droits*; (Paris : Comède, 2006), p.175.

<sup>74</sup> Ibid.

The *PASS* was created precisely to facilitate all people experiencing social exclusion to access mainstream hospitals and health care since part of its mission is to accompany these patients and help them to achieve the full exercise of their rights. Nonetheless, the public services still has a limited impact.

#### 4. The Role of Civil Society and Local Actors

Although the law seems to be rather extensive, it has been shown that there are still failures in the system. This fact explains why organizations working with undocumented migrants feel obliged to intervene to make the system work.

Practice shows that in most cases the intervention of organizations helps to solve problems arising during the administrative process. By making telephone calls to social security centers or to *caisses primaires*, NGOs manage to overcome many of the problems faced by undocumented migrants when trying to go through the necessary procedure to get the *AME*. As explained by the Paris-based organization *Comède*, “without such help it is most of the time impossible for applicants to tackle the obstacles encountered.”

Since 1979, the organization *Comède (Comité médicale pour les exilés)* has provided medical, social and psychological assistance to asylum seekers and migrants with precarious status.

*Comède* consists of 35 professionals including doctors, nurses, physiotherapists and social workers. It is assisted by a group of interpreters and also works in cooperation with many other health care providers, hospitals and public health centers. Among its main activities are:

- i) prevention and health education;
- ii) help to access the *CMU* or *AME*;
- iii) provision of health care, including psychological assistance and medicine free of charge;
- iv) legal advice and protection against removal on medical grounds;
- v) information and training for individuals, professionals, activists and NGOs.

In the past 27 years, *Comède* has provided assistance to 85,000 patients of 130 nationalities, including refugees, asylum seekers, unaccompanied minors and migrants with precarious administrative status.

<http://www.comede.org>

Many undocumented migrants face serious marginalization as regards access to health care. Due to isolation or language barriers, they are often unaware of their rights and only try to obtain the *AME* when they are severely ill. Given this lack of information, many are reluctant to use hospital services because they think that they will not be able to afford medical costs. In addition, they often are afraid to approach any kind of public administration since they confuse the different level of administrations and wrongly believe that the police have a link with them.

Practice shows that for many cases in which undocumented migrants try to gain access to health care services, the intervention of organizations helps to solve problems arising during the administrative process. By making telephone calls to social security centers or to *caisses primaires*, NGOs manage to solve many of the problems faced by undocumented migrants when trying to go through the necessary procedure to get the *AME*.

These circumstances push many NGOs to maintain a very pro-active approach trying to reach them and help them to access the *AME* scheme or providing direct medical assistance through clinics and mobile units.

The organizations *Comède* and *Médecins du Monde* (as well as *Médecins Sans Frontières*, until recently) run medical centers to provide assistance to undocumented migrants free of charge. However, since the main objective of these organizations is to make the common law system work, they always try first to help their patients to access the mainstream health system through the *AME* scheme.

Another important piece of their work is devoted to witnessing cases where undocumented migrants and other foreigners with precarious administrative status do not successfully access the public health system, the reasons behind this lack of access is then analyzed.

Besides constituting a reference center for undocumented migrants, *Comède* is also a national resource center in the field of access to health care for persons living in France with precarious status. To this aim, they have a telephone-based help desk, organize training sessions, conduct research and publish a newsletter and an annual guide that provides extensive information about the health system, the conditions and ways to access health care in France, the most common barriers, contact information, etc.<sup>75</sup>

*Médecins du Monde* witnesses the failures of the system and highlights the most frequent obstacles encountered by undocumented migrants when trying to access health care. Every year, the organization issues a report on the observatory on access to health care with statistics about patients (age, gender, nationality, living and working situation, administrative status and health conditions) and about access to health care (obstacles, denials, assistance provided, etc.).

One of the priorities of *Médecins du Monde France (MdM)* is to facilitate access to health care. To this aim there are nearly 2,000 volunteers working in health centers, mobile units and harm reduction programs.

In 2005, 89% of the patients treated for the first time in the 21 health care centers were foreigners; 60% of them were undocumented migrants and 30% had applied for asylum. The main obstacles to access health care quoted by patients are the lack of an address, financial difficulties, poor knowledge of rights and systems, administrative difficulties and language barriers.

All of the projects provide consultations, do prevention and refer migrants to partners and public health systems. *Médecins du Monde France* also develops prevention and screening programs for HIV, hepatitis and sexually transmitted illnesses (STI) as well as psychological support programmes.

The European Access to Health Care Monitoring Center (started in 2004) lobbies European Union institutions and collects data from the field about difficulties encountered by people living in insecure situation in accessing health care.

<http://www.medecinsdumonde.org>

<sup>75</sup> See Comède (2006), available online at: [http://www.comede.org/rubrique.php3?id\\_rubrique=165](http://www.comede.org/rubrique.php3?id_rubrique=165).

Many organizations active in the field of access to health care in France belong to the *OSDE - Observatoire du droit à la santé des étrangers* (Observatory on Foreigners' Right to Health Care), a group of organizations aiming at denouncing the obstacles faced by foreigners when they try to access health care or to obtain a residence permit for medical reasons.

*OSDE* demands equal treatment for nationals and foreigners in regular or irregular status in the field of health. In their opinion, this implies the provision of real universal health coverage and the effective implementation of the right to stay for foreigners who are ill.

The *OSDE - Observatoire du droit à la santé des étrangers* started in 2000 as a group of organizations committed to advocate universal health care and to follow up on laws in the field of health insurance, *AME* and residence permits on medical grounds. The founding members are *ACT UP Paris, Aides, Arcat, Cimade, Collectif national contre la double peine, Comède, GISTI, Médecins du Monde, Mrap* and *Sida info service*. Other organizations have also joined (*Afvs, Aides Île de France, Catred, Creteil-Solidarité, Fasti, Ftc, Pastt* and *Solidarité Sida*).

The observatory makes statements on the basis of data provided by the different organizations.

<http://www.odse.eu.org>

It is a shared opinion among organizations in France that with the introduction of the *AME* and its requirements, the system has become particularly stigmatizing. The National Commission for Human Rights (*Commission Nationale Consultative des Droits de l'Homme*) has also acknowledged this by stating that "the requirement of so many justification documents which are difficult to gather goes against the spirit of the act aimed at challenging social exclusion."<sup>76</sup>

These reasons are behind the strong advocacy campaign developed by numerous NGOs to change the current system in place which makes undocumented migrants' access to health care subject to a specific administrative mechanism with a high degree of complexity.

<sup>76</sup> Assemblée Plénière de la Commission Nationale Consultative des Droits de l'Homme, pp. 19-20. Available online at : <http://acatparis5.free.fr/telechargement/CNCDHsante.pdf>

## 4. GERMANY

*As a result of living in an irregular administrative situation and in complete physical and mental exhaustion, an undocumented woman collapsed on the street in Munich and had to get treated in a psychiatric hospital. During the long therapy in the hospital, the police stopped in almost every week to ascertain if she was fit enough for deportation. While doctors tried to provide adequate treatment, the hospital administration informed the registration office about the uncertain residence status of the woman.*

### » Terms:

*Bundesländer* - states of the Federal Republic of Germany

*Duldung* - temporary suspension of deportation

*Landkreise* - administrative districts

### GENERAL HEALTH CARE SYSTEM

Health care for the majority of the German population is organized via a contribution-financed obligatory health insurance system, characterized by a separation of public and private health insurances unique in Europe. While most people living in Germany are covered by the Statutory Health Insurance System,<sup>77</sup> existing private health insurance only insures those whose income is above a certain threshold for compulsory insurance (47,700.00 EUR in 2007), as well as self-employed persons, freelancers and civil servants.

For the long-term unemployed, homeless people, asylum seekers and refugees who neither have health insurance nor can afford it, the social welfare office covers the costs for health care, either by

paying (part of) their health insurance fees or by directly paying for medical treatment confirming the medical necessity of treatment. In 2003, 87% of the German population received health care through statutory health insurance, an additional 10% took out private health insurance and 2% were covered by governmental schemes. An estimated 0.3% of the registered German population had no health insurance of any kind.<sup>78</sup>

A fundamental facet of the German political system – and the health care system in particular – is the sharing of decision-making powers amongst the sixteen states (*Bundesländer*), the federal government and authorized civil society organizations. In health care, governments traditionally delegate competencies to membership-based, self-regulated organizations of payers and providers.

<sup>77</sup> Gesetzliche Krankenversicherung – GKV

<sup>78</sup> The German health care system is predominantly financed by insurance fees. A recent reform introduced funds partly contribution funded and partly tax funded, thus breaking the principle of a contribution financed system and turning even further away from a system financed in equal parts by employers and employees. Also, a proceeding privatization of health risks can be noticed throughout the whole health care system. The reform measures, which went into effect on January 2003, require patients to pay an increasing portion of their health care separately (for example co-payment for outpatient visits) and there is a trend towards merely very basic provisions being taken over by the insurances combined with the possibility to separately insure further provisions (e.g. dental care). Additionally, provisions have been made that allow for greater competition in the health care system. All of these reforms have drastic consequences for the character of the German health care system. They lead further away from the “principle of solidarity” which is said to be at this system’s basis. See Große-Tebbe S. and Figueras J., (2004:25-26). Available online at <http://www.euro.who.int/document/e85400.pdf>.

Typical for the German health care system is a sharp division between mobile and stationary health care. Besides the mobile medical treatment (with decentralized physicians', dentists', psychologists' etc., surgeries) and in-patient medical treatment (at hospitals) there is also the public health service, which has offices in administrative districts (*Landkreise*) and in bigger cities. Among their tasks are preventative health care like medical check-ups at schools, counseling of pregnant women and mothers, some arrangements for psychiatric and social-psychiatric care, surveillance and counseling arrangements in the fields of hygiene, infectious diseases and medication, and, sometimes even treatment of sexually transmitted diseases and tuberculosis. The public health service may also provide information and carry out some vaccinations.<sup>79</sup>

## HEALTH CARE FOR UNDOCUMENTED MIGRANTS

### 1. Legal Entitlements to Access Fully or Partially Publicly Subsidized Health Care

The Asylum Seekers Benefits Law regulates the entitlement of refugees, asylum seekers, persons who hold a residence permit for humanitarian reasons and persons with a *Duldung* (temporary suspension of deportation) to state subsidies for

medical care.<sup>80</sup> In theory, this law is also applicable for undocumented migrants, who are considered "persons obligated to leave the country."<sup>81</sup>

The Asylum Seekers Benefits Law reduces entitlements to health care services compared to regular health insurance or provisions made by social welfare for German nationals and migrants not falling under the Asylum Seekers Benefits Law.<sup>82</sup>

Uninsured persons in financial distress are obliged to go to the social welfare office before the date on which they wish to receive health care services in order to be referred to a hospital, a physician or another health service provider. This obligation is only waived in cases of emergency.

Access to the emergency system for undocumented migrants is provided by the Penal Code which states that in cases of emergency, everyone should receive help.<sup>83</sup>

The Law for Infectious Diseases<sup>84</sup> provides for anonymous counseling and check-ups in cases concerning tuberculosis and sexually transmitted diseases, which are either organized at public health offices or in private medical centers collaborating with these offices. Accordingly, these services are accessible for undocumented migrants. In particular cases, if deemed necessary in order to prevent the spreading

<sup>79</sup> Bundeszentrale für politische Bildung. *Die wichtigsten Akteure im deutschen Gesundheitswesen. Teil 1: Staat und Politik*. Bonn: BPB, 2007; Betriebskrankenkassen (BKK) Bundesverband. *Gesundheit Hand in Hand. Das deutsche Gesundheitssystem – Ein Wegweiser für Migrantinnen und Migranten*. 2005. Available online at: [http://www.bkk.de/bkk/common/download/infomaterial/gesundheits\\_hand\\_in\\_hand\\_-\\_ein\\_wegweiser\\_fuer\\_migrantinnen\\_und\\_migranten.pdf](http://www.bkk.de/bkk/common/download/infomaterial/gesundheits_hand_in_hand_-_ein_wegweiser_fuer_migrantinnen_und_migranten.pdf)

<sup>80</sup> Asylbewerberleistungsgesetz of 5 August 1997, last modified on 31 October 2006 – AsylbLG.

<sup>81</sup> § 1 para. 1 No. 5 AsylbLG.

<sup>82</sup> Sinn A., Kreienbrink A. and von Loeffelholz H. D., *Illegally resident third-country nationals in Germany Policy approaches, profile and social situation*, (Nürnberg: Bundesamt für Migration und Flüchtlinge, 2005), p. 56. Boundaries are set to this reduced eligibility by medical ethics and by the German Grundgesetz (Basic Law), in which every person's right to a maximum of human dignity and to life and physical inviolability are codified. Classen thus holds that, in fact, the extent of treatment should for those reasons equal that granted to a German national. See Classen G. *Krankenhilfe nach dem Asylbewerberleistungsgesetz – aktualisierte und ergänzte Version 2007*. Available online at <http://www.fluechtlingsrat-berlin.de>

<sup>83</sup> Strafgesetzbuch of 13 November 1998, last modified on 13 April 2007 – StGB.

<sup>84</sup> Gesetz zur Verhütung und Bekämpfung von Infektionskrankheiten beim Menschen of 20 July 2000, last modified on 31 October 2006 – IfSG.

of sexually transmitted diseases or tuberculosis, mobile treatment by a physician of the public health office may also be included.<sup>85</sup> Undocumented migrants with HIV/AIDS can receive free and anonymous testing at public health offices.

According to the Asylum Seekers Benefits Law, asylum seeking pregnant women have access to preventive medical check-ups, services concerning delivery, care, etc.<sup>86</sup> For undocumented women, however, access to maternity care and health care for children is only possible if they successfully apply for a *Duldung*, which is usually only granted during the so-called “period of maternity” (from 6 weeks prior to delivery to 8 weeks after delivery; 12 weeks in cases of multiple or pre-term births) for the reason that mother and child are deemed unfit for travel during this period and can thus not be deported.

Finally, statutory accident insurance has to cover payments in cases of accidents in the workplace or on the way to the workplace even if the employer has never paid social security contributions and the injured person has neither a work or residence permit. The insurance company has the right to recover its expenses from the employer.<sup>87</sup>

## 2. The Procedure and the Financing of the System

In Germany, access to publicly subsidized medical treatment for undocumented migrants in financial distress is limited to very few cases. Due to the public authorities’ obligation to report undocumented migrants to the *Ausländerbehörde* (Foreigners Office), it is impossible for an undocumented migrant to gain access to public subsidies for secondary health care. The undocumented migrant would have to apply for such subsidies in person at the social welfare office, which is under a duty to denounce them to the Foreigners Office.

In cases of emergency, undocumented migrants can seek health care directly at a hospital or from a general practitioner who is obliged by law to provide medical treatment. However, there is still a great risk that their whereabouts become known to the authorities. The possibility exists for the service provider to attain reimbursement for the costs of emergency treatment from the tax-funded social welfare office according to the regulations of the Social Code.<sup>88</sup> In order to obtain such a reimbursement the service provider must have made sure that the patient is neither insured nor can he/she pay for the treatment by his/her own financial means.<sup>89</sup>

<sup>85</sup> §19 IfSG.

<sup>86</sup> § 4 para. 2 AsylbLG.

<sup>87</sup> See Classen G., p.2. Available online at: <http://www.fluechtlingsrat-berlin.de> and Sinn A. et al. (2005:56) According to the Social Code (According to § 211 SGB VII Sozialgesetzbuch Siebtes Buch (VII) – Gesetzliche Unfallversicherung – of 7 August 1996, last modified on 20 April 2007 – SGB VII) the insurances are obliged to work together with, among others, the immigration authorities, so that again there is a real risk that the undocumented stay of the migrant will become known. Another frequent problem in cases of injuries at work places is that undocumented migrants are often immediately fired if they are injured and cannot go on working, which makes it difficult for them to prove that they really have been working, which is a prerequisite for claiming benefits from the accident insurance. See Spieß K. *Die Wanderarbeitnehmerkonvention der Vereinten Nationen. Ein Instrument zur Stärkung der Rechte von Migrantinnen und Migranten in Deutschland*. (Berlin: Deutsches Institut für Menschenrechte, 2007), p. 58.

<sup>88</sup> Sozialgesetzbuch Zwölftes Buch (XII) - Sozialhilfe - of 27 December 2003, last modified on 20 April 2007 – SGB XII. “Complicated administration procedures and the reluctance of the social welfare centers to cover these costs make this inquiry very time consuming and of an uncertain outcome. Furthermore, not every hospital administration seems to know about this possibility” quoted from PICUM (2001:41). Available online at: <http://www.picum.org/Publications/Sample%20pages%20Health%20care.pdf>

<sup>89</sup> §§ 4 and 6 AsylbLG.



Once the social welfare office has been notified, it is obliged to establish the residence status of the patient and, in case of irregularities, is held by law to inform the Foreigners Office which will begin the procedures for the individual to receive an order for deportation.<sup>90</sup>

For any medical treatment other than emergency treatment, including HIV treatment or pre- and postnatal care, undocumented migrants have to successfully apply for a *Duldung* (temporary residence permit) in order to be eligible for public subsidies from the social welfare office. Both do not eliminate the possibility of deportation but temporarily suspend it.<sup>91</sup>

### 3. The Situation in Practice

Although access to limited medical provisions is guaranteed for undocumented migrants according to the Asylum Seekers Benefits Law, the existence of both legal and practical obstacles renders the exercise of these rights impossible without risking deportation. The two major legal barriers in Germany are the “duty to denounce”<sup>92</sup> and the “penalization of assistance.”<sup>93</sup>

#### a) Duty to Denounce

According to German legislation, “any public institution immediately has to inform the Foreigners Office if it gains knowledge of the stay of a foreigner who does not possess the necessary residence permit and whose deportation has not been suspended.”<sup>94</sup> If they neglect to report to the Foreigners Office on their own initiative they risk penalization.

Consequently, although undocumented migrants are not exempt from applying for benefits at the social welfare office, this entity (like all other public institutions) has the duty to denounce them to the Foreigners Office, which will immediately try and end the undocumented migrant’s stay in Germany.<sup>95</sup>

It is uncertain what the expression “to gain knowledge” of undocumented stay in Germany actually means in this context. The German Ministry of the Interior has recently tried to clarify the situation. It states that there is a differentiation to be made between knowledge gained “within the scope of the institution’s duty” and information acquired “at the opportunity of carrying out its duty.”<sup>96</sup> The duty to denounce would only apply in the first case. However, with no legal definition of these terms, there can only be “relative legal certainty” for everyone involved.<sup>97</sup>

<sup>90</sup> See Classen, p. 6. Available online at: <http://www.fluechtlingsrat-berlin.de>

<sup>91</sup> Flüchtlingsrat Thüringen. *Guidebook for Refugees in Thuringia*, pp.10. Available online at: [http://www.tguv.de/fluechtlingsrat-thr.de/infoheft/Ratgeber\\_englisch-web.pdf](http://www.tguv.de/fluechtlingsrat-thr.de/infoheft/Ratgeber_englisch-web.pdf)

<sup>92</sup> § 87 para. 2 AufenthG.

<sup>93</sup> § 96 AufenthG. See PICUM, (2002: 43-45)

<sup>94</sup> § 87 para. 2 No. 2 AufenthG.

<sup>95</sup> Classen G., “Sozialleistungen für MigrantInnen und Flüchtlinge. Grundlagen für die Praxis”, in *Zeitschrift für Flüchtlingspolitik in Niedersachsen*. Hildesheim: Sonderheft 106/107 2005, p. 67 and Groß J., *Möglichkeiten und Grenzen der medizinischen Versorgung von Patienten und Patientinnen ohne legalen Aufenthaltsstatus*, (2005b), pp.9. Available online at: <http://www.medibuero.de/attachment/39b520617b75d0e45fa5eb4f5da202aa/e98aee3b56b36b349988096301dc1c23/Faltblatt.pdf>

<sup>96</sup> “Kenntniserlangung im Rahmen der Aufgabenerfüllung” resp. “Kenntniserlangung bei Gelegenheit der Aufgabenerfüllung”. See Bundesministerium des Inneren. *Illegal aufhältige Migranten in Deutschland - Datenlage, Rechtslage, Handlungsoptionen*. (Berlin: Bundesministerium, 2007), pp.38. Available online at: [http://www.emhosting.de/kunden/fluechtlingsrat-nrw.de/system/upload/download\\_1232.pdf](http://www.emhosting.de/kunden/fluechtlingsrat-nrw.de/system/upload/download_1232.pdf)

<sup>97</sup> According to Groß, institutions “gain knowledge within the scope of their duties” of a fact if this fact is vital to the accomplishment of their tasks. See Groß J., *Medizinische Versorgung von Menschen ohne legalen Aufenthaltsstatus*, (Berlin, 2005a), Available online at: [http://gesundheitspolitik.verdi.de/gesundheit\\_von\\_az/migration/medizinische\\_versorgung\\_von\\_menschen\\_ohne\\_legalen\\_aufenthaltsstatus](http://gesundheitspolitik.verdi.de/gesundheit_von_az/migration/medizinische_versorgung_von_menschen_ohne_legalen_aufenthaltsstatus)

Doctors and nurses are bound by the medical code and professional secrecy and are thus not obliged to denounce undocumented migrants, a fact that the German Medical Association has repeatedly asserted.<sup>98</sup> Matters are less clear, however, in cases involving public hospitals, where it is disputed if these hospitals are bound by legal regulations, concerning protection of patients' personal data or if they, just like any other public institution, must submit relevant data to the Foreigners Office.<sup>99</sup>

If a hospital seeks reimbursement for emergency treatment from the social welfare offices and wanting to make credible its specifications, it may wish to also include the residence status of the patient in question. In such cases, the social welfare office in turn has the obligation to inform the Foreigners Office. In practice, this process mostly occurs after treatment has been completed.<sup>100</sup>

Sometimes hospital administrations wish to avoid costs, leading to the denunciation of undocumented migrants to the Foreigners Office. Some hospitals do not hesitate to call the police at the point of admission in order to clarify a patient's residence and insurance status before they commence treatment.

In many such cases, the threat of being deported after treatment is very real, often resulting in situations in which hospitalized undocumented migrants discharge themselves from hospitals before the treatment is completed.<sup>101</sup>

These legal and practical obstacles reduce the entitlement of undocumented migrants to very few cases, and undocumented migrants may receive health care if their deportation is not feasible or is legally impermissible<sup>102</sup> or if a severe acute or chronic illness deems necessary an undeniable medical treatment, which leads to the certifying of an inaptness to travel by a physician.<sup>103</sup>

#### b) Penalization of Assistance

Another legal hindrance opposing undocumented migrants' right to access health care is the penalization of assistance. The Residence Act stipulates that anyone who assists undocumented migrants will be penalized if acting for financial gain, if they do it repeatedly or for the benefit of several foreigners.<sup>104</sup> People providing assistance to undocumented migrants may be sentenced to a fine or imprisoned for up to five years if they entice or assist undocumented migrants to irregularly stay or overstay.<sup>105</sup>

<sup>98</sup> Since 1995 the German Association of Doctors (Deutscher Ärztetag) has taken a firm stand against the Asylum Seekers Benefits Law and confirmed that doctors have the obligation to treat people independently of their residence status. See Deutscher Ärztetag. "Medizinische Behandlung von Menschen in Armut ohne legalen Aufenthaltsstatus" in *Beschlussprotokoll des 108. Deutschen Ärztetages vom 03.-06. Mai 2005 in Berlin*. Available online at: <http://www.bundesaerztekammer.de/page.asp?his=0.2.20.1827.1832.1909.1913>

<sup>99</sup> Classen G., Available online at <http://www.fluechtlingsrat-berlin.de> and Spieß K., (2007: 59) For legal expert Rolf Fodor it is clear that the residence status of a person is irrelevant for the completion of the main task of a public hospital that is to provide medical assistance. Therefore, "hospitals are not obliged to ask for information about the residence status of their patients and accordingly they are not subject to the Duty to Denounce". See Fodor R., "Rechtsgutachten zum Problemkomplex des Aufenthalts von ausländischen Staatsangehörigen ohne Aufenthaltsrecht und ohne Duldung in Deutschland", in Alt J. and Fodor R., *Rechtlos - Menschen ohne Papiere*, (Karlsruhe: Loeper Literaturverlag, 2001), pp. 175. See also Anderson P., "Dass sie uns nicht vergessen...", *Menschen in der Illegalität in München: Eine empirische Studie im Auftrag der Landeshauptstadt*, (München: Landeshauptstadt, 2003), pp. 37-38. Available online at: [http://www.gruene-muenchen-stadtrat.de/seiten/pdfs/studie\\_illegalitaet.pdf](http://www.gruene-muenchen-stadtrat.de/seiten/pdfs/studie_illegalitaet.pdf)

<sup>100</sup> Spieß K., (2007:59)

<sup>101</sup> See PICUM (2001:40). Available online at: <http://www.picum.org/Publications/Sample%20pages%20Health%20care.pdf>

<sup>102</sup> This occurs when the country of origin refuses to take back a migrant, there are no transport links, a stop of deportation has been issued for a particular country, maternity protection, etc.

<sup>103</sup> Classen G., p. 1. Available online at: <http://www.fluechtlingsrat-berlin.de>

<sup>104</sup> § 96 AufenthG.

<sup>105</sup> Ibid.

After years of uncertainty, the German Ministry of the Interior has now explicitly exempted medical (emergency) aid from the forms of assistance to undocumented migrants that are punishable under the Residence Law.<sup>106</sup>

Even though there have been no examples of penalization of medical assistance, the mere existence of the penalization of assistance under the Residence Act has caused unrest among humanitarian organizations, health care providers and other advocates of undocumented migrants' rights in Germany. For instance, several persons working in centers for refugees and migrants in Munich and in Berlin declared that staff are obliged to take home all folders containing confidential data of undocumented migrants on a daily basis in order to keep this data safe.

It is very difficult for undocumented migrants to access health care at hospitals even in cases of emergency. If a person does not show an insurance card, hospital administrations usually try to find a substitute person or institution to bear the medical expenses, often before they begin treatment. Hospitals may retain personal documents such as passports in order to guarantee payment. Also, some physicians and hospitals admit that they had decrease their standards of treatment in cases where insurance status could not be clarified in advance, for example by treating a fracture with a plaster dressing rather than fixing the fractured bone surgically.<sup>107</sup>

Planned surgeries or treatment of chronic diseases are generally not available for undocumented migrants since they are very expensive.<sup>108</sup> Still, in cases where emergency treatment is directly followed by an operation or long-term hospitalization, the patients may receive very high bills, such as in the following case:

*A 30-year-old undocumented Latin American man came to the emergency unit of a hospital in Berlin, suffering from severe stomach pain. The physician diagnosed a perforated stomach ulcer, which had to be operated urgently. As it was an emergency situation, his family had signed documents to agree to pay the costs. Some days later they received a bill of about 10,000 Euros.<sup>109</sup>*

For secondary health care, most undocumented migrants visit general practitioners, specialists and dentists and pay them in cash or use another person's health insurance card. In the opinion of *Médecins du Monde Germany (Ärzte der Welt)*, undocumented migrants can realistically receive medical care only from doctors willing to forego payment of fees and agreeing not to report them. Still, there are limits to medical care, even if some physicians are willing to provide medical treatment free of charge. Problems arise particularly when laboratory diagnoses, X-ray examinations or further consultations of specialists are needed.

<sup>106</sup> See Bundesministerium des Innern, pp. 43. Available online at: [http://www.emhosting.de/kunden/fluechtlingsrat-nrw.de/system/upload/download\\_1232.pdf](http://www.emhosting.de/kunden/fluechtlingsrat-nrw.de/system/upload/download_1232.pdf)

<sup>107</sup> See PICUM, (2001:40). Available online at: <http://www.picum.org/Publications/Sample%20pages%20Health%20care.pdf>

<sup>108</sup> There are however few exceptions of hospitals that have created social funds or special agreements for undocumented migrants. Ibid., p.41.

<sup>109</sup> Ibid., p.40. Available online at: <http://www.picum.org/Publications/Sample%20pages%20Health%20care.pdf>

The fear of being discovered and deported also prevents undocumented migrants with tuberculosis or other serious contagious diseases to seek treatment in public health offices. Undocumented migrants with HIV/AIDS are only eligible for free treatment if they successfully apply for a temporary residence permit.<sup>110</sup> If not, they are faced with exorbitant costs that, according to Antje Sanogo, General Counsellor specialised in migration at *Aids-Hilfe* in Munich, can amount to up to 1,300.00 Euros/month.

In 1984 *Münchner Aids-Hilfe e.V.* (Munich Help for Aids) became the first regional HIV/AIDS help-centre founded as a non-profit association. Over time it developed a comprehensive infrastructure comprised of voluntary and paid work. Today almost 100 voluntary workers and 60 paid personnel offer assistance, ranging from information and counseling to care and questions of housing and employment.

According to their principles they offer help to everyone who turns to them for help. The organization seeks to provide individual help to people with HIV/AIDS, gay men, drug users, women and migrants, while also concentrating on structural issues and challenging the social framework.

<http://www.muenchner-aidshilfe.de>

In addition to the risk of deportation once the temporary residence permit has expired, another problem is that undocumented migrants who are not in need of

immediate treatment have very little chance of receiving a temporary residence permit. Antje Sanogo and Peter Wiessner of *Aids-Hilfe* in Munich have stated that “the situation of undocumented migrants with HIV/AIDS thus poses an ethical dilemma for doctors: On the one hand treatment should be started as late as possible since there are only a certain amount of efficient drugs to protract the course of disease. But on the other hand the early start of treatment and therewith the possibility of receiving a temporary residence permit can constitute a measure against the deportation of undocumented migrants with HIV/AIDS.”

For undocumented pregnant women, the situation is extremely sensitive as well. They have the right to apply for a *Duldung* and therefore to receive pre- and postnatal care, however this temporary limitation of a *Duldung* entails that both mothers and children lose their status at the end of the legally protected maternity and since the authorities are informed about their names and addresses, they run a serious risk of deportation.<sup>111</sup>

Moreover, the newborn child will only receive a birth certificate if the mother holds a valid residence permit or a *Duldung*. If a pregnant woman does not apply for a *Duldung* and delivers her child at home or as a private patient in a hospital, the child will be born into “illegality” as it is impossible to get a birth certificate for a child whose mother is unregistered. However, without a birth certificate, the mother cannot prove parenthood and it is possible that the child is taken away from her, for example in the deportation process.<sup>112</sup>

<sup>110</sup> A temporary residence permit for HIV/AIDS is granted if treatment cannot be obtained in the undocumented migrant’s country of origin. In some rare cases, when additional conditions apply, undocumented migrants with HIV/AIDS may receive temporary residence permits even if treatment could be provided in the country they would be deported to. Such conditions may include the developing of a second severe illness like hepatitis, which needs to be treated, the developing of diabetes as an adverse reaction to the medication given for HIV/AIDS, or a resistance to certain drugs. Telephone interview with Antje Sanogo of Münchner Aids-Hilfe (Munich Aids-Aid) on 25 May 2007 on HIV/Aids and residence permits in Germany.

<sup>111</sup> See Anderson, P., (2003: 67) and Braun T., Brzank P. and Würflinger W. “Gesundheitsversorgung illegalisierter Migrantinnen und Migranten - ein europäischer Vergleich”, in Borde T. and David M. (eds.) *Gut versorgt? Migrantinnen und Migranten im Gesundheits- und Sozialwesen*, (Frankfurt am Main: Mabuse Verlag, 2003), pp. 119-141.

<sup>112</sup> See PICUM (2001: 49). Available online at: <http://www.picum.org/Publications/Sample%20pages%20Health%20care.pdf>

The choices available to undocumented pregnant women are very limited: they go back to their countries of origin to have the baby there, get an abortion, give birth at home, find a midwife or a hospital willing to help or else opt for an “anonymous birth” in certain hospitals which may entail the obligation to give their newborn babies up for adoption.<sup>113</sup>

In some cities, special arrangements exist between organizations and hospitals that allow for pregnant women to give birth without having a *Duldung*. One example can be found in Berlin. The *Büro für medizinische Flüchtlingshilfe* as well as the *Malteser Migranten Medizin* have an agreement with the *DRK Klinik Westend*, a private hospital of the German Red Cross. Both organizations refer undocumented migrants to this hospital for maternal care or delivery. The organization referring the patient pays a major part of the costs for care (including a preparatory visit with the doctor) and delivery (345 EUR per delivery). This cost does not however cover the hospital’s total expenses (costs for a normal birth are at least 800.00 EUR; for a Caesarean they amount to approximately 1,500.00 EUR), especially in cases when complications arise. The remaining cost amounts to a financial loss for the hospital’s gynecological department. If the treatment is very expensive, social workers at the hospital try to convince pregnant women to apply for a *Duldung*. On average, two undocumented pregnant women are taken care of each month.

The ***Malteser Migranten Medizin*** (MMM - Malteser Medicine for Migrants) is a project of the Catholic Malteser organization that offers medical counseling and treatment to undocumented migrants and other people without health insurance. The MMM provides primary medical check-ups, emergency health care and pre-natal care for women without health insurance during their pregnancy and provides the possibility of giving birth in hospital. The main medical reasons for which people seek help at the MMM are pregnancies, accident-related problems, acute dental problems, tumors and infectious diseases. Apart from the first contact point of MMM in Berlin, which was opened in 2001, new medical centers have been established in Munich, Darmstadt and Cologne. Further contact points are planned for Frankfurt, Hamburg, Hanover and Stuttgart.

*Malteser Migranten Medizin* has received two awards from the German federal government. The Botschafter der Toleranz 2004 (Ambassador of Tolerance) award by the Federal Ministers of Justice and of the Interior was offered to the whole organization, while the Federal Order of Merit bestowed by the German President Horst Köhler went to Dr. Adelheid Franz, director of MMM Berlin, in 2006. The physician Dr. Herbert Breker, head of MMM Cologne, received the Honorary Post-Award of the state of North Rhine-Westphalia in 2006.

<http://www.malteser-migranten-medizin.de>

The extremely restrictive legal framework and all of the existing risks compel ill undocumented migrants to seek alternative, informal routes for treatment. Self-medication and consulting community networks seem to be the first steps undocumented migrants take when getting ill. Only if these strategies fail,

<sup>113</sup> See Anderson P., [2003: 67]. Available online at: [http://www.gruene-muenchen-stadtrat.de/seiten/pdfs/studie\\_illegalitaet.pdf](http://www.gruene-muenchen-stadtrat.de/seiten/pdfs/studie_illegalitaet.pdf)

will undocumented migrants consider looking for additional professional help, sometimes borrowing the health insurance card of a family member or a friend.

The delay in seeking professional help often occurs at the expense of the patient's health, and in cases involving infectious diseases placing others at risk. In addition, the costs incurred from delayed treatment are usually considerably higher than if treatment was given immediately. Nevertheless, alternative routes often constitute the only feasible possibilities for ill undocumented migrants, as actively seeking medical help always carries the risk of discovery and deportation.<sup>114</sup>

#### 4. The Role of Civil Society and Local Actors

Undocumented migrants unable to access another person's health card and who are not in touch with medical professionals offering treatment free of charge often rely on assistance provided by aid organizations.<sup>115</sup>

In recent years, the number of such solidarity initiatives towards undocumented migrants has grown significantly. Most seek to provide direct medical assistance and medication to undocumented migrants, to pay treatments and to refer them to doctors and hospitals that are prepared to treat undocumented migrants.

Organizations such as *Büro für medizinische Flüchtlingshilfe*, *Malteser Migranten Medizin* and *Café 104* constitute good examples of these initiatives for undocumented migrants in the field of

health care. Their contribution is remarkable although they certainly cannot compensate undocumented migrants' lack of access to the public health care system. Because of their restricted resources, the capacities of non-governmental networks and individual health care providers reach their limits before long, particularly if cost-intensive or in-patient treatment is required.

**Café 104** is a non-governmental organization that was founded in Munich in 1998 by people who had previously worked on asylum related issues on a professional or voluntary basis and who felt the growing need to address the issue of health care for undocumented migrants. The organization offers medical advice and legal support to those without access to the public health care system because of their irregular residence status. It collaborates with a network of volunteer doctors and nurses who provide medical treatment for free. All staff members work without pay and independently from governmental institutions. In 2002, "Café 104" was offered the "Lichterkette" (Chain of Light) anti-racism award.

Since July 2006, "Café 104", in cooperation with *Ärzte der Welt (Médecins du Monde Germany)*, has offered direct health care for people without health insurance in Munich twice a week. This recent cooperation provides the opportunity to combine direct medical treatments with social and legal counseling. An emergency telephone line assures daily accessibility.

<http://www.cafe104.de/>

<sup>114</sup> Scott P., "Undocumented Migrants in Germany and Britain: The Human 'Rights' and 'Wrongs' regarding Access to Health Care", in *Electronic Journal of Sociology*, 2004. Available online at: <http://www.sociology.org/content/2004/tier2/scott.html>. Also, Alt J., (1999) and Anderson P., (2003: 34). Available online at: [http://www.gruene-muenchen-stadtrat.de/seiten/pdfs/studie\\_illegalitaet.pdf](http://www.gruene-muenchen-stadtrat.de/seiten/pdfs/studie_illegalitaet.pdf).

<sup>115</sup> PICUM (2001: 37). Available online at: <http://www.picum.org/Publications/Sample%20pages%20Health%20care.pdf>; Sinn A. *et al*, (2005:65); Schmitt E., (2006: 34). However, a great number of undocumented migrants are not reached by those organizations, because they are mainly present in the urban centers. Additionally, many undocumented migrants lack information not only about their legal entitlements to access health care in the host country but also about the existence of medical centers linked to organizations or private institutions where health care is provided free of charge.

The strong resistance of the federal and state governments to recognize the presence of undocumented migrants and address their basic social needs is opposed to the social reality encountered by health officials at the local level. Left to witness the experiences and difficulties confronting undocumented migrants in need of care, health professionals face serious dilemmas when enforcing the law and therefore at times feel obliged to break the law.

There have been some institutional attempts at the local level to explore possibilities to improve the social situation of undocumented migrants in Germany. A good example is the initiative taken in 2001 by the City Council of Munich that commissioned a study on the housing, working and health conditions of undocumented migrants.<sup>116</sup> Following some recommendations proposed by the study, the city of Munich decided to take some steps to improve the situation of undocumented migrants. One of them was the establishment of a medical contact point for “uninsured people” that was opened by the *Malteser Migranten Medizin* in July 2006. This first initiative taken by a municipality in Germany awoke the interest of other local departments dealing with legal, social and humanitarian aspects of undocumented migrants in Germany.

Some other public health services offer anonymous consultation hours making it possible for undocumented migrants to make use of their services. Two examples are the Düsseldorf Public Health Service and the Department of Health of the City of Frankfurt.

The ***Gesundheitsamt Stadt Düsseldorf*** (Düsseldorf Public Health Service) offers medical check-ups and social counseling for migrant women working in prostitution, regardless of their residence status. Five days a week they provide counseling and support on health related concerns (especially on HIV/AIDS and sexually transmitted diseases) and contraception, but also on partnership and family related problems, debts, drug addictions, human trafficking, professional re-orientation and problems concerning the Social Code. They offer assistance with contacting public authorities and institutions.

They provide free contraception and check-ups for venereal diseases and other sexually transmitted diseases as well as gynecological examinations.<sup>117</sup>

<http://www.duesseldorf.de/buergerinfo/>

<sup>116</sup> The study also deals with police controls and undocumented migrants’ experiences with the authorities, the specific situation of undocumented women and children and the dilemma faced by people who were trying to assist them. See Anderson P. (2003) Available online at: [http://www.gruene-muenchen-stadtrat.de/seiten/pdfs/studie\\_illegalitaet.pdf](http://www.gruene-muenchen-stadtrat.de/seiten/pdfs/studie_illegalitaet.pdf)

<sup>117</sup> <http://www.duesseldorf.de/frauen/download/migrantinnen.pdf>

The *Gesundheitsamt der Stadt Frankfurt* (Department of Health of the City of Frankfurt) offers anonymous medical consultation and treatment, justifying these services due to the risk of epidemics. The City of Frankfurt has called for the opening of an intercultural health service, as the residence status of migrants in addition to the fear of undocumented migrants of being detected should be taken into account when planning such health care services.

Five days a week they offer consultation hours to prevent the spreading of sexually transmittable diseases, mainly directed at women working in prostitution.<sup>118</sup> Every Thursday there is the *Afrikasprechstunde* (Africa consulting hours) in which medical and psycho-social consultation is offered<sup>119</sup> and every Wednesday there is the *Roma-Sprechstunde* (Roma consulting hours).<sup>120</sup>

[http://www.frankfurt.de/sixcms/detail.php?id=2996&ffmpar\[id\\_inhalt\]=102326](http://www.frankfurt.de/sixcms/detail.php?id=2996&ffmpar[id_inhalt]=102326)

These public and private initiatives indeed contribute to ease some of the terrible consequences that insufficient access to the public health care system has for undocumented migrants and society in general. It is clear for German civil society initiatives that a situation in which the bulk of responsibility for tackling the problems remains on their shoulders is no longer sustainable. The state must assume responsibility concerning public health and ensure that undocumented migrants' basic human rights are protected – instead of merely giving awards to recognize the humanitarian work of organizations like *Malteser Migranten Medizin*.

The *Büro für medizinische Flüchtlingshilfe*, for instance, goes beyond providing medical assistance and advice to undocumented migrants and has held several actions to protest against discrimination and racism as well as to raise awareness about the situation of undocumented migrants. Also involved in the activities of the Federal Working Group on Access to Health Care for Undocumented Migrants, they publicly protest against discriminatory practices of hospitals and co-organize anti-racism demonstrations.<sup>121</sup>

<sup>118</sup> [http://www.frankfurt.de/sixcms/detail.php?id=2999&myvars\[id\\_listenartikel\]=102351](http://www.frankfurt.de/sixcms/detail.php?id=2999&myvars[id_listenartikel]=102351).

<sup>119</sup> [http://www.frankfurt.de/sixcms/media.php/738/seiten\\_aus\\_afrika\\_gesund.brosch.pdf](http://www.frankfurt.de/sixcms/media.php/738/seiten_aus_afrika_gesund.brosch.pdf).

<sup>120</sup> [http://www.frankfurt.de/sixcms/detail.php?id=2999&myvars\[id\\_listenartikel\]=177411](http://www.frankfurt.de/sixcms/detail.php?id=2999&myvars[id_listenartikel]=177411)

<sup>121</sup> Büro für medizinische Flüchtlingshilfe Berlin. *10 Jahre Büro für medizinische Flüchtlingshilfe. Eine Erfolgsgeschichte?*, pp.36. Available online at: <http://www.medibuero.de/attachment/39b520617b75d0e45fa5eb4f5da202aa/f0763d7d937829c0768bc96fd03c1f82/MBBrosch%C3%BCreWeb.pdf>



The ***Büro für medizinische Flüchtlingshilfe*** (Bureau for Medical Aid for Refugees) in Berlin arranges anonymous and free medical treatment by qualified medical personnel for people without residence status and health insurance twice a week. The *Büro* is a non-governmental, self-organized project within the anti-racism movement. All staff work on a non-fee, voluntary basis. Additional costs for medication, X-rays examinations, glasses, etc. are covered by donations.

The *Büro* was founded in 1996 with the aim of combining practical solidarity with political activism. People working in the *Büro* share the opinion that every human being must be allowed to choose freely where to live and work. Apart from providing health care for ill people, they also take part in various actions against the discrimination of foreigners by national or local authorities and legislation, as well as against racist attitudes and actions.

Apart from Berlin, *Medibüros* exist in Bochum, Bonn, Bremen, Freiburg, Göttingen, Halle, Hamburg, Hanover, Cologne, and Munich (Café 104). All *Medibüros* have office hours once or twice a week for 1-2 hours, and also have permanent phone lines and answering machines.

<http://www.medibuero.de>

The *Federal Working Group on Access to Health Care for Undocumented Migrants*, set up by the *German Institute of Human Rights*<sup>122</sup> and the *Katholisches Forum Leben in der Illegalität*<sup>123</sup> (Catholic Forum Living in Illegality) in early 2006, have also clearly expressed the urgent need for political action. The working group is made up of experts from academia, political parties, medical practice, churches, welfare organizations and NGOs.

Stressing that the lack of medical treatment for undocumented migrants has serious consequences both for the health of the concerned persons and for public health, the working group also points out that delayed treatment often creates higher costs. Taking into account the difficulty to address these problems under the existing administrative, legal and political structures, they strongly recommend the abolishment of the penalization of assistance for humanitarian reasons and the duty to denounce as well as the creation of a specific public fund that would cover the costs for medical treatment for undocumented migrants.<sup>124</sup>

<sup>122</sup> <http://www.institut-fuer-menschenrechte.de>

<sup>123</sup> <http://www.forum-illegalitaet.de>

<sup>124</sup> Koch U., *Kranksein in der Illegalität. Statement im Rahmen der Anhörung zum Recht auf Gesundheit am 7. März 2007 im Bundestagsausschuss für Menschenrechte und humanitäre Hilfe*. Available online at: [http://www.forumillegality.de/Materialien/Ute\\_Koch/MenschenrechtsausschussStatement\\_Ko.pdf](http://www.forumillegality.de/Materialien/Ute_Koch/MenschenrechtsausschussStatement_Ko.pdf)

## 5. HUNGARY

*Even if the Hungarian Constitution declares the right of everybody living in Hungary “to the highest possible level of physical and mental health,” with the exception of stateless persons, undocumented migrants are not entitled to benefits of the Hungarian health insurance scheme.*

### » Terms:

HIF - National Health Insurance Fund

### GENERAL HEALTH CARE SYSTEM

Hungary introduced a compulsory social insurance system in 1990. Entitlement to health care is based mainly on participation in the social insurance scheme (with compulsory membership) and for a few services it is based on citizenship.

The National Health Insurance Fund (HIF) provides universal population coverage with a benefit package that applies throughout the country without disparities. The HIF only covers the recurrent costs of services while tax revenues are used to cover the deficit of the HIF as well as certain special services (e.g. public health) and co-payment for certain medicine and therapeutic devices for the socially disadvantaged. The owners of health care facilities, mainly local governments, are obliged to cover the capital costs of services, which usually come from general and local taxation.<sup>125</sup>

The most applicable law is the Health Act which sets general rules in the field of health care. It covers all health services providers operating and health activities pursued in Hungary. The Act on Local

Governments assigns responsibility for arranging the provision of primary health care services to local governments while placing county governments in charge of providing specialist health care.<sup>126</sup>

While in principle entitlements are linked to paying contributions, in practice coverage is universal since entitlement is not checked by the providers. In the context of health system reform, there is a tendency to reduce access to publicly financed health care even for Hungarians. Revision of the entitlements to health care is currently under consideration by expanding the scope of services to all emergency care for which every citizen is eligible. The remaining health services will be provided on the basis of participation in the social insurance scheme, but it will be checked whether the patient is in fact entitled to health services.<sup>127</sup>

Finally, there is a lack of medical personnel in Hungary, especially in small villages and rural areas where people are obliged to travel to see a doctor. As the Roma Press Center of Budapest informed, “many members of the Hungarian Roma community are suffering from this lack of access to the health system.”

<sup>125</sup> Gaal P., “Benefits and entitlements in the Hungarian health care system”, in *European Journal of Health Economics* Supplement 1, 2005, p. 37.

<sup>126</sup> Hungarian Ministry of Health, *Legal and operational environment of the health care system*, (2004b), available at: [http://www.eum.hu/index.php?akt\\_menu=3550](http://www.eum.hu/index.php?akt_menu=3550).

<sup>127</sup> Ibid.

## HEALTH CARE FOR UNDOCUMENTED MIGRANTS

### 1. Legal Entitlements to Access Fully or Partially Publicly Subsidized Health Care

Even if the Hungarian Constitution declares the right of everybody living in Hungary “to the highest possible level of physical and mental health,”<sup>128</sup> with the exception of stateless persons, undocumented migrants are not entitled to benefits of the Hungarian health insurance scheme.<sup>129</sup> Therefore, they do not have access to any publicly subsidized health care in Hungary besides emergency care that is always free of charge.

When granting the right to emergency care, the Health Act does not refer expressly to undocumented migrants but to the general term “non-citizen” by providing that “a non-citizen in need of emergency care within the borders of the Republic of Hungary shall receive immediate treatment.” In addition, it states that “a non-citizen requiring medical intervention within the borders of the Republic of Hungary shall have access to the said intervention under the same conditions as a Hungarian citizen.”<sup>130</sup> Since it does not provide any conditions on grounds of residence status, it may be assumed that undocumented migrants are covered by this provision.

Therefore, costs incurred for providing emergency care to undocumented migrants are covered by the National Health Insurance Fund.

As regards other medical services, undocumented migrants, as with any other person without a national health insurance identification card, must pay the conventional fees established for each category of services. After treatment they will receive an invoice listing all services or treatments received with the price applying. The billing system has been compulsory since 2006.

### 2. The Situation in Practice and the Role of Civil Society and Local Actors

In the absence of a clear-cut definition of “emergency care”, it falls to health providers to interpret what constitutes an “emergency”. There are many differences of interpretation among hospitals. Nonetheless, as explained by Dr. Ferenc Falus, Director of the *Nyíró Gyula Kórház* hospital in Budapest, “in Hungary, hospital staff have the tendency to interpret this concept quite widely, especially if the patient is an ethnic Hungarian or speaks the language.”

This situation may sometimes entail that the health care providers report doubtful “emergency” cases to the competent authority in order to receive reimbursement. The payment usually takes place quite late and on occasion the authority does not have the same appraisal concerning what can be considered an “emergency.”

Very few undocumented migrants seek health care in Hungarian public hospitals. Most probably, undocumented migrants use their own informal networks and may even use health insurance cards from family members or friends, making it very difficult for hospitals to know their real administrative status. In opinion of Dr. Ferenc Falus of the *Nyíró Gyula Kórház* hospital, this is likely a regular occurrence among the Chinese community in Budapest.

The situation is best explained by the fact that many of the undocumented migrants residing in Hungary are temporarily present in the country, which is why they rarely seek health care in public hospitals. This is also the experience of private hospitals like the *OLTALOM-Hospital*, the only hospital in Budapest providing access to health care to everyone free of charge, including undocumented migrants. The vast majority of their patients are homeless, have not been accepted by public hospitals or returned from public hospitals to die. According to Dr. Iványi Tibor,

<sup>128</sup> Section 70/D Paragraph 1 of the Hungarian Constitution (Act 20 of 1949).

<sup>129</sup> Hungarian Ministry of Health, *Beneficiaries of health care in Hungary with special regard on foreigners*, (2004a), Available online at: [http://www.eum.hu/index.php?akt\\_menu=3550](http://www.eum.hu/index.php?akt_menu=3550)

<sup>130</sup> Act CLIV of 1997 on Health, promulgated on 23 December 1997, section 243.

the hospital has been treating no more than 30 or 40 uninsured persons a year and most of them were Romanians. “They are mostly men coming for not so serious problems such as the flu and skin diseases due to poor living conditions. Others are directly coming from the detention centers.”

The **OLTALOM-Hospital** is the only hospital providing direct medical assistance to uninsured people in Budapest completely free of charge. Together with the shelters, the hospital constitutes one of the main activities of the *Oltalom Charity Society*, an organization created in 1989 and linked to the Methodist Church whose main aim is to support people in need. The hospital is partially financed by the National Health Insurance Office as well as by private donations. The hospital has around 70 beds and 30 staff members including nurses, social workers, psychologists, physiotherapists and medical doctors with specialization in pediatrics, psychiatry, neurology, surgery, vascular surgery, plastic surgery, anesthesiology, intensive therapy, radiology, dental and oral affection, dermatology, bacteriology, pathology, public health and medical science.

Hospital staff hope that they will soon be entirely financed by the state since, as Dr. Iványi Tibor said, “the hospital faces major pressure given the fact that many homeless people are sent to us by public hospitals, in many cases, due to clear discrimination practices. Sometimes we have to go back to our informal networks to send our patients back to public hospitals for specific specialized treatments. Even in those cases, sometimes patients are returned here again just to die”.

<http://www.oltalom.hu/>

Within the current global and European context, it is unlikely that the number of undocumented migrants present in Europe will decrease. Thinking of future scenarios, where the presence of undocumented migrants in Hungary may become much more significant, civil society organizations have serious doubts about the approach of Hungarian society to this problem. They think that Hungarians will most likely show great resistance to freely grant access to the national health system. There is a big concern about “sharing” access to social services in Hungary. This resistance has also been shown largely among those with the same ethnic origin since one of the main reasons that Hungarians voted against a referendum which proposed granting Hungarian nationality to ethnic Hungarians was the opposition to “foot the bill” for their access to social services.

Since 1995, the organization **Menedék – Hungarian Association for Migrants** has operated in Budapest as a non-governmental organization. Its main mission is to represent refugees, asylum seekers and migrants’ vis-à-vis the wide society and promote their legal, social and cultural integration. Their main activities are project-based and include information and counseling, training of interpreters, awareness raising and network building. They also help undocumented migrants, mainly rejected asylum seekers.

<http://www.menedek.hu>

## 6. ITALY

*“The Chinese community is quite self-sufficient. They use their own networks to solve even medical problems. Nonetheless, we had always suspected that something else was preventing Chinese from visiting our charity clinic. We decided to approach them through a cultural mediator. After some time, our clinic started to be visited daily by Chinese undocumented migrants. How can you explain this? By looking at their eyes one can easily realize how afraid they are. In addition, they face enormous language and cultural barriers.”*

Doctor at an NGO providing health care to undocumented migrants in Rome

» **Terms:**

*A.S.L. (formerly U.S.L.)* - local health administration

*Fondo sanitario nazionale* - National Health Fund

*Stato di indigenza* - indigence status

*STP (Stranieri Temporaneamente Presenti)* - temporarily residing foreigner

### GENERAL HEALTH CARE SYSTEM

The Italian National Health Service is a public system aiming to grant universal access to a uniform level of health care throughout the country.

According to the principle of subsidiarity, the central government and the regions share responsibility for the provision of health care. The state is responsible for defining the basic benefit package (*Livelli Essenziali di Assistenza*) and guarantying access to health care for everyone throughout the country. The twenty regions must implement these objectives and have the exclusive competence to regulate and organize the health care system. Local health authorities are responsible for the delivery of health care services at the local level.

Universal coverage has been achieved although there are many differences in services and expenditure among regions. This aspect constitutes precisely one of the remaining challenges of the Italian health care system.

The system is financed by general taxation (direct and indirect taxes). Local health care administrations also receive payment of the moderating fee - the so-called “ticket” - and the payment of other health services delivered at cost.<sup>131</sup>

### HEALTH CARE FOR UNDOCUMENTED MIGRANTS

#### 1. Legal Entitlements to Access Fully or Partially Publicly Subsidized Health Care

Undocumented migrants do not have the right to register in the Italian National Health Service. However, since 1998 the state has subsidized (fully or partially) their access to the following types of health care:

- i) “urgent” and “essential” medical care (both including continual treatment);
- ii) preventive care;
- iii) care provided for public health reasons including:

<sup>131</sup> Große-Tebbe S. and Figueras J., (2004:41). Available online at: <http://www.euro.who.int/document/e85400.pdf>

- a) prenatal and maternity care;
- b) care for children;
- c) vaccinations
- d) diagnosis and treatment of infectious diseases.  
The treatments can be received at a district public health center or at a public hospital (*cure ambulatoriali et ospedaliere*).<sup>132</sup>

Whilst some of these treatments are provided free of charge to undocumented migrants who have a “STP code” (*Stranieri Temporaneamente Presenti* - temporary residing foreigner) and an “Indigence status” (*stato di indigena*), others are only provided upon payment of the “ticket,” a fee established by the regions and that is paid also by nationals and regular residents.

Care always provided free of charge (without the “ticket” payment) to undocumented migrants is the following:

- i) emergency care (*cure urgenti*);

- ii) “basic” essential care (i.e. primary care and all kinds of inpatient hospital care, including inpatient treatment of contagious diseases such as tuberculosis and chronic diseases such as HIV/AIDS);<sup>133</sup>
- iii) maternity care;
- iv) any care for the elderly (over 64 years);
- v) any care for children (under 6 years).<sup>134</sup>

Nevertheless, undocumented migrants have to pay the “ticket” in case they seek:

- i) “specialized care” (i.e. outpatient care to be carried out on the general practitioner’s request); and
- ii) outpatient treatment of contagious and chronic diseases, including HIV/AIDS.<sup>135</sup>

The Italian legislation provides definitions for the terms “urgent” and “essential” medical care. “Urgent medical care” is defined as care that cannot be deferred without endangering the patient’s life or damaging his/her health.<sup>136</sup>

<sup>132</sup> Note, however, that the implementing regulations were only adopted some years later. See Article 35(3) of the Decree-Law No. 286 of 25 July 1998 known as the “The Single Text” regulating immigration (Decreto Legislativo n. 286, 25 Luglio 1998, Testo Unico delle disposizioni concernenti la disciplina dell’immigrazione e norme sulla condizione dello straniero, *Gazzetta Ufficiale* n. 191 del 18 agosto 1998 – Supplemento Ordinario n. 139): “*Ai cittadini stranieri presenti sul territorio nazionale, non in regola con le norme relative all’ingresso ed al soggiorno, sono assicurate, nei presidi pubblici ed accreditati, le cure ambulatoriali ed ospedaliere urgenti o comunque essenziali, ancorché continuative, per malattia ed infortunio e sono estesi i programmi di medicina preventiva a salvaguardia della salute individuale e collettiva. Sono, in particolare, garantiti: a) la tutela sociale della gravidanza e della maternità, a parità di trattamento con le cittadine italiane (...); b) la tutela della salute del minore (...); c) le vaccinazioni secondo la normativa e nell’ambito di interventi di campagne di prevenzione collettiva autorizzati dalle regioni; d) gli interventi di profilassi internazionale; e) la profilassi, la diagnosi e la cura delle malattie infettive ed eventuale bonifica dei relativi focolai*”; See also Article 43 (1) and (2) of the Decree of the President of the Republic No. 394 of 31 August 1999, implementing the Decree-Law No. 286 (*Decreto del Presidente Della Repubblica 31 agosto 1999, n. 394. Regolamento recante norme di attuazione del testo unico delle disposizioni concernenti la disciplina dell’immigrazione e norme sulla condizione dello straniero a norma dell’articolo 1, comma 6, del decreto legislativo, 25 luglio 1998, n. 286, Gazzetta Ufficiale* n. 190 del 3 novembre 1999 – Supplemento Ordinario n. 258).

<sup>133</sup> HIV screening is also provided anonymously and free of charge.

<sup>134</sup> For this summary and interpretation of the Italian legislation, see Panizzut D. and Olivani P. *Il diritto alla salute- Come e Perché*. (Siena: NIE, 2006), p. 52. See also Article 35(4) of the Single Text and Section II B of the Circular of the Ministry of Health No. 5 of 24 March 2000, implementing the Decree-Law No. 286 (Circolare 24 marzo 2000, n. 5 del Ministero della Sanità).

<sup>135</sup> *Ibid.* For chronic and infectious pathologies defined as “exonerated pathologies”, access occurs through the outpatient special department and the exonerated of the ticket for the special performances in the public or operating within the NHS sanitary structures.

<sup>136</sup> See Section II B of the Circular of the Ministry of Health No. 5 of 24 March 2000.

The concept of “essential medical care” as defined by law is both diagnostic and therapeutic, related to pathologies which are not dangerous in the immediate or short-term, but which could subsequently lead to serious damages and risks for the patient’s health (*complicanze, cronicizzazioni, o aggravamenti*).<sup>137</sup> The concept of “essential care” is rather wide and includes “essential” primary and secondary care, hospitalization and medicine that may be defined as “essential.”<sup>138</sup>

The law also establishes the principle of continuation for “urgent” and “essential” treatments. Accordingly, undocumented migrants in need of “urgent” or “essential” treatment will receive health care until the moment that their whole therapeutic and rehabilitation period is completed.<sup>139</sup>

## 2. The Procedure and the Financing of the System

To enjoy the entitlements of accessing health care and medicine necessary for “urgent and essential care,” undocumented migrants must obtain the anonymous “STP code”. The document providing this anonymous code is issued by a specific public health authority and is valid throughout Italy.

The code is issued by a hospital administration or by the local health administration (A.S.L., formerly U.S.L.). Undocumented migrants may receive the “STP” any time, even before they get ill. They obtain it free of charge. The code has a validity of six months and can be renewed.

When an undocumented migrant requests the “STP” from the administration, they normally also apply for the “Indigence status” (*stato di indigenza*) by declaring their situation of poverty and filling in an official form. This status does not render undocumented migrants exempt from paying the “ticket” when required so by law.

The cost incurred for providing “urgent” or “essential” medical care to undocumented migrants is covered by the Ministry of Interior. The hospital or the district health center administration where undocumented migrants have been treated inform the local health administration (A.S.L.) which is in turn reimbursed by the Ministry of Interior. To this aim, they provide the anonymous code correspondent to the patient (assuring non-traceability), the diagnosis, the care provided as well as the sum to be reimbursed.<sup>140</sup>

As regards preventive care and care provided for public health reasons as defined by the Italian legislation, costs covered by the so-called “National Health Fund” (*Fondo sanitario nazionale*) follow a similar procedure.<sup>141</sup>

## 3. The Situation in Practice

Generally speaking, the system of health care for undocumented migrants in Italy is viewed very positively by many organizations working with undocumented migrants because good health coverage is provided by law to these migrants. Nonetheless, many NGOs also denounce that the law is not uniformly implemented throughout Italy. Important differences still exist between regions as well as within regional health centers and hospitals.

<sup>137</sup> Ibid.

<sup>138</sup> Medicines are distributed by those chemist shops that have made an agreement with the health care system.

<sup>139</sup> Section II B of the Circular of the Ministry of Health No. 5 of 24 March 2000.

<sup>140</sup> See Article 43(4) and (5) of the Single Text; See also section II B of the Circular No. 5 of 24 March 2000.

<sup>141</sup> See Article 35(6) of the Single Text; Article 43 (3-8) of the Decree No. 394 of 31 August 1999; section II B of the Circular No. 5 of 24 March 2000.

In practice, access to health care appears less guaranteed in towns where the immigrant population or the pressure of NGOs is relatively low. The same situation applies to many agricultural regions in the south of Italy. A report by *Medici Senza Frontiere* about the living and health conditions of seasonal migrant workers in agricultural regions of southern Italy notes:

*“The lack of access to health care and diagnoses of these migrants is very serious. Besides their extremely precarious living and working conditions and the lack of basic sanitary facilities (water, electricity, toilets, etc.), there are in fact no ASL’s district health centers in the migrants’ proximity. Consequently, they seek health care only in very extreme emergency situations. The health administration must provide a solution to this problem, facilitating access to health care for example by opening a center compatible with working schedules.”*<sup>142</sup>

88.6% of undocumented migrants interviewed within the *MSF* project did not have any access to health care although all of them had been living in Italy from one to three years.<sup>143</sup>

Since 1999, ***Medici Senza Frontiere (MSF)*** has managed health and legal assistance projects to help migrants and asylum seekers in Italy.

During the summer of 2003, *MSF* became aware of the conditions facing immigrants working with tomato crops in the area of Foggia in Puglia. *MSF* started a broader project with the aim of inquiring on the reality of migrant seasonal workers in the south of Italy and help all the people they could. The findings have been published in a report.<sup>144</sup>

During the 2004 season (from April to December) a team seven health care providers and cultural mediators went to Calabria, Puglia, Campania, Basilicata and Sicily. They provided legal advice as well as direct medical assistance from a mobile unit. *MSF* managed to help and interview 770 people out of an estimated 12,000 immigrant seasonal workers employed in the south of Italy, 51.4% of whom were undocumented.

Living and hygienic conditions were unacceptable and led to dramatic consequences for the immigrant workers’ health conditions. Only 5.6% out of 770 people had been diagnosed as having “good health conditions.” All the others had at least one health problem, more or less serious. 50% had infectious diseases and 63.6% had chronic diseases. *MSF* has also informed that the so-called “well-being laps” (time passed between the arrival in Italy and the onset of illness) was getting shorter: 10% of the immigrants needed medical care one month after their arrival in Italy and 39.7% showed this need within a period varying between one to six months.

<http://www.msf.it/>

<sup>142</sup> Médecins Sans Frontières, *Il Frutti dell’ipocrisia. Storie di chi l’agricoltura la fa. Di nascosto*, (Roma: Sinnos Editrice, 2005b), pp. 60 and pp.143.

<sup>143</sup> Ibid.

<sup>144</sup> Ibid.



In areas where there are not so many immigrants, many civil servants are familiar with the “STP system” resulting in extremely restrictive interpretations of the terms “urgent and essential care.” An example of this has been provided by *Médecins du Monde*: “In some regions, like Lombardia, children have to pay tickets because pediatricians are wrongly categorized as secondary health care. This practice is taking place in clear violation of Italian legislation and of the Convention of the Rights of the Child,” explained Marco Zancheta.

In the opinion of some experts, the lack of clarity of the concept of “essential care” could be behind all of these problems. In this sense, *Caritas* recommends official clarification of the definition in order to avoid new barriers contrary to the spirit of the law.

Strict interpretations of the law do not only occur in small towns or agricultural areas; it has also been observed that within individual cities, levels of awareness and information about access to public health services for undocumented migrants may vary greatly among the relevant actors.

Even in cities like Rome, with a significant immigrant population, authorities in charge of the STP system continue establishing conditions and requesting documents from undocumented migrants not provided by the law. For instance, some local health administrations (ASL) unlawfully ask undocumented migrants to present their passports or even residence permits to get the STP code, thus ignoring that regular migrants have access to health care through the general National Health Service. *Caritas* has informed that in Rome there is a clinic

(*policlinico*) that in an attempt to “avoid abuses” has been requiring migrants to demonstrate that they have been living in Italy at least three months.

The lack of knowledge is not only experienced by administrations and providers. There is evidence that shows that in Italy many undocumented migrants are not aware of their rights.

This lack of awareness is particularly evident in certain immigrant communities like the Chinese. Following a very pro-active approach, the “Poliambulatorio Via Marsala” clinic of *Caritas Roma*, which treats numerous undocumented migrants in the area of the Termini train station in Rome, realized that although very numerous and present for a significant number of years, there were almost no Chinese migrants seeking health care at the *Caritas* clinic. This was particularly evident when compared to the large number of migrants from other communities coming daily to the clinic. As Dr. Salvatore Geraci of the health department of *Caritas Roma* stated, “it is true that the Chinese community is quite self-sufficient. They use their own networks even to solve medical problems. Nonetheless, we had always suspected that something else was preventing Chinese from visiting our clinic. We decided to approach them through a cultural mediator. After some time, our clinic started to be visited daily by Chinese undocumented migrants. How can you explain this? By looking at their eyes one can realize how afraid these people are. In addition, they face enormous language and cultural barriers.” Thanks to this initiative, 589 Chinese patients visited the *Caritas* clinic from 2000 to 2004, of which 63% were undocumented.<sup>145</sup>

<sup>145</sup> Geraci S., Maisano B. and Marceca M. *Accesso e fruibilità dei servizi: scenari nazionali ed esperienze locali*, (Unpublished, 2005), pp.6.

The **Area Sanitaria** of **Caritas Rome** started in 1983 with the aim of providing basic health care to people not accessing public and free health care in Rome. Providing social and health support to immigrants is becoming one of its main priorities. Most of its medical and administrative staff are volunteers.

Health services (basic and specialised) are provided through three clinics and a number of centers:

- a) *Poliambulatorio Via Marsala di Medicina Generale* that provides general medicine and some specialised health care;
- b) *Poliambulatorio Alessandro VII* and the *Poliambulatorio San Paolo* providing also different specialised health services;
- c) The dentistry center;
- d) The pharmaceutical center.

The *area sanitaria* also seeks to raise awareness among health care providers and administrations about marginalized people and makes recommendations for improving accessibility to the health system. To this aim, they also have a center for studies and documentation on health and immigration that publishes studies and statistics about immigrants and health in Italy.

<http://www.caritasroma.it/settori/sanita/sanita.asp#>

As shown by this example, language, cultural barriers and the fear to be discovered also impede undocumented migrants residing in Italy from accessing health care even at clinics run by volunteer organizations.

This fear to be denounced and expelled is also very real as regards women who arrive in Italy irregularly and wish to give birth in safety. There is often the mistaken assumption that, once they have made use of the public services, they will be made known to the authorities and therefore deported.<sup>146</sup>

Italian legislation does not impose any duty on health administrations to denounce undocumented migrants. On the contrary, the law clearly states that authorities should not be informed whenever these migrants seek health care but only if their illness falls under the categories of illnesses that have to be reported to the authorities on equal grounds with Italians.<sup>147</sup>

Another obstacle encountered by undocumented migrants to access health care in Italy is the payment of the moderating fee, the “ticket”. As reported by *Caritas Roma*, “it is difficult for those with a precarious economic situation to pay the ticket since the rates are sometimes high. This can even prevent some Italians from seeking health care. The system of health and social protection should be better adjusted to the different economic situations so that it facilitates real access to health care, also for people who are suffering a high degree of marginalization.”<sup>148</sup>

#### 4. The Role of Civil Society and Local Actors

As illustrated by all these examples, the existence of generous legal entitlements does not automatically guarantee the enjoyment of rights by undocumented migrants. It is necessary to improve accessibility as regards this group of socially excluded persons and to this aim more active accompanying public policies and measures have to be adopted at local and regional levels. The important role that NGOs continue to play in this field shows that the system is not fully addressing the specificities of this population.

<sup>146</sup> PICUM, *Book of Solidarity. Providing assistance to undocumented migrants in France, Spain and Italy*, Vol. 02 (Brussels: PICUM, 2003), p. 36. About the fear to be denounced see also IDOS – National Contact Point EMN (eds.), *Illegally resident third country nationals in Italy: state approaches towards them and their profile ad social situation*, (Rome: EMN, 2005).

<sup>147</sup> See Article 35(5) of the Single Text: “L’accesso alle strutture sanitarie da parte dello straniero non in regola con le norme sul soggiorno non può comportare alcun tipo di segnalazione all’autorità, salvo i casi in cui sia obbligatorio il referto, a parità di condizioni con il cittadino italiano”.

<sup>148</sup> Caritas Diocesana di Roma, *Il diritto alla salute degli immigrati. Scenario nazionale e politiche locali*, (Rome, July 2002), p. 20.

In many cases, the intervention of NGOs helps to tackle barriers encountered by undocumented migrants when trying to access public health services. This is particularly evident, for instance, when undocumented migrants need specialised care. In Italy, general practitioners act as gatekeepers to secondary care. Sometimes they refuse to provide undocumented migrants with the necessary prescription. Many civil society organizations usually intervene in these kinds of situations to solve the malfunctioning of the system by directly contacting health care providers and administrations.

Some health administrations are already aware of this gap between law and practice and make efforts to address these issues by publishing and disseminating information guides, targeting specific groups and building partnerships with NGOs. An example of this kind of cooperation scheme is a project funded by the city of Rome and carried out jointly by the health administration (ASL) of the “Rome B” district with the organization *Opera Nomadi*. The project’s main purpose is to guarantee minimum health coverage and preventive care to the Roma community residing in the referred area. To this purpose, a multidisciplinary team (composed by health care providers, social workers and cultural mediators) is currently working with the help of a mobile unit that is present every day in all Roma camps providing information and direct medical assistance.

It is very common that NGOs publish guides with contact information and brochures explaining the rights and procedures to access medical assistance and where to go to seek health care in a particular district or city.

Some organizations like *NAGA* in Milan and *Caritas Roma* also have clinics where they provide health care and diagnoses free of charge to undocumented migrants and other marginalized persons. These clinics do not seek to run alternative health services competing with the public ones but rather

address those specific needs and problems related to migrants’ health that are not always taken into account by public authorities.

*NAGA* is an organization based in the region of Lombardy giving social and health assistance to foreigners and temporary residing persons. A high percentage of people seeking *NAGA*’s help are undocumented.

In the region of Lombardy, civil society organizations play a fundamental role given the particular organization of the system to provide access to health care for undocumented migrants. The general legislation regarding health care for undocumented migrants is not properly applied in this region. The public services only provide specialised care, diagnosis and hospital care to undocumented migrants. To access this type of health care, patients must obtain a prescription from a general practitioner. For basic health care and prescriptions for secondary care, undocumented migrants must therefore seek help from one of the volunteer organizations’ clinics, for example, one operated by *NAGA* which is the only one to provide basic health care and which they do free of charge.

*NAGA* provides basic health care as well as some specialized care, including cardiology, surgery, dermatology, gynecology, orthopedics, psychiatry, psychology, ultrasound scanning and electrocardiograms. They do so, as Dr. Pierfranco Olivani of *NAGA* explains, because there is not yet any evidence that the public health service is satisfactorily guaranteeing access to secondary care.

*NAGA* opened its clinic for temporary residing foreigners with the intention that it would be a short-term project, capable of resolving the issues it would address. Even if the clinic does close, the organization remains committed to vigilantly ensuring health care entitlements are implemented and respected.

***NAGA, Associazione Volontaria di Assistenza Socio-Sanitaria e per i Diritti di Stranieri e Nomadi***, began its work in Milan in 1987. It counts on more than 300 volunteers, most of whom are doctors, nurses and psychologists.

Its mission is to promote solidarity and provide social and medical assistance to guarantee temporary residing migrants' health rights.

During working days, *NAGA's* medical clinic provides general and specialised health care to refugees and temporary residing immigrants, including undocumented migrants. Most of their patients face a situation of serious exclusion and marginalization. Since 1987, the clinic has provided health care to more than 100,000 foreigners (around 80 people per day).

In recent years, *NAGA's* work has been extended to cover many other areas beyond direct medical help: migrant women, refugees and victims of torture, ethnic psychiatry, pharmacy, research and documentation, legal advice and return and training for intercultural mediators and volunteers.

*NAGA* is also very active in organizing campaigns to target public opinion vis-à-vis undocumented migrants' specific health and social needs. Its website provides a full range of information about the legal system and useful contact addresses.

<http://www.naga.it/>

The situation in Rome seems to be very different since the STP system is better implemented. Nonetheless, the existence of clinics like those run by *Caritas Rome* show that many health care needs of marginalized people are still not fully met.

The *San Gallicano Hospital* is an example of a public hospital which has developed a very friendly approach towards undocumented migrants. The hospital is known for the promotion of health and medical services relating to migrants. Besides health care, it provides social and psychological assistance to documented and undocumented migrants. The

result has been a high reliance on this hospital from undocumented migrants living in Rome and many of them seek health care there.

This hospital has also accumulated a high level of expertise on immigrants' health needs since it also has a research center for preventive medicine of immigration, tourism and tropical dermatology.

Since its foundation by Pope Benedict XII, ***San Gallicano Hospital*** has had a long tradition in the provision of assistance to travelers and temporary residing in the city of Rome.

The Center for Preventive Medicine of Immigration, Tourism and Tropical Dermatology started in 1985 and was the first public health center offering free medical assistance to marginalized Italians and foreigners.

By 2003, the hospital had treated about 65,000 documented and undocumented migrant adults and children coming from 120 different countries. The hospital provides basic as well as specialised health care (dermatology, internal medicine, tourist medicine, gastroenterology, infectious and tropical diseases, podiatry, preventive oncology, gynecology, ethnic psychiatry and psychology, nutrition medicine, hematology, neurology, infant psychiatry, surgery, etc.).

The hospital counts on the presence of social workers and intercultural mediators to cover basic needs and facilitate access to health care. The welcoming service assists undocumented migrants in nine languages: Arabic, English, French, Polish, Portuguese, Rumanian, Russian, Spanish and Turkish.

The San Gallicano Hospital also organizes training sessions on health and migration, intercultural mediation and international medicine. It constitutes a centre of reference for the city of Rome and for the different district health administrations.

[http://www.00100roma.com/it,servizi,ospedali/all,00153\\_5109,ospedale+san+gallicano.html](http://www.00100roma.com/it,servizi,ospedali/all,00153_5109,ospedale+san+gallicano.html)

Given the relatively recent implementation of regularization in this area (2001), the help provided by civil society has revealed itself as indispensable and led to a substantial accumulation of expertise in the field of immigration and health.

Generally speaking, organizations have been very active concerning analysis and research activities to the extent that the government invited many of their experts to give advice on the drafting of the laws concerning health care for undocumented migrants.

In addition, some doctors realized that there was a need to regularly exchange information among the different experts in the field. This was precisely the idea behind the foundation of the *Società Italiana di Medicina delle Migrazioni (S.I.M.M.)* (Italian Association for Migration Medicine). This association goes beyond strictly scientific and epidemic issues; it is very active at the structural level. *S.I.M.M.* plays a crucial role in monitoring the right to health in Italy by making sure that the law is effectively applied and that migrants' cultural aspects are also considered by health authorities when organizing public services.

Besides national advocacy campaigns, *S.I.M.M.* has also been acting at the European level by urging European institutions to promote the right to access health care for every resident in the EU, including undocumented migrants. To this aim, they have prepared and presented the text of a draft resolution of the European Parliament and a draft Council directive based on the Italian model as well as a petition to the president of the European Parliament. This initiative occurred with the support of different Italian institutions and health administrations, scientific institutes and civil society organizations. The campaign on the non-expulsion of seriously ill undocumented migrants has been also very active.<sup>149</sup>

The ***Società Italiana di Medicina delle Migrazioni (S.I.M.M.)*** (Italian Association for Migration Medicine) was founded in 1990 by a group of doctors, many of whom were providing direct voluntary assistance to immigrant patients in different Italian cities. The purpose was to create a forum for regularly exchanging experiences and knowledge.

Nowadays, the association consists of about 100 members including doctors, nurses, psychologists, anthropologists, sociologists, social workers and health-related staff. *S.I.M.M.* has organized several national and international conferences on health and migration.

***S.I.M.M.*** also monitors the correct implementation of the regulation of immigrants' access to health care, acts at the structural level to promote the right to health in general and to raise awareness about the importance of taking into account the aspects related to health and culture.

<http://www.simmweb.it/>

<sup>149</sup> This campaign was promoted within the *S.I.M.M.* by three Italian organizations: NAGA, Area Sanitaria Caritas and OIKOS. More information is available at <http://www.simmweb.it/>.

## 7. NETHERLANDS

*“Why should I care so much about these patients? These people do not exist in our country. There is no place where I can send them, whereas for those who have a legal status and are poor, I can at least send them to social services. I cannot send undocumented migrants anywhere.”*

General practitioner in Amsterdam

» **Terms:**

*GGD (Gemeentelijke Gezondheidsdienst)* – public health service

### GENERAL HEALTH CARE SYSTEM

The Netherlands has an insurance-based health system operated since 2006 by private health insurance companies. The new Health Insurance Act<sup>150</sup> has, however, set some public limiting conditions in order to guarantee that health care insurance is affordable for all, including those on low incomes or with high care costs.

All regular residents in the Netherlands are obliged to take out health insurance covering a standard package of essential health care. Anyone who fails to do so will be fined. The content of the standard package is determined by the government and includes practically all essential care, from a visit to the general practitioner to hospital admission, as well as prescription charges.<sup>151</sup>

The insurers are obliged to accept everyone residing in their area of activity irrespective of age, gender or health status, in order to prevent discrimination on the basis of risk.

The insured person pays a fixed nominal premium to the health insurer. The Health Insurance Act also provides for an income-related contribution to be paid by the insured and by the employer.<sup>152</sup> Children up to 18 years old pay no premium. In addition, those who cannot afford the full standard premium can apply for a care allowance. This amount is paid as a monthly tax credit and is financed by the government from general tax revenue.

Adult insured parties will have part of their fixed premium reimbursed if during a year they have used less than 255 EUR in health care costs.

<sup>150</sup> Zorgverzekeringswet (entered into force on 1 January 2006).

<sup>151</sup> The standard package reimburses the costs of: general practitioners, specialists and hospitals; dental care for children until the age of 18; specialised dental care and dentures; medical appliances, such as medical stockings; medicines; maternity care and obstetrics; health care transport (ambulances, wheelchair taxis, etc.); limited access to physiotherapy, remedial therapy, speech therapy and occupational therapy; and advice on nutrition and diet.

<sup>152</sup> Employers contribute by making a compulsory payment towards the income-related insurance contribution of their employees.

For care not included in the standard package (e.g. dental care for adults), there is the option to take out supplementary insurance whose premium is freely determined by private insurers who are entitled to pursue profits.<sup>153</sup>

Although the government claims that the new system is a good balance between a solid social basis and the dynamics of the market, it is expected to increase the number of uninsured people in the Netherlands. There is a fear that those who cannot afford the contributions could fall outside the system. According to *Doctors of the World*, many people cannot afford the premium of 92 EUR per month and will not be supported enough with the health insurance allowance.

In addition, there is also the fear that some people will not take any insurance or when taking it, they will not seek health care in order to receive the reimbursement of the no-claim. Finally, it may be pointed out that people suffering from chronic diseases or handicaps will be confronted with a higher premium, as the standard package will not be sufficient.

## HEALTH CARE FOR UNDOCUMENTED MIGRANTS

### 1. Legal Entitlements to Access Fully or Partially Publicly Subsidized Health Care

Undocumented migrants are not entitled to take out health insurance in the Netherlands.

In 1998, with a clear intention to discourage undocumented migrants from establishing themselves in the Netherlands, the Benefit Entitlement Act, or Linkage Act<sup>154</sup>, linked certain rights, such as the right to state medical insurance to the condition of authorized residence. Before that date, undocumented migrants had the right to access the public insurance system. The Linkage Act can be seen as the centerpiece of migration control in the Netherlands.<sup>155</sup>

However, undocumented migrants can still receive “care that is medically necessary.” In principle, they should always bear the costs of medical treatment. Nonetheless, if undocumented migrants cannot pay, the cost will be covered by a special fund which directly reimburses the health care provider, but never the patient.

The Aliens Act (2000) embedded the principle of the Linkage Act; however, it referred to two exceptions related to health care: “the provision of care that is medically necessary” and “the prevention of situations that would jeopardize public health.”<sup>156</sup>

<sup>153</sup> See “The new care system in the Netherlands”, available online at: <http://www.minvws.nl/en/themes/health-insurance-system/default.asp>. Before 2006, there were two types of health insurances: compulsory and voluntary. Employees, people entitled to social benefits and self-employed people with incomes up to a certain level were compulsorily insured under the Social Health Insurance Act (Ziekenfondswet). People with a higher income could choose to either take out a private health insurance or to be uninsured.

<sup>154</sup> Koppelingswet 1998.

<sup>155</sup> Since the introduction of the Linkage Act, the entitlement or access of immigrants to secondary or higher education, housing, rent subsidies, facilities for the disabled, health care and all social security benefits has indeed become dependent on their residence status. Entitlement to these public services is restricted to immigrants with a regular residence status. Only publicly funded legal assistance, necessary medical care and education for children up to the age of 18 remain accessible to all immigrants, including undocumented migrants. See PICUM (2002:35).

<sup>156</sup> Article 10 of the Alien Act of 23 November 2000 (Vremdelingswet, 2000): “An alien who is not lawfully resident may not claim entitlement to benefits in kind, facilities and social security benefits issued by decision of an administrative authority”. (...) The first subsection may be derogated if the entitlement relates to education, the provision of care that is medically necessary, the prevention of situations that would jeopardize public health or the provision of legal assistance to the alien”.

There is not a clear-cut definition of the concept of “medically necessary care.” Since the Linkage Act was passed, discussions have taken place and there have been several attempts to define the concept.

In 1999, the Ministry of Health stated that this term concerns research, treatment and care that are needed according to acknowledged medical-scientific grounds and judged by the treating doctor who has an obligation to help anybody regardless of his or her position in society, race and belief. Care will be considered “necessary” in the following situations:

- i) in cases – or for prevention – of life threatening situations, or in cases – or for prevention – of situations of permanent loss of essential functions;
- ii) if there is a danger for a third party, e.g. certain contagious diseases (in particular tuberculosis) and for psychological disturbances and consequent aggressive behavior;
- iii) in cases of pregnancy (before and during birth);
- iv) if related to preventive care and vaccinations for children.

In 2005, The National Committee on Medical Aspects of Immigration Policy<sup>157</sup> interpreted the concept

of “medically necessary care” as comprising care provided in the (former) basic national health care package. This package encompassed practically the same types of health services as the new standard package.

A positive aspect of this system is that it requires medical professionals to determine when the provision of care for undocumented migrants is “necessary.” This was established by the Ministry of Health following strong resistance to the Linkage Law from organizations representing human rights advocates or medical physicians.<sup>158</sup>

The particular role that health care providers have been playing as regards the day-to-day definition of this concept has created a rather flexible concept allowing undocumented migrants to access – at least potentially – a wide range of services provided by individual health care providers and hospitals, including HIV/AIDS treatment and medicine.<sup>159</sup> As practice shows, since there are no laws expressly mentioning it, only mental health care (unless causing disturbances and aggressive behavior) and rehabilitative treatments seem to be regularly denied to undocumented migrants.<sup>160</sup>

The concept is again currently under discussion by a committee of health care professionals

<sup>157</sup> This committee was set up in the Netherlands in May 2001 by the Ministry of Justice and the Ministry of Health, Welfare and Sport. The committee was charged with the responsibility of investigating the influence of medical aspects upon the influx of aliens into the Netherlands. The main conclusion of this committee was that contrary to the views of the parliament and media, it was not true that a lot of asylum tourism to the Netherlands was taking place on medical grounds. Concerning the concept “medically necessary care”, the committee stated that “from a medical and ethical point of view, no reasons exist for a further limitation of the concept in addition to the limitation, introduced by the health insurance scheme, that already applies to all (other) residents in the Netherlands, nor does there exist any reason to deviate from the practice that a doctor determines whether or not health care is necessary, based on the principle that all patients are equal”. See National Committee for Medical Aspects of Aliens Policy, *Medical aspects of Aliens Policy*, (Staatscourant 11 mei 2001, nr. 91/ pag.8). An English version can be downloaded at [http://www.aidsmobility.org/inc/pdf.cfm?pdf=Conclusions\\_report\\_Smeets-ENG1.pdf](http://www.aidsmobility.org/inc/pdf.cfm?pdf=Conclusions_report_Smeets-ENG1.pdf); See also AIDS & MOBILITY Europe, (2006:30-34). Available online at: <http://ws5.e-vision.nl/systeem3/images/WG%20IV%20-%20You%20can%20speak.pdf>

<sup>158</sup> See PICUM (2001:52). Available online at: <http://www.picum.org/Publications/Sample%20pages%20Health%20care.pdf>

<sup>159</sup> As regards medicines, they will have to pay a contribution.

<sup>160</sup> Mental health care is financed by the Exceptional Medical Expenses Act (AWBZ). The Linkage Act excludes undocumented migrants from these services. Most psychiatric carers refuse to treat undocumented migrants until they become a real danger to society. However, follow-up care after acute diagnosis is usually not existent. An increasing number of undocumented migrants need treatment but are not able to receive it and it is also very difficult to place them in emergency shelters.



working under the auspices of several medical associations.<sup>161</sup>

Finally, regarding patients with tuberculosis, the “secret code” system allows undocumented migrants to remain anonymous when receiving health care in order to prevent these individuals from stopping their treatment, creating a risk for public health. There is also the possibility to obtain a residence permit for medical reasons that allows them to stay during the length of the treatment.<sup>162</sup>

## 2. The Procedure and the Financing of the System

When undocumented migrants get sick, they can go directly to a general practitioner or to a hospital.

Health care providers or hospital administrations will request payment for the cost of treatment. If the patient cannot pay, they will provide health care and claim for reimbursement afterwards from the funds set aside to cover the cost incurred for providing health care to uninsured persons without residence permit.

In the Netherlands, the costs resulting from providing health care to undocumented migrants are covered through two different systems, depending on whether care is provided by general practitioners, midwives, pharmacists and dentists on the one hand, or by hospitals on the other hand.

The “Linkage Fund”<sup>163</sup> compensates general practitioners, midwives, pharmacists and dentists. This fund does not serve to pay the bills of patients, but rather to reimburse doctors for their earning losses.

These service providers cannot declare “unpaid bills” of their patients. Applying for refunds has to be seen as applying for “subsidies.” To be reimbursed, they must, however, fill in a standard form requesting their date of birth and nationality. In practice, these professionals are also asked to provide the identity and evidence of the insolvency of the patient.

General practitioners, midwives, pharmacists and dentists then have to prove that: i) their patient was actually undocumented and therefore, the cost of health care cannot be claimed in any other way (e.g. insurance); and ii) the financial burden on them was excessive.<sup>164</sup> Nevertheless, it is important to keep in mind that reimbursement is simply a possibility. Medical professionals do not have a recognized right to claim a refund.<sup>165</sup>

The request is made through a form submitted to the *Gemeentelijke Gezondheidsdienst (GGD)* (public health service) of the province concerned who will:

- i) examine the request – paying special attention to the economic situation of the patient by even controlling bank accounts;
- ii) ask the Linkage Fund to reimburse a certain amount if the requirements are met; and
- iii) directly pay to the provider of health services.

The second category of providers - hospitals, rehabilitative centers and ambulance services - has a budget line within their own budget (0.1% of their total annual budget) arranged with insurance companies named “dubious debtors.” This is in fact the remit of the existing hospital funds, extended in order to

<sup>161</sup> The Royal Dutch Medical Association (KNMG, Koninklijke Nederlandse Maatschappij tot Bevordering der Geneeskunst), the National Association of General Practitioners (LHV=Landelijke Huisartsen Vereniging), the Dutch Society of Medical Specialists (Orde van Medisch Specialisten) and the Netherlands Society of Psychiatry (NVvP=Nederlandse Vereniging voor Psychiatrie).

<sup>162</sup> PICUM (2001: 57). Available online at: <http://www.picum.org/Publications/Sample%20pages%20Health%20care.pdf>

<sup>163</sup> This fund (*Koppelingsfonds*) is a public institution created in 1998. In 2006, it consisted of 5.5 million EUR. It is funded from tax revenue and managed by a public entity.

<sup>164</sup> See PICUM (2001: 54). Available online at: <http://www.picum.org/Publications/Sample%20pages%20Health%20care.pdf>

<sup>165</sup> The Ministry of Health is, however, considering the possibility of reviewing the system as to recognise by law that health care providers have the right to get reimbursed any time they provide a health service to undocumented migrants.

include the payment of unpaid bills. These providers also use this fund to cover expenses generated by the provision of services to undocumented migrants.

### 3. The Situation in Practice and the Role of Civil Society and Local Actors

The Dutch system is very complex and the complicated procedures, lack of clear definitions and lack of information among all actors involved entails considerable barriers for undocumented migrants to access health care in practice.

There has been, and still is, much misunderstanding about the meaning of “medically necessary care.” This is particularly evident as far as health care providers and hospital administrations are concerned.

The absence of a clear-cut definition of this term has allowed many health care providers to broadly interpret the concept. This circumstance as well as pressure from civil society organizations has contributed to a move towards a rather flexible concept of “necessary care” in the Netherlands.

Nevertheless, the uncertainty about the meaning of “medically necessary care” and reimbursement from the fund has also created a remarkable degree of confusion resulting in denials to undocumented migrants to access health care, particularly at hospitals.

Given the fact that what constitutes “necessary care” is decided upon by each individual medical practitioner, it is not inconceivable that in practice, serious differences of interpretation will occur, resulting in a situation in which one undocumented migrant receives a particular type of treatment, whilst the same treatment is denied to another.

As recommended by the Advisory Committee for Aliens Affairs, “this situation is undesirable. The term ‘medically necessary care’ requires a precise definition, a definition that is as consistent as possible since in cases where major differences exist, ‘medical shopping’ could occur.”<sup>166</sup>

General practitioners (GPs) are generally accessible. However, in certain areas of big cities with a relatively high concentration of foreigners (more than 10%), a limited percentage of GPs (5%) regularly receive undocumented patients in their consultations. There are often a few GPs who have a reputation for rendering services to undocumented migrants and who are overloaded with many patients. Undocumented migrants are becoming increasingly dependent on those few doctors who are willing and able to provide health services. One of the reasons for this is that GPs are free to accept or reject undocumented migrants as patients without any possibility of a complaint being lodged to a public institution.<sup>167</sup>

Access to hospitals is becoming more and more difficult. Health administrations usually prevent undocumented migrants from accessing health care if they cannot pay, particularly in cases where there is no clear or external evidence that their life is at risk when they arrive at the hospital. According to a study conducted by Prof. Engbersen in the city of Rotterdam in 1999, it is more likely that care is refused in outpatient clinics rather than in the emergency departments, where care is normally provided.

In most of the cases where undocumented migrants have an appointment with a health care professional in a hospital, they are firstly transferred to the financial administration to arrange the payment. If they are unable to guarantee payment, access is denied.

<sup>166</sup> See Advisory Committee for Aliens Affairs (ACVZ), *National Aspects of Return* (2005).

<sup>167</sup> See PICUM (2001:55). Available online at: <http://www.picum.org/Publications/Sample%20pages%20Health%20care.pdf> and NIVEL. *Illegalen aan de ‘poort’ van de gezondheidszorg: Toegankelijkheid en knelpunten in de zorg van huisartsen, verloskundigen en spoedeisende hulpafdelingen*. (Utrecht: NIVEL, 2000).

Whilst there are hospitals accepting payment in installments after treatment or not actively pursuing unpaid bills, it may happen that a person who did not pay previous bills is refused further treatment.<sup>168</sup>

In addition, since the new insurance system entered into force, undocumented migrants are requested to show an identification card and insurance card at the administration desk. There are cases where access to health care has been denied to undocumented migrants because they were unable to show an identification card or passport, and the organization *Lampion* has also informed of cases where care was refused due to the impossibility of showing a health insurance card.<sup>169</sup>

Many civil society organizations, health care providers and local authorities stress that one of the biggest problems in the Netherlands is the existing lack of information about how the system works: individual health care providers are not well informed about their duties or how to reclaim their fees; hospital administrations are not given clear instructions on the impossibility of making health care dependant on the affordability to pay; not all *GGD* (public health services) are flexible enough regarding the reimbursement of costs to doctors providing health care for undocumented migrants.

The existing confusion and aptitude of some health care providers, particularly hospitals, is also creating a misconception among undocumented migrants who, contrary to their legal entitlements, think that they do not have the right to seek health care they cannot pay for. This fact, together with the fear that

undocumented migrants have to be identified and sent to the police, means that they postpone or even do not seek needed health care.

Research conducted by the Netherlands Institute for Research in Health Care at the request of the Ministry of Health in 2004 revealed that health needs of undocumented migrants are generally more serious, i.e. life threatening, than those people consulting a doctor on a regular basis. In addition, it was shown that undocumented migrants are most likely to postpone their visit to the doctor.<sup>170</sup>

A concrete example illustrating this was provided by a study conducted in 2000, which revealed that many undocumented migrant women may not seek health care during pregnancy. This finding was based on the fact that half of the interviewed midwives stated that they have, at least once in their career, been called to assist pregnant women during delivery who had not received any pre-natal check-up.<sup>171</sup> A similar conclusion was reached by the organization *Lampion* since one third of the total number of undocumented women as well as a relevant number of social workers contacting its “e-help desk” service in 2006 (150 callers) were asking questions about pre-natal care.

On many occasions, the only way undocumented migrants safely seek health care is through informal strategies such as the use of insurance cards of family members or friends. This informal method of receiving health care has, however, already caused many problems since doctors insert medical data corresponding to the patient in the file of the card holder.

<sup>168</sup> PICUM (2001:56). Available online at: <http://www.picum.org/Publications/Sample%20pages%20Health%20care.pdf>

<sup>169</sup> *Lampion Report 2006*, available at <http://www.lampion.info>.

<sup>170</sup> The number of undocumented migrants seeking health care in serious life-threatening situations was three times higher than the figure applying to regular migrants and six times higher than the rate relating to general reference population. See National Committee for Medical Aspects of Aliens Policy, *Medical aspects of aliens policy*, (2004). Available at: [http://www.justitie.nl/Images/jaarnota\\_integratiebeleid\\_2004\\_tcm74-38880.pdf](http://www.justitie.nl/Images/jaarnota_integratiebeleid_2004_tcm74-38880.pdf), visited on 10 February 2006. See also Ministry of Justice, *Illegal resident third country nationals in the EU member states: state approaches towards them and their profile and social situation*, research conducted by the Netherlands contact point within the European Migration Network (2005), available at: <http://www.european-migration-network.org/>.

<sup>171</sup> NIVEL (2000:54) and PICUM (2001:56). Available online at: <http://www.picum.org/Publications/Sample%20pages%20Health%20care.pdf>

Apart from this method, undocumented migrants may also receive treatment by trying to pay the full cost of the care received, negotiating with doctors or going to organizations delivering medical assistance free of charge.

Some organizations like *Lampion-Pharos*, *Doctors of the World* or *Gezondheidszorg Illegalen Leiden (GIL)* make remarkable efforts to provide accessible information to all, to record incidents where undocumented migrants do not successfully receive medical treatment and inform local health inspectors and other actors.

One of the objectives of *Lampion-Pharos* is to make the health system more accessible to undocumented migrants residing in the Netherlands. To this aim, it conducts research, develops new methods for providing assistance, sets up prevention and information activities, designs training programmes, collects information from daily practice and disseminates it through its wide network of actors. The Lampion “e-helpdesk” project intends to solve questions related to access to health care for undocumented migrants in the Netherlands. In 2006, the system was contacted 538 times mainly by undocumented migrants and family members, social workers, grassroots organizations and health care providers. Most of the questions were directly related to the financing of health care, pre-natal and health care for children, as well as mental health care. Project staff have been trained to answer the questions by themselves; however, they also refer the cases to other organizations within their network when the request is too specific.<sup>172</sup>

**LAMPION** is a platform for cooperation on health issues in the Netherlands. The network includes the National Mental Health Organization (GGZ), the National Primary Care Organization (GGD), the General Practitioners Association (NHV), the SOA/AIDS organization, the Dutch Council for Refugees, the General Health Inspectorate and the Linkage Fund (Stichting Koppeling).

The Lampion helpdesk constitutes a national information and advisory service (website and help desk) for undocumented migrants. Health care workers, volunteers and undocumented migrants themselves consult the Lampion helpdesk. Lampion provides information and advice and refers to relevant partner organizations if necessary. The high number of questions received by Lampion in 2006 confirms the lack of information on health care issues from undocumented migrants and shows that Lampion fulfils a need. Lampion plays an important role in drawing attention to bottlenecks and trends regarding access to health care for undocumented migrants in the Netherlands.

<http://www.lampion.info>

<sup>172</sup> Frequently asked questions regarding financial issues, legal matters, housing and basic medical rights can be found at <http://www.lampion.info>.

**PHAROS** is the independent center of expertise of LAMPION, and aims at providing qualitative health care and making the system more accessible to refugees, asylum seekers and undocumented migrants. *PHAROS* is inspired by the definition of health used by the World Health Organization (WHO), according to which “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

To this general aim, *PHAROS* collaborates and builds partnerships with different categories of actors at the national and international levels and transfers in-depth and applicable knowledge on health care to individuals and organizations working with refugees, asylum seekers and undocumented migrants, such as general practitioners and physicians, nurses, mental health professionals, social workers, psychotherapists, outreach workers, staff in medical care services for asylum seekers, primary and secondary education teachers, child welfare personnel, immigration and naturalization officials, and other relief workers and supervisors.

<http://www.pharos.nl>

The organization *GIL (Gezondheidszorg Illegalen Leiden)* took the initiative to establish a protocol for all hospitals in the region to guarantee accessibility and quality of care for all undocumented migrants. It also developed a procedure for referrals, which enables general practitioners to more easily refer undocumented patients to hospitals. Finally, it creates newsletters addressed to health care staff in the region, explaining the procedures.

Some other partnerships are being built at the local level involving cooperation amongst NGOs, health care providers and local authorities. For example, in the city of Amsterdam, a platform composed of the public health services (*GGD*), the Linkage Fund and several representatives from the local General Practitioners’ Federation and from the Academic Medical Center has been established to distribute money from the Linkage Fund. The added participation of *Doctors of the World* ensures that the platform surpasses mere considerations of a financial nature and takes into account other concerns relating to undocumented migrants and the barriers they encounter when seeking health care.

In Rotterdam, the program of the *GGD* on vaccinations constitutes an interesting practice in a field where administrative barriers are not infrequent. In the Netherlands, those migrants who want to vaccinate their children must register in the “burgerlijke stand” (County Clerk’s office) for which they must provide their names, country of origin as well as the child’s name and date of birth.

The city of Rotterdam facilitates the vaccination of children whose parents are not registered by accepting them on referral by midwives, general practitioners or schools. In these cases, they provide vaccinations free of charge.

The ***Gemeentelijke Gezondheidsdienst (GGD) Rotterdam*** is the public health service of the city of Rotterdam.

*GGD* mainly acts in the field of prevention, intervention, coordination, research and health policy issues. This public service is also responsible for access to health care for undocumented migrants. Public health services act as intermediaries between health care providers and the Linkage Fund.

They carry out activities in the following fields:

- a) infectious diseases - help is provided to undocumented migrants without verification of identity;
- b) mental health - mentally ill undocumented migrants are sent either to clinics (if there is a risk for public order) or to charity organizations and shelters;
- c) health care for children - a support unit provides advice, organizes activities and develops specific policies; there is also a vaccination program;
- d) access to health care - health service provides information and monitors refusals by hospitals to provide health care;
- e) cooperation with relevant actors - a platform exists to gather professional organizations to exchange information about current trends in the population and in the health system.

<http://www.ggd.rotterdam.nl/>

From July 2005 to June 2006, *Doctors of the World* developed another project in Amsterdam called the "Pilot Project: MEDOC, Medical Document for Undocumented Migrants." It was formulated to respond to one of the persistent problems affecting undocumented migrants' health care throughout Europe, that is, the absence of sound medical records.

This organization provided undocumented migrants with a record they could bring with them whenever they visited a doctor in order to keep record of their medical history. The document was a kind of template presented in four languages (Dutch, English, French and Spanish) on which doctors could record medical visits and specific data related to the undocumented patient: allergies, serious illnesses and surgeries, vaccinations, infectious diseases, psychosocial problems, pregnancies and deliveries, chronic diseases, current medication, etc.

***Dokters van de Wereld – Netherlands*** (*Médecins du Monde*) based in Amsterdam.

As part of *Médecins du Monde*, the mission of *Dokters van de Wereld* is to provide medical assistance to vulnerable groups and improve their access to health care. This organization has special projects in different European states addressing the specific needs of high risk groups such as the homeless, undocumented migrants, prostitutes and people with substance abuse problems.

The “Pilot Project MEDOC: Medical Document for Undocumented Migrants” of *Doctors of the World* in Amsterdam was developed between July 2005 and June 2006. The project aimed to ameliorate access to health care for undocumented migrants and contribute to the continuation of care.

Within this project, several activities were developed:

- a) informing undocumented migrants about their rights and duties under the Dutch health care system;
- b) raising awareness among health care providers about the need to improve health care for undocumented migrants;
- c) developing and disseminating “MEDOCs,” a medical document for undocumented migrants;
- d) gaining deeper knowledge of the problems faced by undocumented migrants.

The first evaluations of the project showed that MEDOC was indeed an important tool for undocumented migrants, allowing them to better inform and communicate with health care providers and also ensure the continuation of treatments. This initiative was very positively received in Amsterdam as well as in other cities across the Netherlands.

<http://www.doktersvandewereld.org>

The Dutch physician Dr. Joost den Otter summarizes: “Access to health care for undocumented migrants is getting more restrictive in the Netherlands. Hospitals are refusing patients more and more... we should thus continue working to make health care accessible and affordable for undocumented migrants.”

This was also the line of reasoning expressed in 2004 by the National State Committee for Medical Aspects of Aliens Policy when it recommended that the government needed to (i) explicitly acknowledge responsibility for the health care of each person residing in the Netherlands; and (ii) continue to guarantee their right to necessary health care, leaving medical professionals in charge of setting indications and continued monitoring in the years ahead access to necessary care for both uninsured aliens and uninsured Dutch citizens.”<sup>173</sup>

Dominique van Huijstee of the organization *Stichting LOS* in Amsterdam finds that “everything will function a bit better if the government assumes its responsibility to inform about the system and the provisions applying to undocumented migrants to

all actors involved: undocumented migrants, health care providers, hospital administrations or health local authorities.” Similar recommendations are made by Erik Vloeberghs and Marjan Mensinga of *Lampion*, who remind of the importance of disseminating clear information about pregnant women and children’s entitlements to health care.

In recent years, many complaints have been expressed by organizations in relation to the existence of two different funds for primary and secondary health care. In their view, the government should create a unique fund to solve all problems related, particularly those arising from the “dubious debtor system” that make hospitals excessively careful of their potential budget losses.

Fortunately, the Ministry of Health has shown certain openness to insert some reforms in the system in order to simplify the funding system by creating a sole fund for all types of care and to clarify the provisions entitling individual health care providers and hospitals to claim for reimbursement. A concretization of this step is still expected.

<sup>173</sup> National Committee for Medical Aspects of Aliens Policy, *Medical aspects of aliens’ policy* (Amsterdam: Ministry of Justice, 2004), p. 12. Available online at: <http://www.justitie.nl>, visited on 26 January 2006.



## 8. PORTUGAL

*A 43-year-old undocumented woman from Angola went to an NGO seeking health care. The laboratory tests requested by the volunteer doctor showed a strong anemia demanding an immediate blood transfusion. She went to the emergency unit; however, before treating her, the hospital administration asked her for immediate payment of an old debt. She was turned away, even though the law allowed her to gain access to treatment. Only after the medical office of the National Center for Migrants (CNAI) called the hospital upon the request of the NGO, was the mistake corrected and the woman finally accessed the treatment needed.*

### » Terms

*Inscrição esporádica* - temporary registration

*Juntas de Freguesia* - local borough councils

### GENERAL HEALTH CARE SYSTEM

The universal right to enjoy health protection and care is laid down by the Portuguese Constitution. In Portugal everybody – at least in theory – “has the right to health care and the duty to defend and promote it.”<sup>174</sup>

The Portuguese health system is characterized by three co-existing systems: the National Health Service (NHS), special social health insurance schemes for certain professions and voluntary private health insurance. The NHS provides universal coverage and is predominantly funded through general taxation. The health subsystems, which provide either comprehensive or partial health care coverage to about a quarter of the population, are funded mainly through employees’ and employers’ contributions (including state contributions as an employer). A large proportion of funding is private, mainly in the form of direct payments by the patient and to a lesser extent in the form of premiums to

private insurance schemes and mutual institutions, which cover respectively 10% and 6.5% of the population.

The Ministry of Health is responsible for developing health policy as well as managing the National Health Service. Five regional health administrations implement the national health policy objectives, develop guidelines and protocols and supervise health care delivery. They also have some budgetary competences in the field of primary care.

Within the NHS, health care is subsidised, taking into account the social and economic situation of the users. For each health check or service used (including diagnostic tests), the user must pay an amount known as a moderating fee, although there are exceptions provided by law.<sup>175</sup> The moderating fees are relatively low. For instance in 2004, for general health checks in health centers, patients contributed 2 EUR and in emergency services, 6.10 EUR if in a hospital.

<sup>174</sup> See Article 64(3)(a) of the Portuguese Constitution: “Todos têm direito à protecção da saúde e o dever de a defender e promover”.

<sup>175</sup> These exceptions are: i) children up to twelve years; ii) young people when given an adolescent consultation; iii) pregnant women and women in sixth to eighth week after giving birth; iv) women receiving a family planning appointment; v) unemployed persons and their dependents (registered at the Employment Office); vi) recipients of welfare provision from an official body; vii) persons with certain legally recognised chronic diseases; viii) foreigners who whilst not making Social Security payments have a member of the family unit paying; and ix) persons who are in need of welfare provision or find themselves in a situation where there is a risk for public health (infectious diseases; maternity care, child care and family planning; and vaccination).

Despite the remarkable achievements in health policy, a number of challenges remain such as the need to improve access to health care services, to reduce health inequalities and to modernize the organizational structure and management of the National Health Service.<sup>176</sup>

## HEALTH CARE FOR UNDOCUMENTED MIGRANTS

### 1. Legal Entitlements to Access Fully or Partially Publicly Subsidized Health Care

Undocumented migrants' entitlements to access the NHS in Portugal depend on the time they have been residing in Portugal, with the exception of children who have access to public health care on equal grounds as national and documented children.

To guarantee access to health care and education for undocumented children, there is a national registry of foreign undocumented children managed by the High Commissioner for Immigration and Ethnic Minorities (*ACIME*). This registry cannot be accessed by the authorities with the aim to obtain proof of the irregular stay of their parents.<sup>177</sup>

Those undocumented migrants able to prove that their residence in Portugal exceeds 90 days have access to health care, medicine and tests upon presentation of a document called "temporary registration" (*inscrição esporádica*) which allows, according

to practice, access to health care on single or multiple occasions. A moderating fee is charged, with exceptions in place for the following care: diseases of mandatory notification (such as tuberculosis, HIV/AIDS and sexually transmitted diseases), maternity care, vaccination and family planning.

If the competent authority does not officially recognize that an undocumented migrant has been living in a specific district for more than 90 days, they may only be entitled to access emergency care in public hospitals upon payment of the full cost of treatment. Nonetheless, emergency care cannot be refused if the patient lacks the means. The bill will only be received after the care has been given. In addition, the law stipulates that the economic situation of the patient will always be taken into account by the authorities when charging the expenses incurred.<sup>178</sup> Nonetheless, many administrative obstacles prevent undocumented migrants from final exemption.<sup>179</sup>

### 2. The Procedure

Undocumented migrants residing in a particular district area for more than 90 days may access health facilities and services of the National Health Service only after compliance of two conditions.

First, they have to get a document issued by the local borough council (*Junta de Freguesia*)<sup>180</sup> officially certifying that they have been residing in the area for more than 90 days. This document is renewable.

<sup>176</sup> See Große-Tebbe S. and Figueras J., (2004:25). Available at: <http://www.euro.who.int/document/e85400.pdf> and Bentes M., Dias C.M., Sakellarides C. and Bankauskaite V. *Health Care Systems in Transition: Portugal*. (Copenhagen: WHO, 2004).

<sup>177</sup> Regarding children, see Decree-Law No. 67/2004 of 25 March 2004 (Decreto Lei N.º 67/2004 de 25 de Março, Diário da República – I Série A – N.º 72); See also Portaria n.º 995/2004 de 9 de Agosto, Diário da República – I Série B, N.º 186.

<sup>178</sup> Alto Comissariado para a Imigração e Minorias Étnicas (ACIME). *Immigration in Portugal 2004/2005*, pp. 54–82. Available online at: [http://www.acime.gov.pt/docs/Publicacoes/brochingsl/EmigPort\\_Ingles.pdf](http://www.acime.gov.pt/docs/Publicacoes/brochingsl/EmigPort_Ingles.pdf). See also Despacho n.º 25 360/2001 (2 série), Diário da República N.º 286 12.12.2001; Circular 14/DSPCS of 02/04/02 from the Directorate General Health (Circular Informativa. Direcção-Geral da Saúde, N.º 14/DSPCS); Circular 48/DSPCS of 30/10/02 from the Directorate General Health (Circular Informativa. Direcção-Geral da Saúde, N.º 48/DSPCS); Decree-Law No. 34/2003 of 25 February 2003 (Decreto-lei n.º 34/2003 de 22 Abril).

<sup>179</sup> See Jesuit Refugee Service, *Report on Destitute Forced Migrants* (Brussels: JRS, 2007), p. 79.

<sup>180</sup> There are around 4200 "Junta de Freguesia" in Portugal. The average population is 2,300 inhabitants. See "L'accès des étrangers en situation irrégulière au système de santé », Les documents de travail du Sénat Français. Série Législation comparée n° LC 160 (March 2006), <http://www.senat.fr/lc/lc160/lc160.html>, Accessed on 15 May 2007.

The document can be obtained upon presentation of two witness statements by local registered residents confirming the undocumented migrant's residence in the neighborhood. They may be private individuals or people working in a commercial establishment such as a hostel or a shop. The law also provides for the possibility for undocumented migrants themselves to make a signed declaration about their residence but, according to Portuguese NGOs, this provision is rarely valued in practice.<sup>181</sup>

Secondly, after this document has been issued, undocumented migrants must then go to a health center in their geographical area to register as a patient there and, when possible, also register with a family doctor.<sup>182</sup>

As its name indicates, the "temporary registration" (*inscrição esporádica*) has only very limited validity. In most cases practice shows that every time undocumented migrants need to receive medical treatment, they have to be registered. This implies that they will have to continuously strive to overcome reoccurring administrative barriers to successfully access health care.

If undocumented migrants cannot pay the moderating fee, they will have to apply to the Social Security services or to the local borough councils (*Juntas de Freguesia*) for a document officially certifying their precarious economic situation.

### 3. The Situation in Practice

The practical enjoyment of legal entitlements in Portugal depends to a great extent on overcoming all of the administrative steps and complicated bureaucracy needed to get the *inscrição esporádica*. Nonetheless, given the limited and unbalanced human resources structure of the NHS, even those undocumented migrants in possession of this document can face serious problems in effectively accessing health care in Portugal, especially at hospitals. These problems are common to all NHS users, including nationals. Emergency rooms are often overcrowded and there are waiting lists especially to visit a family doctor.

Moreover, as many Portuguese actors have clearly expressed, the applicable legislation regarding undocumented migrants' entitlements to health care is highly ambiguous. This has led to the progressive development of a wide and complex set of implementing norms and informative notes that are very difficult to understand. "I even tried to establish a legal working group that could help NGOs to better understand how the system works for undocumented migrants, however, even they do not have clarity on this. The only explanation I find to this uncertainty is that it responds to a real political choice," explains Camila Rodrigues, social worker at the *Jesuit Refugee Service Portugal* in Lisbon.

This circumstance makes the daily work of all actors involved at local level even more difficult, namely social workers, NGOs, local administrations, health centers, hospital administrations and medical personnel. The ambiguity reinforces the existing remarkable lack of information among health administrator and migrants themselves. As a result, an increasing number of direct and indirect obstacles to access health care are created.

<sup>181</sup> See Article 34 of Decree-Law No. 135/99 of 22 April 1999 (Decreto-lei n.º 135/99 de 22 Abril): "Os atestados de residência (...) devem ser emitidos desde que qualquer dos membros do respectivo executivo ou da assembleia de freguesia tenha conhecimento directo dos factos a testar, ou quando a sua prova seja feita por testemunho oral ou escrito de dois cidadãos eleitores recensados na freguesia ou, ainda, mediante declaração do próprio".

<sup>182</sup> See Article 34 of Decree Law No. 135/99.

The system for registration is extremely complex since it entails numerous administrative steps and involves different administrations. Practice shows that it is very difficult for undocumented migrants to get the document which recognizes their residence in Portugal issued by the local borough council. In fact, many undocumented migrants do not succeed in getting declarations from two witnesses mainly because they feel forced to move from one address to another. The situation is particularly hard for homeless undocumented migrants.

The law also provides that undocumented migrants may make a signed declaration to affirm their residence, but as reported by *JRS Portugal* and *Centro Padre Alves Correia (CEPAC)*, “this right is not always respected or even known by the competent authorities (*Juntas de Freguesia*).”<sup>183</sup> In addition, to accept the declaration signed by an undocumented migrant, the latter must present a valid identity document. This creates another remarkable barrier since many undocumented migrants do not have such a document and the administration tends to only accept passports.

These organizations also inform that some *Juntas de Freguesia* refuse to issue the attestation using justifications that do not have any legal basis. Thus, some go beyond the legal requirements requesting the provision of further documents or the compliance of some conditions not provided by the law.

Sometimes, there are also problems to register at health care centers and hospitals. As Isabel Sardinha, a retired nurse from the regional health authority in the area of Lisbon explains, “clerical staff often refuse to take in undocumented migrants under false pretexts in ignorance of the law and of their superiors.” Despite their entitlements, in some cases undocumented migrants are simply turned away from health centers because they would not pay for the treatment they sought to receive. There are, however, many differences among health centers’ knowledge of undocumented migrants’ entitlements to access health care. As reported in an *IMISCOE* study, “some health care centers seem unaware that basic nursing care and vaccinations were free services, while others knew and assumed it as a daily practice.”<sup>184</sup> In addition, access depends to a large extent on the good will of the administrative and medical staff. There have been cases where undocumented migrant women have received medical assistance in one health center but were systematically refused medical assistance in another health care center.<sup>185</sup>

Although there have been a number of cases where access to emergency care was denied, undocumented migrants are generally accepted in emergency units. Pressure from NGOs has positively influenced their access to emergency rooms but this does not imply that undocumented migrants frequently seek health care. As happens all over Europe, “they only turn to the hospital emergency ward when their state of health is truly threatened.”<sup>186</sup>

<sup>183</sup> *Ibid.*, paragraph 2.

<sup>184</sup> IMISCOE (International Migration, Integration and Social Cohesion), *Social Integration & Mobility: Education, Housing & Health*. (Lisbon: Universidad de Lisboa, 2005), pp.115. Available online at: <http://www.imiscoe.org/research/clusters/b5.html>

<sup>185</sup> See Jesuit Refugee Service (2007:79), Available online at: <http://www.jrseurope.org/EPIM/intro.htm>

<sup>186</sup> *Ibid.*

In cases where emergency care is provided to recent arrivals or homeless undocumented migrants, hospitals often send the bills to NGOs. Since in most cases undocumented migrants cannot afford to pay, “many of these bills remain unpaid, thus in the end, it is the state finally covering the costs for treating undocumented migrants,” said Camila Rodrigues of *JRS*.

The inexistence of a clear system of social assistance and health care for all people present in Portugal, regardless of the length of stay, leads to further problems with implications for all NHS users. “For instance, sometimes after medical discharge, homeless undocumented migrants stay at hospitals, thus contributing to fill already overcrowded hospitals. In Portugal, to leave the hospital, you also need to be discharged by the hospital social service. Nonetheless, in many other cases, homeless undocumented migrants are sent back to the street straight after receiving serious medical treatment,” states Mário Faria Silva, director of the *Centro Padre Alves Correia* in Lisbon. “Sometimes this happens to people with chronic diseases or health problems that need strict follow up.”

As happens in other countries, undocumented migrants living in Portugal face a number of additional barriers linked to language, health culture and the lack of information. All these circumstances contribute to complicate their access to health care.

In relation to this, *JRS* and *CEPAC* state that “in general, health centers and hospitals do not have interpreters or cultural mediators. Consequently, undocumented migrants not only face difficulties to go through all the bureaucracy but also to communicate with key actors such as medical personnel.”

Finally, undocumented migrants often fear that seeking health care could lead to a risk of deportation even if, in principle, authorities in Portugal do not have access to patients’ medical records and health professionals are subject to a code of confidentiality.<sup>187</sup>

#### 4. The Role of Civil Society and Local Actors

In a country where there is a big gap between law and practice, the role of civil society is of significant importance. As has been largely explained, the uncertainty regarding applicable norms and procedures has raised numerous barriers against accessing health care in Portugal.

The remarkable lack of knowledge about undocumented migrants’ rights amongst local borough councils has forced institutes, such as the immigrant government body, the *High Commissioner for Immigration and Ethnic Minorities (ACIME)*, to publicly announce to all local borough councils that they must cooperate in correctly implementing the law.

*ACIME* plays a significant role in directly informing undocumented migrants by publishing informative brochures and booklets. Some brochures seek to explain undocumented migrants’ entitlements to access health care, the different steps to take when seeking medical treatment, and contact addresses of NGOs and health centers providing support.

*ACIME* is also very active concerning the promotion of cooperation amongst actors involved and the funding of partnerships and NGO initiatives.

<sup>187</sup> Article 68 of the Statute of the Portuguese Medical Association, approved by Decree-Law No. 282/77 of 5 July 1977: Doctors are forbidden from revealing “all facts which have become known to the doctor during the course of carrying out, or because of, their profession”.

The ***Alto Comissariado para a Imigração e minorias étnicas - ACIME*** (*High Commissioner for Immigration and Ethnic Minorities*) is an governmental interdepartmental support and advisory structure concerning immigration and ethnic minorities. Its mission is to promote the integration of immigrants and ethnic minorities in Portuguese society, to ensure the participation and collaboration of associations which represent immigrants, social partners and institutions of social solidarity in the definition of social integration policies and combat against exclusion, as well as to accompany the application of legal instruments to prevent and prohibit discrimination in the exercise of rights for reasons based on race, color, nationality or ethnic origin.

The High Commissioner provides information about organizations and institutions providing assistance to migrants and edits numerous brochures, booklets and videos to directly inform migrants about immigration law, family reunion, voluntary return, access to education, access to health care and legal means of fighting racism. *ACIME* also has an observatory on immigration.

*ACIME* recently changed its name to ***ACIDI - High Commissioner for Immigration and Intercultural Dialogue (Alto Comissariado para a Imigração e Diálogo Intercultural)***. Among its new competences will be the definition and implementation of horizontal and specific public policies to enhance the social integration of immigrants and ethnic minorities and to promote dialogue among different religions, cultures and ethnic groups.

<http://www.acime.gov.pt>

The existing confusion and lack of information together with inefficiency of the Portuguese health system to meet the health care demand has largely contributed to the mobilization of actors. Similarly, it has furthered formal and informal cooperation schemes and partnerships between NGOs, local administrations and the social and administrative personnel of hospitals.

Local actors confront difficult situations on a daily basis. They are challenged by the need to find quick solutions whenever ill undocumented migrants come to them seeking medical care. “Many times, when ill undocumented migrants who encounter difficulties in gaining access to the system come to our offices, I phone some of our contacts at the social department of a hospital or of a health center here in Lisbon and it normally works,” explains Camila Rodrigues of *JRS*.

Many actors in fact take the initiative to help undocumented migrants. Even neighborhood social centers react to this situation and adopt measures to guarantee access to health care for undocumented migrants. A good example is the *Centro Social Barrio 6 de Maio* in Lisbon that primarily mediates between the patients and the health service providers to facilitate access.

The solidarity of Portuguese civil society towards undocumented migrants’ needs is also reflected in the work carried out by many organizations and religious institutions. They indeed play a crucial role in helping migrants to access the public health system. Many of these organizations also make great efforts to establish parallel medical centers where, besides basic health care, medicine, food and clothes are provided. These initiatives usually monitor the health situation of the migrant over a period of time and even pay bills when migrants who are not holders of the health card need special treatments or diagnoses.

In the medical support unit *GAMI* (*Gabinete de Apoio Médico para Imigrantes*) of the *Jesuit Refugee Service* in Lisbon, volunteer doctors provide health care free of charge to undocumented migrants. They provide basic health care and medicine and, when necessary, refer patients to two specialist doctors within the unit's network (a gynecologist and a dentist) who treat undocumented migrants free of charge. The unit treats many homeless undocumented migrants, mainly from countries in Eastern Europe (that did not recently join the European Union) and Brazil.<sup>188</sup> From January to June 2005, 70% of the total number of patients (83) were undocumented. Some of the undocumented patients who sought health care at this center had chronic diseases.

Medicine, donated by pharmaceutical companies, pharmacists and private donors, is distributed after consultation at the medical center or upon presentation of a prescription. The organization tries to take into account the economic situation of the patients. Sometimes, they receive requests for medicine from hospital's social services although the limited resources of their dispensary make it impossible to satisfy all the queries.

***Jesuit Refugee Service (JRS)*** is an international Catholic organization founded in 1980 with the mission to accompany, serve and defend the rights of refugees and forced displaced persons.

***JRS Portugal*** began working in Lisbon in 1992 providing different services free of charge to refugees, asylum seekers and migrants, including undocumented migrants. Besides assistance provided in its *Centro de Acolhimento Pedro Arrupe* shelter, this organization provides food and clothes (donated by private donors) as well as social, legal, medical and psychological assistance. They also support migrants in seeking work and accommodation, organize Portuguese language courses and have a special program to support immigrants who are health care providers.

In 2003, the social service of this organization provided assistance to 157 persons of which 109 were undocumented migrants. In 2005, 139 out of 243 social interventions were made to help undocumented migrants.

*JRS Portugal* is a very active organization concerning awareness raising campaigns and network building. They often participate in debates, conferences and occasionally also in events promoted by the media. Similarly, they have developed initiatives in primary and secondary schools to increase awareness about the situation of migrants in Portugal.

This organization works in strong cooperation and partnership with many other local, national and international organizations and institutions involved in the work with undocumented migrants.

<http://www.jrsportugal.pt>

<sup>188</sup> For more information on homeless undocumented migrants in Lisbon, see Rodrigues C., "The Changing Profile of Rough Sleepers: Immigrants from Eastern Europe Sleeping Rough in Lisbon", in *Homeless in Europe* (Winter 2005), pp.18-20, available online at: [http://www.feantsa.org/files/Month%20Publications/EN/EN\\_winter\\_2005\\_social\\_emergency.pdf](http://www.feantsa.org/files/Month%20Publications/EN/EN_winter_2005_social_emergency.pdf), accessed on 15 May 2007.

A similar initiative has been put in practice by the *Centro Padre Alves Correia (CEPAC)* which since 2005 has maintained a health unit to treat undocumented migrants. The center also provides food, clothes and medicine. They mainly treat people from Portuguese speaking countries in Africa and Brazil.

The ***Centro Padre Alves Correia (CEPAC)*** is a religious social solidarity institution founded in 1992. Its fundamental mission is to support immigrants, promoting their integration through the provision of several social services free of charge. Although the organization does not exclude anyone, they focus their work on undocumented migrants coming from Portuguese speaking African countries and Brazil. Undocumented migrants represent 28.4% of the persons helped by this center, many of whom are homeless and do not have strong networks.

*CEPAC* provides food and clothes, social and legal assistance as well as medical assistance and medicine through its medical unit. They also have a nursing unit which is run jointly with *Médecins du Monde*.

The medical unit started its work in October 2005 and does not yet have relevant statistics available. *CEPAC* also treats family members of permit holders to receive medical assistance in Portugal according to health agreements between Portugal and certain countries.

<http://www.espiritanos.org/cssp/correia.asp>

Another example of an organization which has been working in this field in Lisbon is the *Obra Católica Portuguesa de Migrações (OCPM)*.<sup>189</sup> From 1993 to 2005, this organization helped undocumented migrants in accessing the mainstream health care system as well as direct medical and psychological assistance and medicine. This organization has undertaken these activities individually and in partnership with other civil society organizations and temporary immigrant shelters.

The ***Obra Católica Portuguesa de Migrações (OCPM)*** is a religious organization that provides direct assistance to migrants and also carries out advocacy activities in Portugal.

In the medical and psychological units (*Gabinete médico e psicossocial*) volunteer specialists help undocumented migrants by providing health care, medicine and economic support for diagnosis tests. To this aim, a solidarity fund of about 600 to 900 EUR per month was created to sustain these activities.

From 2003 to 2005, the *OCPM* was one of the partners of the temporary shelter for immigrants *S. João de Deus*. They were in charge of the medical unit of the shelter.

<http://www.ecclesia.pt/ocpm/>

Portuguese organizations are increasingly bringing complaints before the government claiming that undocumented migrants' health needs are not being met and urging the government to take the necessary steps to make the system work better.

Many reasons are behind the failure of the system in Portugal. No matter if it is due to the excessive bureaucracy or to the general inefficiency of the National Health System, the reality is that an urgent solution is needed since, as described by Mário Faria Silva of *CEPAC*, "the situation of ill undocumented migrants in Portugal, many of whom are living in the streets, is a real drama."

<sup>189</sup> <http://www.ecclesia.pt/ocpm/>



## 9. SPAIN

*Joaquín arrived in Spain from Argentina in 2002. Since he overstayed his tourist visa and became undocumented, he thought that if he registered at the city hall to receive his health card it could negatively affect his chances of receiving a residence permit. "I knew that to get the health card I had to register at the town hall, but I was afraid. Therefore, I waited to get ill to seek health care in the emergency system. They treated me well there and a social worker at the hospital advised me to register at the city hall and get the health card," he said.*

### » Terms:

*Tarjeta Individual Sanitaria* - Individual Health Card

### GENERAL HEALTH CARE SYSTEM

In Spain, there is a tax-based national health system. The system has been largely decentralized to the autonomous communities. Whilst the Ministry of Health defines the minimum standards and requirements for health care provision, the autonomous communities' health departments have the power to decide how to organize or provide health services and implement the national legislation. The local councils' role is limited to complementary public health functions linked to health and hygiene as well as collaboration in the management of public services.

The universal right to enjoy health protection and care is laid down by the Spanish Constitution and the General Health Act. Spain provides free and holistic health care to "all Spanish citizens and foreign nationals residing in the national territory."<sup>190</sup> According to data from 1997, more than 99% of the population is in fact covered, including the low-income and immigrant population.<sup>191</sup>

The health care system is financed by general taxation such as VAT and income tax as well as regional taxes. Public financing is complemented by out-of-pocket payments to the public system (for example co-payments for pharmaceuticals) as well as to the private sector (for example private outpatient care) and contributions to voluntary insurance.<sup>192</sup>

Despite the different reforms accomplished, citizens' satisfaction regarding waiting times and administrative procedures for accessing hospital care remains low.<sup>193</sup> In addition, the sustainability of such a "generous" system of universal coverage is coming under increasing discussion in Spain. This tendency is explained by existing perceptions about the increased rate of the pharmaceutical and hospital expenditure, the raise of demands coming not only from immigrants, but also from an aged population and from so-called "health tourists."

<sup>190</sup> See Article 42 of the Spanish Constitution of 1978: "The right to health protection is recognized". See also Article 1(2) of the General Health Act 14/1986 of 25 April.

<sup>191</sup> Große-Tebbe S. and Figueras J., (2004:53). Available online at: <http://www.euro.who.int/document/e85400.pdf>.

<sup>192</sup> Ibid. See also information available at: <http://www.msc.es/en/organizacion/sns/docs/proteccion.pdf>.

<sup>193</sup> Ibid.

## HEALTH CARE FOR UNDOCUMENTED MIGRANTS

### 1. Legal Entitlements and Procedure to Access Publicly Subsidized Health Care

Access to the emergency system in Spain is generally guaranteed free of charge to all documented and undocumented foreigners present in the country who become severely ill or have an accident, for the duration of their treatment.

Regarding undocumented migrants' access to other health services and medicine, a distinction is made between pregnant women and children on the one hand and other categories of undocumented migrants on the other.

Undocumented children under the age of 18 and undocumented pregnant women are entitled to access the Spanish national health system free of charge under the same conditions as nationals. However, the remaining undocumented migrants only enjoy this right if they are registered in the local civil registry of their habitual residence.<sup>194</sup>

The document allowing them to gain access to the health system is called "Individual Health Card" (*Tarjeta Individual Sanitaria*) and, besides women and children, they only get it if registered at the city hall. There are, however, some conditions to meet for being registered by the municipal authorities.

Registration is free of charge but the precondition is to be in possession of a valid passport. Similarly, it is necessary to provide proof of habitual residence thorough a housing contract, an authorization for registration signed by the landlord or co-tenant or a contract for water, gas or electricity. If the individual is homeless, s/he can provide a valid address to receive correspondence. In these cases, however, the police or the local social services will have to visit the place in advance to certify that the person does in fact live at the declared address. Finally, in order to retain validity of the health card, the registration must be renewed every two years.<sup>195</sup>

This is the most common situation in Spain. Nevertheless, the high degree of decentralization of powers has allowed several autonomous communities to develop less restrictive systems. For instance in Andalusia, thanks to a special joint agreement<sup>196</sup> made by the regional department of health, NGOs and trade unions, undocumented migrants can access the health centers directly or via the so-called "referral card" obtained at a participating organization.

Other examples are Valencia, where free medicine is provided to immigrants without resources<sup>197</sup> and Murcia, where, thanks to the pressure of NGOs like *Murcia Acoge*, the so-called "solidarity health card" has been recently put in place for migrants who are not registered at the town hall.

<sup>194</sup> See Article 12 of the Act 4/2000 of 11 January 2000 on the Rights and Freedoms of Aliens in Spain according to which:

- "1. Los extranjeros que se encuentren en España inscritos en el padrón del municipio en el que residan habitualmente, tienen derecho a la asistencia sanitaria en las mismas condiciones que los españoles.
2. Los extranjeros que se encuentren en España tienen derecho a la asistencia sanitaria pública de urgencia ante la contracción de enfermedades graves o accidentes, cualquiera que sea su causa, y a la continuidad de dicha atención hasta la situación de alta médica.
3. Los extranjeros menores de dieciocho años que se encuentren en España tienen derecho a la asistencia sanitaria en las mismas condiciones que los españoles.
4. Las extranjeras embarazadas que se encuentren en España tendrán derecho a la asistencia sanitaria durante el embarazo, parto y postparto."

<sup>195</sup> See Article 16(1) and (2) of the Act 4/2000 as amended by the Act 14/2003 of 20 November. See also Resolution of 4 July 1997 from the presidency of the National Institute of Statistics and the General Director of Territorial Cooperation on technical instructions to municipalities to update the local registry ("padrón").

<sup>196</sup> "Convenio de colaboración entre la Consejería de Salud, la Asociación Médicos del Mundo, Federación Andalucía Acoge, la Cruz Roja Española en Andalucía y la Fundación Progreso y Salud, en materia de salud pública para el colectivo de inmigrantes", signed in Almería on 19 March 1999. The agreement has been recently renewed.

<sup>197</sup> The general system consists of a general reduction of 40% and 90% for certain categories of medicines with the exception of some categories of persons who receive them free of charge.

In 1999, the Department of Health of the government of the **Autonomous Community of Andalusia** signed, along with several NGOs and trade unions (UGT and CC.OO.), a special agreement to guarantee and facilitate immigrants' access to the health care system (*Convenio andaluz de atención sanitaria a inmigrantes*).

According to this agreement, undocumented migrants residing in Andalusia do not have to be in possession of the health card to access health care. They can directly access the health system or receive an official document from any of the collaborating entities. The partner organizations commit themselves to inform and accompany undocumented migrants seeking health care at a public health center or hospital. The agreement also sets up a monitoring committee at the regional level and other monitoring commissions at the county level.

Another outcome was the issuing of some publications and other information materials:

- i) for immigrants - a brochure with information about health centers in Andalusia in several languages as well as a "portable medical history," a document presented in different languages where health professionals can write down background information and actions taken on immigrants' health such as vaccinations, treatments, etc.;
- ii) for organizations - a manual to provide medical assistance to immigrants in Andalusia, an official form to refer people to the health system, address lists, a small dictionary of medical terms, leaflets with information about women's health, etc.

[http://www.juntadeandalucia.es/servicioandaluzdesalud/principal/default\\_en.asp?version=En](http://www.juntadeandalucia.es/servicioandaluzdesalud/principal/default_en.asp?version=En)

## 2. The Situation in Practice and the Role of Civil Society and Local Actors

Many practical obstacles prevent undocumented migrants from gaining access to the health system in Spain. Contrary to legal provisions, the public health system does not cover all medical needs of a relevant number of undocumented migrants residing in Spain. Therefore, the right to access publicly subsidized health care regardless of administrative status is limited in practice.

Although there is a lack of precise figures about the number of people who do not access health care in Spain, some studies conducted by relevant NGOs reveal the entity of the problem. The organization *Médicos del Mundo* reports to have provided 14,857 social and medical services to 9,558 undocumented migrants in nine of the seventeen Spanish autonomous communities in the year 2005 alone. 6,354 of these services consisted of direct medical and mental health consultations and 8,503 consisted of social assistance to receive the health card.<sup>198</sup> Similarly, according to a project carried out over ten months in 2004 by *Médicos Sin Fronteras*, in two of the Madrid districts with a high immigrant population, 65% of the 264 undocumented migrants seeking direct medical and social assistance at their centers did not have a health card. 52% of undocumented migrants were not registered at the city hall and 21%, even if registered, did not follow the necessary steps to get the health card. 68% were from Sub-Saharan Africa and 24% from North Africa.

<sup>198</sup> Médicos del Mundo. *Informe de Exclusión Social*. Madrid: Médicos del Mundo, (Madrid: MDM, 2005), p.27. Available online at: <http://www.medicosdelmundo.org/NAVG/pagina/IXInformeExclusionSocial.pdf>

The organization *Médicos Sin Fronteras (MSF)* has provided medical assistance to undocumented migrants in the island of Fuerteventura and the city of Ceuta and continues monitoring the situation at the Southern Spanish border. They also use testimonies to advocate undocumented migrants' rights.

In November 2004, they started a project aiming at providing assistance to undocumented migrants and collecting data about:

- i) the percentage of persons who were not accessing the health system in Spain;
- ii) barriers encountered; and
- iii) consequences for their health status.

This project was carried out in two districts of Madrid with the highest undocumented population. The majority of these migrants were from Sub-Saharan Africa and Magreb. The data collected showed that 38% of undocumented migrants who sought help at *MSF* centers (264) did not have a health card. In addition, 21% even if registered at the city hall, did not follow the necessary steps to get the health card. 68% were from Sub-Saharan Africa and 24% from Magreb. After the project, this organization issued a report with the results and policy recommendations which was widely distributed in Madrid and Spain.

<http://www.msf.es>

The conditions for registration at the city hall constitute one of the biggest barriers to access health care. First of all, the requirement of a valid passport poses serious problems. There are many undocumented migrants who enter the country clandestinely, without any kind of identification document. In other cases, undocumented migrants do have a valid passport at the time of registration, however, when the passport expires, they automatically lose the possibility to renew their registration and thus the health card. This can happen for several reasons such as the inexistence of a particular consulate in the city where the immigrant lives, the impossibility of complying with the requirements to renew a passport, or the fear to be identified and expelled. There are undocumented migrants who even try to obtain the new passport directly from their families in home countries, although it can take months to receive it.<sup>199</sup>

It is generally interpreted although not generally applied throughout Spain that in cases where individuals do not have a valid passport they can register showing their *Cédula de inscripción para indocumentados*, a document issued by the Spanish authorities allowing a foreigner to stay for three months. This document is however very difficult to get and most of the time, undocumented migrants are reluctant to apply due to their fear of being deported if their application is denied. In addition, as Cristina Olmedo of the legal department of *Red Acoge* highlights, "this possibility is excluded for those sub-Saharanans arriving in *cayucos* (small wooden boats) to the Canary Islands. As soon as they arrive, they automatically receive an expulsion order and, according to Spanish legislation, this prevents them from getting a *Cédula*."<sup>200</sup>

<sup>199</sup> Ibid., p. 11.

<sup>200</sup> In the opinion of *Red Acoge*, this "Cédula de Inscripción" should be admitted for registration by authorities throughout Spain as is the case in Madrid. See also Médicos Sin Fronteras, *Mejora en el acceso a los servicios públicos de salud de los inmigrantes indocumentados en el área sanitaria 11 de la Comunidad de Madrid. Informe Final* (Madrid, MSF, 2005), pp. 6-7 and 11.

Another remarkable obstacle against successful registration is the necessity of proving residence at a particular address. This barrier is linked to the difficulties encountered by undocumented migrants trying to access housing in Spain. Due in many cases to the owner's reluctance, it is very difficult for undocumented migrants to provide a housing contract or a contract of provision of water or energy supply as provided by law. A similar issue occurs when they try to obtain an "authorization for registration" from the owner or from other registered tenants required in cases where there are others registered in the same address. As *Médicos Sin Fronteras* reports, "sometimes owners deny this authorization as they may have too many people registered at the same address or because they fear inspections or the loss of social benefits. There have also been cases where owners or tenants have asked undocumented migrants for extortionate sums to get it."<sup>201</sup>

The situation is also very complicated for homeless undocumented migrants. If they live in temporary public shelters, they can easily get registered and obtain the health card, although a health card issued under these circumstances always has a validity between 1-6 months and a year. The law also provides the possibility of registering on sub-standard housing - even under a bridge - however, this is practically inapplicable since most undocumented migrants do not use this possibility or fear visitation from the police.<sup>202</sup>

In some cases, undocumented migrants provide the address of an organization but frequently, the authorities show a great degree of resistance to admit it.

Since 2003, the police have been able to access data of foreigners registered at municipalities.<sup>203</sup> Although it appears that the police rarely make use of this provision, some NGOs have reported police visits to their offices inquiring why there were too many undocumented migrants registered at the address. What is particularly sensitive is the message received by undocumented migrants: the very existence of this provision removes the incentive to register at the municipality. Some may still register to obtain health care, but many consider it too risky given the fact that the police may now access their data.

All of these considerations refer to the general situation in Spain. There are however many differences in practice throughout the different regions and also among municipalities. In the view of Elena Ramón of the immigration department of the *Federación Española de Municipios y Provincias*, "whilst there are municipalities implementing the law and facilitating registration, others interpret the rules in a very restrictive way. Some even deny registration in clear violation of the law. This is more likely to occur in towns where the national residents complain a lot about immigrants' access to social services."

According to Ramón Esteso of *Médicos del Mundo*, "language barriers also play a role when trying to register since in some municipalities all the registration documentation to be completed is only in Spanish. This is another reason why one of the biggest demands of undocumented migrants coming to our centers is to receive support with paperwork and assistance to obtain the health card."

<sup>201</sup> Ibid., p. 12.

<sup>202</sup> Ibid., p. 11.

<sup>203</sup> Sixth Additional Provision of the Act 8/2000 of 23 December as amended by the Act 14/2003 of 20 November.

**Médicos del Mundo (Spain)** provides medical assistance to persons excluded from the public health system, including undocumented migrants in nine Spanish autonomous communities. They do this through their “Socio-medical assistance centers” (*Centros de Atención Sociosanitaria*) and mobile units. They provide primary health care, vaccinations, detection of HIV and sexually transmitted diseases, mental health, support for medicine, referring and accompanying people to the health system. Furthermore they issue an annual “Report on Social Exclusion” where they also refer to the situation of exclusion suffered by undocumented migrants due to lack or insufficient access to health care.<sup>204</sup>

<http://www.medicosdelmundo.org>

Undocumented migrants in Spain often require assistance from organizations to obtain or renew the health card, to get a new passport or the landlord’s authorization for registration. Organizations also arrange appointments with doctors or act as mediators between the doctor and the patient to be sure that the patient understands the diagnosis.

This fact proves that undocumented migrants are generally uninformed about their entitlements and procedures. Nonetheless, some Spanish authorities seem to have understood the need to organize information campaigns and frequently publish booklets and other printed materials to inform and facilitate access to health care for undocumented migrants.<sup>205</sup>

Similarly, many public hospitals also take initiatives and develop a number of projects to reach, inform and assist immigrants taking into account their specific needs. One example is the *Hospital Punta de Europa*, a public hospital in Algeciras in the South of Spain. Given its location, this hospital has treated numerous undocumented migrants arriving on the Spanish coast after crossing the Strait of Gibraltar. This fact has made the hospital particularly concerned about immigrants’ health needs. As Antonio Salceda of the management department explains, “we are forced to seriously look at this problem, since we have it literally in front of us” (referring to the location of the hospital, only a few kilometers from the Moroccan coast).

Some of its initiatives are addressed to tackle language and cultural barriers, such as the telephonic simultaneous interpretation system available for users and medical staff 24 hours a day and 7 days a week in six languages. They also provide key documents in several languages (e.g. the “surgical consent form”, the list of rights and duties, and the international clinic interview sheet) and organize courses for medical staff to improve their language skills and the understanding of health and multiculturalism. The hospital is also currently working on the innovative “immigrant patient support unit” (*Unidad de Apoyo al Paciente Inmigrante*), a research project that will constitute the first phase of the future unit of clinical interpretation and cultural mediation.

<sup>204</sup> Report available at <http://www.medicosdelmundo.org/NAVg/pagina/NAVGEstructuraPrpal.jsp>.

<sup>205</sup> See, for example, Consejería de Sanidad y Consumo de la Comunidad de Madrid, Médicos Sin Fronteras e Instituto de Salud Pública, *Manual de Orientación Sociosanitaria para Inmigrantes de la Comunidad de Madrid* (Madrid, 2005), available at <http://www.publicaciones-isp.org/productos/t024.pdf>. See also Consejería de Salud de la Junta de Andalucía, *Manual de atención sanitaria a inmigrantes*, (Sevilla: Junta de Andalucía, 2004).

The ***Hospital Punta de Europa*** is a public hospital belonging to the Health Service of Andalusia (SAS). It serves an area of 243,000 inhabitants and provides approximately 180,000 consultations per year. The hospital provides specialised health assistance through hospitalization, emergency unit and outpatient services.

The *Hospital Punta de Europa* is a collaborating partner in the Andalusian agreement on access to health care for immigrants (*Convenio de atención de inmigrantes de Andalucía*) and has been recently selected as one of the hospitals contributing to design a regional plan to improve pre- and postnatal care also within the immigrant population. The hospital is now trying to link this initiative to the “Migrant Children Hospital” program of the World Health Organization.

In addition, this hospital also took part in the *Migrant-Friendly Hospitals* project, a European initiative to promote immigrants’ health. Currently, *Hospital Punta de Europa* is part of the task force of *Migrant Friendly Hospitals*.

<http://www.juntadeandalucia.es/servicioandaluzdesalud/centros/Detalle.asp?IdCentro=16422>

The ***Migrant-Friendly Hospitals*** project, sponsored by the DG Health and Consumer Protection (SANCO) of the European Commission, brought together hospitals from 12 member states of the European Union, a scientific institution as coordinator, experts, international organizations and networks. The partners agreed to put migrant-friendly, culturally competent health care and health promotion higher on the European health policy agenda and to support other hospitals by compiling practical knowledge and instruments. One major strategy to test feasibility of becoming a migrant-friendly and culturally competent organization was implementation and evaluation of three selected sub-projects in the diverse reality of European hospitals, with the local implementation financed out of hospital funds, but supported in a European benchmarking process.

To assure sustainability of the *Migrant-Friendly Hospitals* movement, a Task Force on Migrant Friendly Hospitals was established in the framework of the WHO Network on Health Promoting Hospitals.

<http://www.mfh-eu.net/public/home.htm>

Not all undocumented migrants are in the same situation and face the same problems. One of the most vulnerable groups in Spain are those who are not registered in the city hall. For them, only the emergency system is available. “They are mainly sub-Saharan Africans who after arriving in Ceuta, Melilla or the Canary Islands without any identification are transported to the peninsula and left by the authorities with an expulsion order that cannot be carried out. They live without any means, no housing, bad nutrition and whenever they get ill they have difficulty accessing integral treatment for recovery. Even if they manage to stay at a shelter, there are no fixed places for ill persons and they are expelled after three months, regardless of their health status and even if they are receiving TB treatment,” said Carlos Ugarte of *MSF-Spain*.

The fact that they can only receive medical help at a hospital – assistance not exempted from barriers<sup>206</sup> – may result in discharge from the hospital without having access to any follow-up treatment.

The existence of these problems has sparked some regional authorities to react. For example, the Autonomous Community of Madrid recently changed its rules and has started to provide health cards with a validity of six months to undocumented migrants without the need to register in the city hall.

Thus far, however, undocumented migrants feel obliged to seek help from NGOs or other health care providers. An example of an organization working in this field in Madrid is *Karibu – Amigos del Pueblo Africano*. This organization assists undocumented Africans who do not have the health card by offering direct medical care from their team of volunteer doctors or by making referrals to other centers relying on their own networks.

The organization ***KARIBU-Amigos del Pueblo Africano*** through its network of volunteers provides assistance to the most excluded refugees and immigrants coming from Africa who are residing in the Madrid region. They have a welcome service and provide temporary housing, food and clothing. They also offer legal advice, medical assistance, help to access housing and the labor markets as well as educational activities for children and adults.

In the field of health, a big part of their work is devoted to assisting undocumented migrants who do not have a health card, providing direct primary medical care and medicine or paying for laboratory tests and other drugs. When patients need specialised treatments, they refer them to cooperating doctors and hospitals.

<http://www.asociacionkaribu.org/>

Seasonal workers also have very limited access to health care. The recent *Report on basic needs and geographical mobility of the seasonal immigrant population in the counties of Lleida*,<sup>207</sup> conducted by the organization *Salud y Familia* in Lleida, Catalonia, on the request of the Catalanian government, has clearly shown that seasonal undocumented immigrant workers, who are mainly sub-Saharan Africans, face very serious barriers to access health care and urgent action is needed to tackle all the consequences. “These migrants usually have very serious physical (muscles, bones, skin, dental...) and mental health problems but they do not seek health care at an emergency unit unless they are totally desperate.”<sup>208</sup> Moreover, the most common response given by hospitals and primary health centers is that “this is not the right place, not the right time, you need a health card, you have to be

<sup>206</sup> According to Médicos del Mundo Spain, in some regions they even block the access to the emergency system. Available online at: <http://www.medicosdelmundo.org/NAVG/pagina/IXInformeExclusionSocial.pdf>

<sup>207</sup> Salud y Familia, “*Necesidades básicas y movilidad territorial de la población inmigrante estacional en las comarcas de Lleida*” (Barcelona: Salud y Familia, 2007).

<sup>208</sup> Ibid.



on our lists first, etc. In the end, they always postpone the treatment.”<sup>209</sup> After issuing this study, the organization is seeking to extend its collaboration with local public authorities with the aim of facilitating seasonal migrant workers’ access to the health card in Lleida.

Also remarkable is the insufficient access to reproductive health care in Spain by undocumented migrant women. The Ministry of Health recently published that 40 to 50% of abortions in Spain are undertaken by migrant women. Elsewhere reports claim that more than 50% of those women are undocumented. Most women refer to their precarious economic situation as the reason behind their decisions and half do not use any contraceptive method.<sup>210</sup>

**Salud y Familia** is a private non-profit organization based in Catalonia that aims to contribute to interdisciplinary analysis, exchange of ideas and the articulation of operative solutions which improve health and the quality of family life as a whole, as well as for each of its individual members, especially the most vulnerable. *Salud y Familia* works in collaboration with public administrations, NGOs and individuals to develop innovative services and projects that involve referrals to the health care system, mediation and direct assistance to women and their families. The organization also cooperates in programmes addressed to immigrants, especially in the field of health.

Its “From Compatriot to Compatriot” project seeks to facilitate undocumented migrants’ access to health care by providing direct medical assistance as well as information, mediation and help to access the public health care system.

<http://www.saludyfamilia.es>

The fact that some Spanish organizations find no alternatives to the provision of direct medical assistance shows that despite broad legal entitlements, the health care system is still failing to efficiently address the issues at hand.

Most organizations seek to avoid parallel systems and alternative providers and claim that they prefer that public administration gives real solutions to have these people covered by the common law system. “The law by itself does not mean anything. There is still the need of active public policies that make possible the enjoyment of these entitlements,” said Cristina Nieto, project coordinator at *Salud y Familia* in Barcelona. In addition, as *MSF* has expressed that financial support by public administrations to organizations providing direct medical assistance to undocumented migrants is not a good solution either from an economic point of view or from a medical perspective.

A recent study has shown that immigrants without residence permits use health services significantly less than documented migrants. The researchers wonder whether in this context the strategy of health care provision through alternative providers is able to effectively meet the health needs of undocumented immigrants. In their view, “as the needs of illegal immigrants are rarely heard specific policies have remained unquestioned.”<sup>211</sup>

It is clear then that, regardless of the existence of a friendly legal system, undocumented migrants living in Spain generally face obstacles. Many of these barriers are linked to the fear of being discovered and deported, fear of making contact with any kind of public administration, lack of information and understanding about the health system and their entitlements, language and cultural differences, bureaucracy, and the fear of losing their jobs.

<sup>209</sup> Ibid.

<sup>210</sup> <http://www.acaive.com/pdf/boletin%200.pdf>. See also *El País*, 28.07.2006 and *El Mundo*, 28.11.2006.

<sup>211</sup> Torres A.M. and Sanz B., “Health care provision for illegal immigrants: should public health be concerned?” in *Journal of Epidemiology and Community Health*, No. 54, 2000, p. 479. The report is based on 300 interviews. The purpose of the study was to test whether undocumented immigrants are effectively able to obtain medical treatment when they are ill.

## 10. SWEDEN

*“One day during winter, my daughter had problems breathing. It was late at night and I really didn’t know what to do. I called a member of the church and he said that regardless of how much it would cost, we had to get to a doctor. However, I didn’t feel comfortable going to the hospital. I was so afraid that people would ask for my identification and would expel us straight away. I tried some syrup for my daughter and she felt a bit better. Although the member of the church told me to go, I never went to see a doctor because I was too afraid.”*

A 28-year-old undocumented migrant woman from Africa<sup>212</sup>

### » Terms

*Gömda*<sup>213</sup> - undocumented migrants

### GENERAL HEALTH CARE SYSTEM

Sweden has a compulsory, predominantly tax-based health care system providing coverage for the entire resident population.<sup>214</sup> Sweden’s health system attracts considerable resources and is recognized as one of the nation’s vital social institutions. Voluntary insurance is very limited and typically provides only supplementary coverage to the public health system.

The Health and Medical Services Act establishes that the goals of health and medical services are to ensure the entire population’s good health on equal terms, and that care should be prioritized according to need.<sup>215</sup>

Health and medical care in the Swedish health care system is the shared responsibility of the state, county councils and municipalities. The state is responsible for overall health, medical care policy and ensuring that the system works efficiently.

The Health and Medical Services Act gives county councils and municipalities considerable freedom

with regard to how their health services are organized. County councils are responsible for providing health care, health promotion and disease prevention. 71% of services are financed by county council taxes although they also receive revenue from patient charges and through central government grants. At the local level, municipalities deliver and finance social welfare services including health care for children, school care services, care for the elderly, people with disabilities and long-term psychiatric patients. They also provide rehabilitation and operate public nursing homes and home care services.<sup>216</sup>

### HEALTH CARE FOR UNDOCUMENTED MIGRANTS

#### 1. Legal Entitlements to Access Fully or Partially Publicly Subsidized Health Care

Undocumented migrants (*gömda*) - not including children who are rejected asylum seekers - lack any legal entitlements to benefit from the Swedish public health system. In contrast to Swedish citizens and

<sup>212</sup> Médecins Sans Frontières, *Experiences of Gömda in Sweden: Exclusion from health care for immigrants living without legal status*, (Stockholm: MSF, 2005a). Available online at: <http://www.lakareutangranser.se/files/ReportGomdaSwedenEn.pdf>

<sup>213</sup> This is a general term used to describe this population in Sweden. It means “hidden”. Many organizations are trying to promote an alternative concept to refer to this group of migrants.

<sup>214</sup> Note however, that asylum-seeking adults do not have access to the same health care as adults domiciled in Sweden.

<sup>215</sup> Hälso- och sjukvårdslag 1982:763, sects. 2.

<sup>216</sup> Große-Tebbe S. and Figueras J. (eds.), (2004:7). Available at: <http://www.euro.who.int/document/e85400.pdf>

regular residents, undocumented migrants have to pay full fees for receiving health care, even in cases of emergency.<sup>217</sup>

There is no specific legislation regarding access to health care for undocumented migrants in Sweden. The only indirectly applicable provision is established by the Health and Medical Services Act.<sup>218</sup> According to this act, county councils are obliged to treat all persons in need of “immediate health care” regardless of legal status. Even if undocumented migrants who seek medical care in a public health-care facility receive the treatment required, this does not imply that they are exempt from paying the entire cost of treatment and medicine, costs that are generally unaffordable for them.

As reported by *Médecins Sans Frontières*, there appears to be no official definition of the concept of “immediate health care,” thus “leaving it up to each hospital manager to set the standards at each health care facility.”<sup>219</sup>

There is a law on disease control<sup>220</sup> whose old wording (“foreign sailors”) does not specify whether migrants without residence permits are entitled to receive treatment in case of very specific contagious diseases. Practice seems to show that undocumented migrants can access treatment of certain sexually transmitted diseases (STDS), such as gonorrhoea, Chlamydia and syphilis, free of charge in specialised clinics. Nonetheless, neither tuberculosis nor HIV/AIDS are included. For the latter, only screening is free of charge provided that undocumented migrants go to the specific clinics established for this purpose.

In relation to children, in 2000 the government agreed to pay a fixed amount to the county councils to cover the costs incurred for providing health care to children whose application for asylum failed. There is not yet any legislation on this but just a financial agreement.<sup>221</sup>

## 2. The Situation in Practice

The absolute lack of entitlements as well as the inexistence of any publicly funded reimbursement scheme to cover expenses incurred by hospitals for providing health care to undocumented migrants has led to numerous and serious consequences for undocumented migrants’ health. Similarly, it has put enormous pressure on health care providers and civil society organizations.

Undocumented migrants constitute one of the most vulnerable groups in Sweden and failure by the Swedish government to recognize their presence and their very basic health needs contributes largely to their stigmatization and discrimination.

Very few undocumented migrants attempt to approach health services in Sweden and most of them find numerous barriers against accessing appropriate health care. In the framework of a survey conducted by *Médecins Sans Frontières* in Stockholm from July to September 2005, 82% of undocumented migrants who had sought health care reported to have encountered barriers against access. They reported barriers such as being turned away by administrative staff at health care centers as well as indirect obstacles like the high costs of consultations and medication, the feeling that they were not entitled to access health care and the fear of approaching the services and being reported to the authorities.

<sup>217</sup> This also applies to tourists and temporary visitors.

<sup>218</sup> Sects. 4 of the Health and Medical Services Act : “Om någon som vistas inom landstinget utan att vara bosatt där behöver omedelbar hälso- och sjukvård, skall landstinget erbjuda sådan vård.”

<sup>219</sup> See *Médecins Sans Frontières*, (2005a: 9). Available at: <http://www.lakareutangranser.se/gomda>.

<sup>220</sup> Disease control Act, Smittskyddslagen (2004:168).

<sup>221</sup> *Överenskommelse mellan staten och Landstingsförbundet om hälsooch sjukvård för asylsökande m.fl.* (financial agreement between the State and county councils regarding asylum seekers).

*Médecins Sans Frontières* is a medical humanitarian organization, working in more than 70 countries across the world. Guided by the principles of medical ethics, MSF's focus is to support people in danger who for whatever reason do not have access to health care, regardless of race, religion, politics, or sex. MSF's work involves provision of direct medical care and awareness raising of the plight of the people in need of help.

**Läkare Utan Gränser (Médecins Sans Frontières Sweden)** started working with undocumented migrants in 2004. *MSF Sweden* is supported by a network of 50 specialised doctors, midwives and other health professionals who work within public and private health services.

This organization carried out research over a two-month period (July to September 2005) using: i) a questionnaire survey on the health and social needs covering basic demographic details, family and social situation in Sweden and in their home country and health experiences in Sweden, including health status, medical needs and barriers to access health care; and ii) a mental health questionnaire (the Hopkins Symptom Checklist-25, HSCL-25) used to determine the clinical levels of anxiety and depression.

Respondents were either new patients or patients who had previously gone to the MSF network for medical assistance and who voluntarily agreed to participate. They were selected from a complete list of the service's patients. 102 undocumented migrants completed the questionnaire on health and social needs, 23 filled in the mental health questionnaire and 6 recounted their personal stories thorough in-depth interviews.

The research describes the wide variety of medical needs for which patients could not access medical care and medication, including chronic diseases (diabetes and asthma), communicable diseases (sexually transmitted diseases and tuberculosis) and pregnancy. 13.7% were helped by MSF to access public health centers or hospitals. The remaining 86.3% were consulted within the volunteer MSF network. As the study expressively mentions, the research is "a testimony in itself to gömda's exclusion from health care."

<http://www.lakareutangranser.se>

When ill undocumented migrants approach a health center, the first thing they are required to do is provide their personal identity number. All individuals who are officially residing in Sweden have a personal identity number that is commonly used to check the rights of individuals to access social and economic rights. Those without a personal identity number are basically denied access to these rights unless there is special legislation covering particular

groups, such as asylum seekers. In a highly regulated society like Sweden, "you cannot practically exist without having a social security number."<sup>222</sup>

Undocumented migrants often go to public hospitals only when facing an urgent health need and will be charged the full cost. Generally speaking, public health services perceive undocumented migrants as synonymous with loss of income and therefore

<sup>222</sup> PICUM, [2003b:34].

are generally reluctant to treat them, especially if they have less urgent health problems. This is not only the case within hospitals but also primary health care centers and maternity centers where on many occasions undocumented women are required to make advance payments. Consequently, many pregnant undocumented women do not receive prenatal check-ups and only show up on the day of delivery.<sup>223</sup>

This seems to be different when treating children. Although undocumented children who have never applied for asylum are excluded by the law and therefore only entitled to “immediate care” at full cost, experience shows that hospitals generally provide free care to all children whatever their status.<sup>224</sup> The problem is that in most cases parents do not dare to bring their children to hospitals or even vaccinate them. Undocumented migrant children’s access to health care is thus conditioned to a great extent by the administrative status of their parents.

Despite this, the tendency seems to be changing as hospitals are becoming increasingly aware of the difference in entitlements of children depending on if they are refused asylum seekers or not. In this sense, as Charlotta Arwidson, Swedish Red Cross’ coordinator of a project in the field of health care for undocumented migrants in Stockholm states, “we are noticing a growing awareness about this difference so more and more parents are calling us about their children.”

In Sweden, the cost of health care (even basic) and medicine is disproportionately higher for undocumented migrants than for Swedish nationals (*see table below*). The exorbitant prices constitute one of the most important barriers impeding undocumented migrants from seeking medical treatment in Sweden.

**Table: Examples of charges for consultations and medication in Sweden**

CONSULTATION/MEDICATION	COSTS FOR SWEDISH NATIONALS	COST FOR GÖMDA AND TOURISTS
Consultation with a doctor at an emergency department	260 SEK (27 EUR)	2,000 SEK (209 EUR)
Consultation with a doctor at a primary health care clinic	140 SEK (15 EUR)	1,400 SEK (146 EUR)
Consultation with a midwife at a maternity center	0 SEK	500 SEK (52 EUR)
Delivery	0 SEK	21,000 SEK (2,197 EUR)
Insulin treatment for diabetes (type 1)	1,800 SEK (188 EUR) per year	13,200 SEK (1,381 EUR) per year

Source: MSF Sweden<sup>225</sup>

<sup>223</sup> Médecins Sans Frontières (2007a: 9,21).

<sup>224</sup> Ibid., p. 10.

<sup>225</sup> Ibid.

Another major barrier is the fear of being reported to the authorities and expelled from Sweden. This fact prevents undocumented migrants from requesting medical assistance even in the most serious cases. In the *MSF* survey, many undocumented migrants expressed that seeking health care was very dangerous and some even reported knowing a close friend or family member who had been arrested by the police at the hospital or right after leaving it.<sup>226</sup>

Although medical personnel do not have an obligation to report to the authorities,<sup>227</sup> they cannot refuse to cooperate with the police. If the police asks questions, they are obliged to answer “yes” or “no.” It may happen that the police ask a hospital “Do you have that person there right now?” If this is the case, the hospital staff must give the information. But the police cannot phone up and say “Do you think you might have any undocumented migrants?” and ask them to give the names.

Moreover, the billing can pose problems. Sometimes hospital administrations think that the treated patient has perhaps been in the asylum system before and thus contact the migration board to check whether they will pay for the costs. “This inquiry in relation to medical costs can lead to the migration board alerting the police. So in that way, there’s an indirect threat.”<sup>228</sup>

For all these reasons, undocumented migrants seek health care only if they are severely ill. Thus, going to hospital is always the very last resort. As *MSF*’s survey shows, more than half of the respondents had not attempted to visit a doctor since they became an irregular resident in Sweden. In the opinion of *MSF*, the restrictive Swedish system has led to the near total exclusion of these individuals

from accessing non-emergency and routine health care in Sweden.<sup>229</sup>

In the meantime, undocumented migrants’ health status continues to worsen. Since their illnesses are not detected at an early stage, their lives can be in real danger. In fact, seemingly minor medical conditions can develop into potentially “life-threatening situations” if they are left untreated. As a result of this situation, patients present themselves at the emergency unit in a very critical state and thus require more costly inpatient care.

### 3. The Role of Civil Society and Local Actors

Faced with these difficulties, undocumented migrants frequently avoid contact with official health authorities and when desperate they turn to a few medical clinics that have been opened in major cities on the initiative of NGOs and concerned health care workers.

At these clinics consultation is free and suitable medicine for common illnesses are available. Sometimes, individuals donate drugs that they no longer take.

The first initiatives emerged in the 1990s in Stockholm and Gothenburg. In the Stockholm area, the “refugee clinic” of *Médecins du Monde Sweden* and the *Asylum Committee* have operated since 1995, providing support to undocumented migrants, mainly rejected asylum seekers. The founders brought together a team of volunteer doctors and nurses who provide health care support at a secret clinic in Stockholm city center every Wednesday. The clinic is financed by private donations.

<sup>226</sup> Ibid.

<sup>227</sup> According to the Secrecy Act, general care staff cannot, as a general rule, divulge information of individuals. See *Sekretesslag 1980* (The Secrecy Act).

<sup>228</sup> See PICUM (2003a:35).

<sup>229</sup> See *Médecins Sans Frontières*, (2005a:9,15,20).

**Läkare i Världen (Médecins du Monde Sweden)** is a humanitarian relief organization that supports vulnerable populations through preventive and curative health care in Sweden and abroad.

Their activities are supported by volunteers, donations and institutional support from donors. Many of their volunteers are health care professionals, with doctors, nurses, midwives and those with international field experience forming the majority. However, the organization welcomes people from other professions. It does not support any political party or religion.

In 1995, a refugee clinic was established in cooperation with the *Asylum Committee* in Stockholm. Patients from the Middle East, Russia, Africa, Asia and the Balkans are treated on a regular basis. The clinic is open on Wednesdays. Amongst the more common diagnoses are tuberculosis, fractures, gynecological ailments and psychosomatic conditions caused by traumatic experiences such as torture and war in the country of origin.

<http://www.lakareivarlden.org>

In Gothenburg, the *Rosengrenska Foundation* established a clinic in 1998 to support undocumented migrants. The purpose was also to attend to “hidden” failed asylum seekers’ health needs. In recent years, the number of volunteers supporting this network has notably increased to the extent to allow this clinic to provide medical, psychological and dental care assistance to about 60 to 100 ill undocumented migrants every week. As happens with the majority of these charitable medical centers throughout Europe, volunteer health care providers make a remarkable solidarity effort considering that they provide this assistance after their daily work commitments.

*Rosengrenska* also uses its expertise to raise awareness about the extreme exclusion of undocumented migrants living in Sweden, pointing out that they completely lack entitlements to enjoy minimum rights. To this aim, some staff members organize campaigns, teach students at university or contact the media. This foundation is also very involved in cooperation with other organizations and hospitals at the national and international levels.

**Rosengrenska** is a voluntary charity network of health professionals. It started its work in 1998 with 25 volunteers aiming at providing medical support to “hidden” migrants overstaying in Sweden after their application for asylum failed. Today, *Rosengrenska*’s network consists of 650 volunteers.

One of their main activities is the provision of direct medical assistance within churches or private offices. Every week, the volunteer network of doctors and nurses forming this clinic meets in order to provide medical, psychological and dental care to about 60 to 100 patients.

*Rosengrenska* also holds university lectures for students and other groups to increase knowledge about undocumented migrants’ lack of access to the national health system. They also bring attention to particularly vulnerable people such as rejected asylum seekers with post-traumatic stress disorder.

Cooperating with other organizations working in this field in Sweden, like the *Red Cross*, *Médecins Sans Frontières*, *Médecins du Monde*, “*No one is illegal*”, *Emmaus Bjorka*, *Amnesty medical group*, and other hospitals and churches, *Rosengrenska* organizes public meetings and participates in media interviews to raise public awareness.

<http://www.rosengrenska.org>

More recently, several other initiatives in Malmö (e.g. the *Delta Foundation*) and in Stockholm have contributed to reinforce the support provided to undocumented migrants.

After an initial assessment which confirmed that the health needs of undocumented migrants were not being met in Sweden, *MSF Sweden* set up a project in 2004 in Stockholm, the Swedish city with probably the largest concentration of undocumented migrants. *MSF's* work was supported by a network of 50 specialised doctors, midwives and other health professionals who work within public and private health services. To access services, undocumented migrants contacted *MSF* through a help line. Where necessary, *MSF's* nurses arranged a consultation within the *MSF* network. The consultation occurred at the regular working place of the volunteer staff, usually outside of normal working hours.

Since 2006, this project has been carried out by the *Swedish Red Cross*. Services provided to undocumented migrants are mostly based on voluntary contributions from skilled professionals. These volunteers are doctors, midwives, psychologists, psychiatrists and physiotherapists who can independently consult and treat patients, in their own consultation or at a hospital, or in the Red Cross refugee center. The Red Cross also has volunteers with specific language skills who can accompany and support patients during a visit. An important part of their work is the help line coordinated by two nurses employed by the Red Cross.

As explained by Charlotta Arwidson of the *Red Cross*, "the purpose is not to create a parallel system, however we continue working in this field as long as the county councils do not take up their responsibilities as regards undocumented migrants' health care."

The *Swedish Red Cross* holds the opinion that in accordance with human rights principles, every person should have access to health care.

In 2006, they started a project to provide direct assistance to undocumented migrants. It was in fact a project formerly carried out by *MSF Sweden*. Since the start in 2004, the project has received and treated 750 patients and provided around 2,000 consultations.

A network of about one hundred persons with a medical background work for the *Red Cross*. They voluntarily receive and provide care to undocumented patients without payment. The *Red Cross* also works in cooperation with the private (but publicly financed) *Ersta Hospital* in Stockholm and maintains contact with organizations working in Gothenburg and Malmö.

They also act at the structural level to convince the Swedish government to change the law. The *Red Cross* demands that the government creates a regulation which provides to all people, regardless of their legal status, access to health care in order to address their medical needs.

<http://www.redcross.se>

Without the solidarity work undertaken by all these networks of doctors, nurses, priests and nuns to cover very basic necessities, the situation of undocumented migrants would be even more precarious. Nonetheless, the geographical coverage and the services offered are indeed limited.

Sometimes, patients require emergency and specialist care or diagnostic tests such as blood tests or x-rays. If this occurs, volunteer health care providers try to refer patients to a regular hospital.



In the opinion of Anne Sjögren, a volunteer nurse working at the *Rosengrenska* clinic, “many doctors and nurses help undocumented migrants inside the hospitals and many women give birth secretly inside the hospitals without paying anything. Until now nobody has been punished as a result of this, but the discussion is sometimes very hard.”

Occasionally, treatment is provided in the private medical sector or by retired practitioners who often waive charges for their services or offer lower rates.<sup>230</sup>

There are also some hospitals that have developed a very friendly attitude towards undocumented migrants. Good examples are the *Ersta Hospital* in Stockholm and the *Sahlgrenska University Hospital* in Gothenburg.

The *Ersta Hospital* is a standard Swedish non-profit hospital funded by the state. At a certain moment, they made the decision to provide free access to health care to everybody, including undocumented migrants. “This decision has always been highly supported by our staff. When *Ersta Hospital* started to treat undocumented migrants, many doctors and nurses showed a great interest and concern towards undocumented migrants,” explains the director, Dr. Henry Nyhlin. The hospital treats around 200 undocumented migrants who consider this hospital a “safe place.” Many of these patients are referred to by different NGOs and by the Red Cross. The hospital provides generalist medical assistance, gastro and gynecologist consultations as well as certain operations including cancer-related ones. “Although we do not provide many specialist treatments such as dermatology, contagious diseases, maternity care or health care for children, we try to be ‘as generalist as possible.’ Otherwise, we have to arrange something with other hospitals,” said Dr. Henry Nyhlin.

Interestingly, the hospital has directly informed the Swedish parliament about its activities with undocumented migrants and has managed to have an informal agreement with public authorities according to which the county council is paying the costs incurred by the hospital for providing health care to undocumented migrants. To make this possible in practice, the hospital provides undocumented migrants with a hospital card containing a personal number. The county council reimburses the hospital based on this number. Some pharmacies even take part in this informal agreement. Upon presentation of the hospital card, undocumented migrants receive partial subsidization of medicine under the same conditions as Swedish nationals.

Since its foundation in 1853, the *Ersta Hospital* has addressed the needs of excluded people (e.g. homeless). It is a publicly funded non-profit hospital with 450 staff members and 150 beds.

Some organizations like the *Swedish Red Cross* regularly remit patients to this hospital where undocumented migrants are treated at no cost. If the hospital cannot treat the patient, they refer them to other hospitals for more specialised treatment.

The hospital collects general data about the patients but never poses questions about their administrative status.

<http://www.ersta.se>

Acknowledging the results of the *MSF's* study “Experiences of Gömda in Sweden,” the *Sahlgrenska University Hospital* has also recently taken an important step to raise awareness about the situation of undocumented migrants and their access to health care in Sweden. In a statement presented to

<sup>230</sup> PICUM, [2003:19-20].

their board, the hospital commits to training its staff members about undocumented migrants' presence and needs. It also encourages staff to be "generous" when examining possible access to health care for undocumented migrants, by suggesting ethical reasons to "provide acute and necessary medical care to hidden refugees and patients that are not covered by insurances or other agreements, regardless of whether the patient is able to pay the fee at the time." They end their statement by upholding many of MSF's recommendations such as the call upon the Swedish government concerning the need for shared rules and regulations that protect undocumented migrants' right to access health care as well as the establishment of a public system for financial compensation to hospitals that provide health care and medical treatment to "hidden refugees."

*The **Salgrenska Hospital** provides emergency and basic care for the Gothenburg area (700,000 inhabitants) and specialised care for western Sweden (1.7 million inhabitants). It is one of the six teaching hospitals with medical education in Sweden.*

It is a religious hospital *funded* by the State. They have taken a small step: training staff members about undocumented migrants' presence and needs and also they encourage the staff to be "generous" when examining possible access to health care for undocumented migrants. They have made a statement following some policy recommendations made before by MSF in its report.

<http://sahlgrenska.se>

Swedish organizations are increasingly raising their voices to ask for a formal and real solution to the problem by bringing the attention of the media, writing shadow reports and trying to change the government's attitude towards undocumented migrants. "So far, the Swedish government has claimed that not paying for undocumented migrants' health care does not give the wrong message to undocumented migrants that they can stay. Surprisingly however, one gets to know that they end up providing some money to specific Swedish NGOs and hospitals to treat undocumented migrants. They give some support at the time that they do not want to hear that these people are here. Is this system sustainable? Until when can we keep this population invisible?" notes George Joseph of Caritas Sweden.

In his country visit to Sweden, Paul Hunt, UN Special Rapporteur for the right to health, clearly stated that Swedish law and practice regarding access to health care for undocumented migrants "is not consistent with international human rights law."<sup>231</sup> The Special Rapporteur also encouraged the Swedish government to reconsider its position with a view to offering all asylum-seekers and undocumented persons the same health care, on the same basis, as Swedish residents.

In his opinion, there is an urgent need for allowing undocumented migrants to access health care not only for human rights and humanitarian reasons but also for compelling public health grounds. In his view, the estimated cost of extending the same medical services on the same basis to residents, asylum seekers and undocumented individuals is unlikely to be significant.

<sup>231</sup> UN Special Rapporteur on the right to health Paul Hunt, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/HRC/4/28/Add.2 28. February 2007, p. 20. Available online at: <http://daccessdds.un.org/doc/UNDOC/GEN/G07/111/82/PDF/G0711182.pdf?OpenElement>

## 11. UNITED KINGDOM

*"G is an Arab man whose nationality is disputed. He suffers from bowel cancer, and was admitted in an emergency because of uncontrolled bleeding. The clinicians in A&E (accident and emergency departments) scheduled him for an operation as soon as the bleeding stopped. However, once the hospital discovered G was a refused asylum seeker, he was given a bill for many thousands of pounds and his operation was cancelled. He was discharged from hospital and told to come back 'when his condition deteriorates.'"<sup>232</sup>*

### » Terms:

GPs - general practitioners

A&E - accident and emergency departments

### GENERAL HEALTH CARE SYSTEM

The United Kingdom's health care system is called the National Health System (NHS). It is financed by national taxation and managed by the Department of Health under the Secretary of State for Health.<sup>233</sup>

Recent figures show that only 10.8% of Britons opt for private insurance, policies which top-up NHS services, enabling shorter waiting times and a greater choice of facilities.<sup>234</sup>

The parliaments of Scotland, Wales and Northern Ireland implement national health legislation and manage regional health bodies. These NHS Trusts oversee the direct provision of health care. In England the system is shared among Primary Care

Trusts, Hospital Trusts, Ambulance Trusts, Care Trusts and Mental Services Trusts. Established in 2002, Primary Care Trusts are "the corner stone" of the health service; they commission and monitor the provision of health services, manage hospitals and forge links with other NHS services.<sup>235</sup>

The right to health is not guaranteed by UK domestic law; as Britain lacks a codified constitution, fundamental principles governing the state derive from written and unwritten sources.<sup>236</sup> The Parliament holds ultimate sovereignty with Parliamentary Acts, Statutory law and EU law taking the place of constitutional legislation.<sup>237</sup> Therefore, while no constitutional guarantee of the right to health exists, national and supra-state protective mechanisms are in place.<sup>238</sup>

<sup>232</sup> Testimony taken from Kelly N., and Stevenson J., *First do no harm: denying health care to people whose asylum claims have failed*, (London: Refugee Council, 2006), p.8.

<sup>233</sup> The NHS is funded from a combination of direct taxes, VAT and employees' income contributions.

<sup>234</sup> Wallis G., *The Demand for Private Medical Insurance*, (London: Office for National Statistics, 2004), p. 47.

<sup>235</sup> The role of public providers in Scotland is taken by Health Boards. In Northern Ireland they are called Primary Care Partnerships and in Wales Local Health Boards.

<sup>236</sup> The British legal system consists of English law, Northern Irish law and Scots Law. While the first two are based on common law principles, Scots Law derives from civil law doctrine.

<sup>237</sup> The 1998 Human Rights Act introduced the tenets of the European Convention of Human Rights into UK law and allowed UK courts to make rulings on its applicability.

<sup>238</sup> However, for undocumented migrants, legal protection of the right to health often requires an innovative application of the European Convention clauses against cruel and inhuman treatment and respect for family life in the national courts.

The NHS is legally bound to provide a “universal service for all based on clinical need, not ability to pay.” Their guiding principles assert “health care is a basic human right...unlike private systems; the NHS will not exclude people because of their health status or ability to pay.”<sup>239</sup>

The birth of the NHS in 1948 has been described by Tony Blair as “an act of emancipation... to a generation brought up with the jar on the mantelpiece for the doctor’s fee and dread if a child fell ill.”<sup>240</sup> Established on values of equal access and free care at the point of delivery, the NHS typified the social citizenship approach of state responsibility for the overall welfare of its inhabitants.

Now, almost sixty years after its inception, there is a concerted move by the NHS to consolidate free health care with legal residency. For many vulnerable undocumented migrants and their families, the NHS system is failing to alleviate the oppressive fear of illness for those living in poverty.

## HEALTH CARE FOR UNDOCUMENTED MIGRANTS

### 1. Legal Entitlements to Publicly Subsidized Health Care

Unspecified and unrecognized in UK health legislation, undocumented migrants accessing health services fall into the category of “overseas visitors.”<sup>241</sup> Recent

legislative amendments have significantly reduced their ability to access health care.

Undocumented migrants may receive primary health care in the UK. This includes first contact treatment with medical providers such as general practitioners (GPs). All residents of the UK are entitled to register with a GP. Once registered, an undocumented migrant has the same entitlements as other NHS patients: they may receive NHS primary services free of charge but are liable for prescription charges. Also included in “primary care,” and therefore exempt from charges, are family planning services and compulsory mental health treatment.<sup>242</sup>

Primary care is currently regulated by the Health Service Circular 1999/18. The circular clarifies that “eligibility to receive free medical treatment should relate to whether a person is ‘ordinarily resident’ in the UK.”<sup>243</sup>

Equally however, the circular reconfirms a GP’s right to “offer treatment to all people” and use their discretion in accepting NHS patients.<sup>244</sup> Nevertheless, undocumented migrants may be turned away from a medical center without the opportunity to speak with a doctor.

A public consultation entitled “Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services” closed in August 2004 but the Department of Health has yet to issue renewed guidelines.

<sup>239</sup> The Department of Health, *The NHS in England: Core Principles*. Available online at: <http://www.nhs.uk/aboutnhs/CorePrinciples/Pages/NHSCorePrinciples.aspx>.

<sup>240</sup> The Department of Health, *The NHS Plan: A Plan for Investment, A Plan for Reform*, (London: Her Majesty’s Stationary Office, July 2000), p. 8.

<sup>241</sup> Hargreaves S., et al, *The identification and charging of Overseas Visitors in Newham*, (London: London Health Observatory, 2007), p. 18.

<sup>242</sup> This applies to those subject to the Mental Health Act 1973 or a court probation order.

<sup>243</sup> Paragraph 1, The Department of Health, *Health Service Circular 1999/018*, (London: HMSO, 1999). A common law term, “ordinarily resident” is not defined within any of the NHS legislation but derives its meaning from the wide application of a House of Lords decision concerning education. Department of Health guidelines offer this interpretation to trusts to determine whether a patient is “living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, whether they have an identifiable purpose for their residence here and whether that purpose has a sufficient degree of continuity to be properly described as ‘settled.’” See Department of Health, *Implementing the Overseas Visitors Hospital Charging regulations: Guidance for NHS Hospital Trusts in England*, (London: HMSO, 2004), p.13.

<sup>244</sup> Health Service Circular 1999/018. This right is codified in Regulation 4 and 5 of the NHS (Choice of medical Practitioner) Regulations 1998.

Emergency care, or treatment considered “immediately necessary” by a medical practitioner, should be provided to “overseas visitors” and therefore, undocumented migrants even if they are unable to pay in advance. Within their practice area, the GP’s term of service necessitates the free provision of treatment the doctor considers “immediately required owing to an accident or other emergency.”<sup>245</sup>

“Urgent” and “immediately necessary treatment” may also be provided free of charge to undocumented migrants within accident and emergency departments (A&E), walk in clinics and by district nurses employed under the Primary Care Trust.

While all care provided within the location of the hospital A&E department is considered “emergency care,” emergency treatment administered in another part of the hospital is chargeable.<sup>246</sup> Therefore, it is the location and not the type of treatment that is relevant.<sup>247</sup>

Undocumented migrants are no longer eligible for free secondary care in the UK. Since April 2004, the National Health Services (Charges to Overseas visitors) (Amendment) Regulations have limited subsidized secondary care to those able to prove one year’s legal residence in the UK. Those unable to prove this legal residence may only access non-urgent secondary care on confirming their ability to pay. “Immediate” and “urgent” treatment should be provided without delay but the patient will be issued a bill.<sup>248</sup>

Under these regulations, NHS trusts, NHS foundation trusts and primary care trusts are placed under a legal obligation to establish the residency status of those to whom they provide services. Patients failing to pay for billed treatment risk having their fees passed to a debt collector.

Secondary care includes all referrals from first-contact staff for outpatient care and hospital treatment (including hospital treatment, in-patient care and out-patient department). Exceptions to charges are granted in certain cases, such as the “easement clause” where a course of treatment continues to be provided free of charge if it had begun before the refusal of an asylum claim.<sup>249</sup>

Of the sexually transmitted diseases and 34 communicable diseases exempt from charges on public health grounds, HIV/AIDS is not included as it was exempt from the original 1989 legislation.<sup>250</sup> For HIV/AIDS patients, care is now limited to a diagnostic test and counseling; those wishing to receive drugs or treatment for their diagnosis are liable for full payment.<sup>251</sup>

Undocumented migrant women seeking maternity care will be charged but Department of Health guidelines confirm that due to the many risks involved, “maternity services should not be withheld if the woman is unable to pay in advance.”<sup>252</sup> After the care has been given she will be liable for charges and the debt “pursued in the normal way,” possibly passed to a debt recovery agency.<sup>253</sup>

<sup>245</sup> Paragraphs 4(1)h, 4(4), and 4(5) of Schedule 2 of the NHS (GMS) Regulations 1992 as amended and paragraph 2 of the Contracts Directions and reaffirmed in the Health Service Circular 1999/18.

<sup>246</sup> Department of Health (2004:17).

<sup>247</sup> For example, an undocumented migrant involved in a near fatal accident would receive free treatment in A&E ‘but once transferred to the intensive care unit would begin incurring charges that would ultimately amount to tens of thousands of pounds’. See Kelly N., and Stevenson J., (2006:8).

<sup>248</sup> Guidelines state that ‘non-urgent or routine elective treatment...could in fact wait until the patient has returned home’, see Department of Health (2004:5).

<sup>249</sup> For a full list of exceptions see ‘Regulation 4 – specific circumstances when an overseas visitor will be exempt from charges’, Department of Health (2004:19 – 24).

<sup>250</sup> Regulation 3 ‘Exempt Services’ in NHS, Guidelines for Overseas visitors, p.17.

<sup>251</sup> However, treatment is still provided free of charge by the Scottish Health Service.

<sup>252</sup> Department of Health (2004:42).

<sup>253</sup> In comparison, women legally residing in the UK, Switzerland or EEA countries are covered for all prenatal and antenatal care until 15 months after the birth.

Undocumented women requesting an abortion must pay the charges in advance. Should they lack the funds, Department of Health guidelines advise hospitals to “decline to provide the service and should advise the woman to seek termination in her own country.”<sup>254</sup> Should the woman’s life be at risk, a termination may be administered but “she remains liable for charges and the debt should be pursued in the normal way.”<sup>255</sup>

Pregnant undocumented women diagnosed with HIV/AIDS are not eligible for subsidized care which can reduce the chance of mother to baby transmission from 33% to 1%.

Children of undocumented migrants are entitled to free health care which is considered “urgent” and “immediately necessary”; their parents or guardian will be liable for charges regarding any secondary care.<sup>256</sup> Unaccompanied minors are also “chargeable”; a bill will be handed to the person accompanying the child and “copies should be sent to the child’s parents.”<sup>257</sup>

Since the April 2004 amendments, medical charges now apply to those in receipt of “hard case” support because they are unable to leave the UK or have yet to receive a decision regarding their claim to stay in the UK under Article 3 or 8 ECHR.<sup>258</sup> As neither group is entitled to a legal source of income, they are effectively unable to access any secondary care.<sup>259</sup>

The Secretary of State for Health may grant treatment to an individual on humanitarian grounds but decisions are purely discretionary.

Before these changes, all NHS care had been available without charge to those who could prove residence, even irregular, in the UK for the previous twelve months.<sup>260</sup> While entitlements were commonly unknown by medical practitioners and difficult for undocumented migrants to access and without any comprehensive evidence of systematic abuse, the government decided to implement additional barriers to tackle so-called “health tourism.”

## 2. The Procedure

GPs are allocated according to catchment areas, varying from town, postcode or even street address. The first step for an undocumented migrant wishing to access GP services is to locate surgeries in their district.<sup>261</sup>

Once identified, the surgery’s reception staff must be contacted for information about available space on the NHS practice list. GP practices are under no obligation to register a patient unless they have been explicitly assigned by the health authority. Owing to clear misunderstanding, a full patient list, open discrimination or perhaps instructions from the GP, reception staff may refuse to register the undocumented migrant as a NHS patient. In these cases

<sup>254</sup> Department of Health (2004:46).

<sup>255</sup> Ibid.

<sup>256</sup> Ironically, children rendered ‘unaccompanied’ due their parents remaining abroad while placing them in private boarding schools are exempt from charges for secondary treatment as the school is legally acting *in loco parentis*. Department of Health, (2004:46).

<sup>257</sup> Ibid.

<sup>258</sup> Joint Committee on Human Rights, Tenth Report, para. 125 available at: <http://www.publications.parliament.uk/pa/jt/jtrights.htm>.

<sup>259</sup> Failed asylum seekers unable to return to their home country may apply for ‘section 4’ or ‘hard case’ support. The few who do qualify for support are often unable to travel due to a physical medical reason or factors beyond their control. Applications for support under section 4(2) and 4(3) of the Immigration and Asylum Act 1999 can be made to the Home Office who will provide support in the form of accommodation support, and vouchers for food and basic toiletries.

<sup>260</sup> ‘NHS Act 1977’ and ‘National Health Service (Charges to Overseas Visitors) Regulations 1989’ with amendments in 1994, 1991 and 2004.

<sup>261</sup> The NHS offers a confidential, 24-hour health and information service issuing lists of practices and the GPs they hold. Information on GP and Dental Services are also available through the interactive search on the NHS website <http://www.nhs.uk>.

they may be offered treatment if they register as a private, fee-paying patient.<sup>262</sup>

If the receptionist confirms the surgery will accept the applicant as an NHS patient, the registration form GMS1 will be issued.<sup>263</sup> The form contains information fields for personal details, address and, in order to retrieve any medical records existing in the UK, details of previous addresses and GPs visited. Some practices inquire about medical history and ask registrants to detail their ethnic background and list serious illnesses.<sup>264</sup> The receptionist will request proof of address and identity documents.

Surgeries may accept undocumented migrants as NHS patients registering them either as “temporary residents” or “fully registered” NHS patients.<sup>265</sup> Once registered as an NHS patient, an undocumented migrant may receive treatment from the GP free of charge, even if not “immediately necessary.”<sup>266</sup>

In hospital accident and emergency departments (A&E), “urgent” and “immediately necessary treatment” is provided free of charge to undocumented migrants. The same applies for emergency care in walk-in clinics and from district nurses employed by the Primary Care Trusts. Upon arrival to the A&E, patients are “triaged” by a medic to decide if they require immediate treatment. If their ailment is not an emergency, they will be advised to visit their GP or make an appointment in another department of the hospital. This process also applies to those arriving in an ambulance.

In situations where the patient is directly admitted to critical care or mental health wards, departmental guidelines state that questioning regarding entitlement “could be inappropriate” and “admitting staff should alert the Overseas Visitors Team of any patient who, on the information before them, could potentially be liable for charges.”<sup>267</sup>

For all other hospital care, including in-patient and out-patient care, undocumented migrants will be charged. It is the legal responsibility of hospital administration staff to identify all patients “who are not ordinarily resident.”<sup>268</sup>

Department of Health guidelines offer “baseline questions” (“Where have you lived for the last 12 months?” and “Can you show that you have the right to live here?”) to be posed to every patient before each new course of treatment commences so as to establish whether or not the patient was eligible for charges. Unlike in other European countries, no safety net exists in the UK to enable particularly vulnerable groups such as children and pregnant women to access health care.

Beginning with a note on “avoiding discrimination,” these guidelines assure staff “it is not racist to ask someone where they have lived for the last twelve months as long as you can show that all patients – regardless of their address, appearance or accent – are asked the same question.”<sup>269</sup> If the patient cannot prove legal residence in the UK for the previous twelve months, booking-in staff or ward-clerks inform them they may be liable to pay for treatment, refers them to the “Overseas Visitors Manager” and places the following note inside their medical file:

<sup>262</sup> Regulations 4 & 5 of the NHS (Choice of Medical Practitioner) Regulations 1998.

<sup>263</sup> Standard version is available online at: <http://www.nhs.uk/aboutnhs/howtheNHSworks/doctors/Documents/GMS1.pdf>

<sup>264</sup> Example available online at: <http://www.burgessroadsurgery.co.uk/pages/Form%20GMS1.htm>

<sup>265</sup> NHS, 1999/18, 5(b)(ii).

<sup>266</sup> Charging exceptions for NHS patients may be provided in the GMS’s term of service or the PMS pilot scheme contract.

<sup>267</sup> Department of Health, (2004:10).

<sup>268</sup> *Ibid*, p.16.

<sup>269</sup> *Ibid*, p.8.

### PATIENT MAY NOT BE ORDINARILY RESIDENT IN UNITED KINGDOM

This patient may not normally be resident in the United Kingdom and has been referred for further interview by the Overseas Visitors Team. The patient may be liable to pay for any treatment received. The patient has been informed. For further information contact: 0113 2545819

The interview with Overseas Visitors Manager should occur before treatment has begun unless it is considered “urgent” or “immediately necessary.” The patient is informed they may be eligible for charges and must then be categorized as either an “overseas visitor” or “ordinarily resident.”

If liable, “appropriate charges must be set” by a member of the trust.<sup>270</sup> The responsibility for recovering charges is then passed to the finance staff who issue invoices. Departmental guidelines state that “Trusts are strongly advised to make use of a debt recovery agency that is experienced in handling the recovery of overseas debt if they have significant levels of unrecovered overseas visitor debt.”<sup>271</sup>

### 3. The Situation in Practice

Administrative staff are the first point of call for those seeking care in a hospital or medical practice. While a doctor is legally bound to provide “urgent” and “immediately necessary care” to all residents in the UK, the decision is initially the receptionists who often guard access to medical professionals. The registration system they oversee is inconsistent and documentation requirements vary dramatically.

While there is absolutely no duty for health care staff in the UK to denounce, the “overseas visitors” amendments and administrative checks have led many staff, both in GP practices and hospitals, to wrongly believe that their duty to check entitlement is also a duty to report to immigration authorities. There are growing reports of staff contacting the Home Office to inform about the immigration status of current or potential patients.

Undocumented migrants may be embarrassed and intimidated by inquiries into their health and residence status and reluctant to provide this information to someone in an official position. “They think once my details are registered onto a computer, this is seen by immigration officers and they will come and find you. Therefore, if you start spreading the news that hospitals and GP surgeries are looking at identifying people for charging, they are not going to come forward at all.”<sup>272</sup>

Restricting access to “overseas visitors” at the point of call for medical care encourages discrimination based on color and origin, adversely incongruent with the ideals of a multicultural Britain.<sup>273</sup> This policy regulation not only causes additional stress and fear among those in urgent need of care, but adds additional burden and cost to NHS resources. “I have noticed that within my own surgery people carry their passports around to show their identification and are being asked for this by receptionists ‘what passport do you hold – can we have a copy of this’. It’s quite daunting when you are trying to access health care.”<sup>274</sup>

The British Medical Association has noted “considerable confusion about overseas visitors’ eligibility for NHS primary medical services; this is largely because of a lack of clarity in the NHS regulations.”<sup>275</sup>

<sup>270</sup> Ibid., p.16.

<sup>271</sup> Ibid.

<sup>272</sup> Testimony taken from Hargraves (2007:40)

<sup>273</sup> The Joint Council for the Welfare of Immigrants criticized the Department of Health for not conducting a race impact assessment.

<sup>274</sup> Testimony taken from Hargraves (2007:38).

<sup>275</sup> See British Medical Association (BMA), General Practitioners Committee, *Overseas Visitors -Who is eligible for NHS Treatment*, (London: BMA, 2006), p.1.



This growing uncertainty coupled with undocumented migrants' lack of knowledge concerning their entitlements has resulted in many unforeseen barriers to health care access.

Language problems also make it difficult to communicate health needs, especially for patients requiring confidentiality, or experiencing mental health issues. Administrative staff unable to establish the care an undocumented migrant wishes to access and with whom communication proves difficult, are likely to refuse registration. NHS trusts may offer telephonic interpretation whereby the receiver can be passed between medical or administrative staff and the migrant, however "such services are not always available."<sup>276</sup>

Whilst prenatal and postnatal care provided in the community are free of charge, payment problems often arise during hospital visits. The fear of accumulating debts forms a major barrier against undocumented women seeking natal care and results in many giving birth at home alone. There is a consistent failure to notify them that, under NHS regulations, care is free at the point of delivery. Advance payment demands are often issued. Furthermore, these women can rarely afford additional treatment for abnormalities identified in the screening process. "D, a young Chinese woman, was given an upfront payment schedule by the trust. She borrowed £800 for the first payment, then was unable to fund the subsequent payments of £800 and £700. She gave birth at home, but was still billed by the Trust for the full amount."<sup>277</sup>

Prior proof of solvency may be requested for treatments not considered "immediately necessary."<sup>278</sup> Undocumented migrants who have been approved for NHS treatment may apply for financial assistance for prescriptions and travel but no help is provided to pay for treatment.<sup>279</sup>

Undocumented migrants have identified the difficulties in registering with GP surgeries as one of the toughest barriers they face.<sup>280</sup> A surgery can "decide for itself" that the patient list is full, leaving full decision in the hands of administrative staff. Such a non-transparent and discretionary system provides little challenge to latent racism and discriminatory practices.

Official guidelines advise primary care workers "to offer private medical treatment if it appears that the patient has come to the UK specifically to obtain treatment."<sup>281</sup> Such procedures may encourage unfounded judgments regarding the motivations of non-nationals accessing health care. "There exists discriminatory practices by reception staff. One told my client 'why don't you learn English' and 'why did you come to this country'...Receptionists and practice managers are a big problem...they don't make it easy for people who have problems in English or who need to register."<sup>282</sup>

The NHS advises staff "the way to avoid accusations of bias is to ensure that everybody is treated the same way," however for those facing daily racism and discrimination, such questioning has a highly negative impact.<sup>283</sup> The British Medical Association finds the "uncertainty unsatisfactory and would welcome clear, non-discriminatory guidance" for practitioners.<sup>284</sup>

<sup>276</sup> British Psychological Institute, written evidence provided to the Joint Commission for Human Rights, Tenth Report. Available online at : <http://www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/81/8115.htm>.

<sup>277</sup> Kelly N. and Stevenson J., Available online at: [http://www.refugeecouncil.org.uk/downloads/rc\\_reports/Health\\_access\\_report\\_jun06.pdf](http://www.refugeecouncil.org.uk/downloads/rc_reports/Health_access_report_jun06.pdf).

<sup>278</sup> Even for those who have the means to pay, evidence may be hard to find when ill and living in an irregular situation.

<sup>279</sup> Leaflets on the NHS Low Income Scheme entitlements and HC1 forms are available from NHS health care centers.

<sup>280</sup> Traore C., 'Speaking notes for a workshop at PICUM Conference on Access to Health Care for Undocumented Migrants' held in Brussels 28-29 June 2007, p.5. Available online at: <http://www.picum.org>.

<sup>281</sup> NHS, Health Service Circular 1999/18.

<sup>282</sup> Testimony taken from Hargraves (2007:37)

<sup>283</sup> Department of Health, (2004:8)

<sup>284</sup> British Medical Association, (2006:1)

#### 4. The Role of Civil Society and Local Actors

Although undocumented migrants have increased health needs, they remain “largely hidden to health services and public health initiatives.”<sup>285</sup> With the British state failing to meet their health care obligations, the duty to protect undocumented migrants falls upon NGOs and voluntary health providers. They offer services ranging from advocacy, advice and medical treatment. Assisting access to mainstream services, civil society organizations work to address the barriers facing undocumented migrants and where access is denied, they create alternative systems of care.

A main concern of NGOs is to enable access to mainstream services. To this end, *Médecins du Monde Project: London* advocates on behalf of undocumented migrants to ensure they have access to a GP; they contact individual surgeries, organize interpretation services and accompany patients on appointments. Support workers will communicate with reception staff of NHS practices and inform them of undocumented migrants’ rights to access services. If registration still proves problematic, they can request the Primary Care Trust to allocate a GP directly.

In order to overcome administrative barriers, walk-in clinics have been established which do not require identification or residency documents. Attracting many undocumented migrants and those in precarious residency status, *Project: London* offers free and confidential support “whatever your status and wherever you live.” Patients are greeted by a “support worker” who will inform them of their entitlements under the NHS and provide support in accessing these services.

*Médecins du Monde* provides health care to vulnerable populations in 54 countries worldwide. Well known for their work in war torn or developing countries, they have been operating in Europe for the past 20 years and opened their first British Clinic in London January 2006.

*Project: London* is an advocacy project run by Médecins du Monde UK providing information and assistance to vulnerable people. As the project makes contact with those who normally avoid mainstream services, they took the initiative to record the numbers and needs of its service users, providing a vital data source for lobbyists and advocates.

In a notable submission to the Tenth Committee on Human Rights, *Project: London* criticized the “overseas visitor” amendments for violating the right to life by “denying some people vital treatment for their survival’. Treating those on very low income or no income at all and therefore totally reliant on the community to survive, *Project: London* considers charging those with potentially terminal diseases, thousands of pounds they will never have “effectively a death sentence.”<sup>286</sup>

<http://www.medecinsdumonde.org.uk/>

Civil society actors have established their own systems of care offering medical assistance through drop in clinics and emergency services. The *Newham Primary Care Trust* actively enables vulnerable migrants to obtain fast and immediate medical advice and treatment at their walk-in center. Open from 7am to 10pm weekdays, the center provides skilled and experienced care with no appointment,

<sup>285</sup> The Health Protection Agency, ‘*Migrant Health: Infectious diseases in non-UK born populations*’, (London: Health Protection Agency, 2007), p.29.

<sup>286</sup> Médecins du Monde, *Written Evidence to the Joint Committee on Human Rights N.41*, (2006) p, 5. Available online at: <http://www.parliament.the-stationery-office.com/pa/jt200607/jtselect/jtrights/81/81we48.htm>

payment or documentation required. Established to complement, but not replace, GP surgeries, the center provides transitional services including screening and treatment for illnesses and injuries.

To bridge language and communication gaps, civil society organizations provide multi-lingual information leaflets to advertise their services and offer translation to visitors seeking information or treatment. Assistance is also provided to enable communication within GP surgeries.

Serving an ethnically diverse borough of London, the **Newham Primary Care Trust** works to reduce health inequalities and promote public health among groups facing existing inequalities, deprivation and ill health. The borough of Newham has the lowest life expectancy and highest infant mortality rates in London and the Trust's 1,050 staff work to reduce health inequalities and improve access among the population of 247,737.

Working within a community where 62% of residents constitute ethnic minorities, including new and recent arrivals, the Trust voiced serious concern regarding the knock on effect recent policy changes has had upon other migrant groups, limiting their entitlement to NHS care.

Actively identifying and addressing inequalities between ethnic groups or geographical areas in Newham, the Trust provides health services in schools, clinics and health centers, GP premises or in the home. They offer a range of complementary services aimed at raising the communities' standard of health such as clinical psychology and counseling, community dentistry, physiotherapy and, speech and language therapy.

<http://www.newhampct.nhs.uk/>

The information provision carried out by local actors is twofold; they not only inform undocumented migrants of their entitlements in a language they will understand, but also work to publicize the situation of undocumented migrants, counteracting government claims of "health tourism" and lobbying against proposed charges for primary health care.

Undocumented migrants are not entitled to a legal source of income in the UK and many find difficulty in affording prescribed medication. This burden is eased by *Project: London* which offers free medication to those to whom they have given a prescription through the use of a partner pharmacy nearby which is sensitive to the needs and concerns of project referrals.

The inability of undocumented migrants to access secondary care is particularly harsh for those suffering from terminal or potentially terminal illnesses. Facing immense barriers against access to care, those with HIV status already find it hard to register for NHS services and medical professionals often treat them in a brisk and awkward manner. Undocumented migrants lack social and medical entitlements and face additional discrimination making them among the most vulnerable groups affected by HIV.

The Terrence Higgins Trust is an HIV and sexual health charity active in both campaigning and providing a wide range of services. As African migrants now constitute the majority of new HIV diagnoses in the UK, the Trust has formulated innovative projects to meet their needs. Concerned that the government policy of non-treatment creates a disincentive against testing and places more individuals at risk, the charity offers additional treatment and a mentoring service as well as providing basic tests.

Established in 1983, the *Terrence Higgins Trust* was the first charity in the UK founded in response to the HIV epidemic and has been at the forefront of the fight against HIV and AIDS ever since. The needs of people living with, and affected by, HIV have been fundamental to its development.

The charity's roots were in the gay community and, for many years, the HIV epidemic in the UK affected mainly gay men. As the shape of the epidemic has changed, so has the Trust. More African people living in the UK are diagnosed with HIV than gay men each year now. So existing services have been developed and new services introduced to meet ever-changing needs.

In a government briefing paper on undocumented migrants' access to HIV treatment, the Trust debunks the myth of "treatment tourism." Their research proves that migrants access HIV treatment a considerable time after their arrival in the UK. The Trust strongly condemned the billing and denial of HIV treatment to undocumented migrants: "The use of health care as an instrument of immigration policy is unacceptable. The withdrawal of accessible life-saving treatments does not speed up removals, it hastens deaths. We are simply arguing that while people are here they should be treated well."<sup>287</sup>

<http://www.tht.org.uk>

The UK has no "sans-papiers" movement challenging structural social exclusion; replacing collective action are community organizations and advice agencies.<sup>288</sup> Civil society bodies providing urgent care must work hard to effectuate policy changes and group linkages.<sup>289</sup>

The government has yet to provide comprehensive evidence of the "health tourism" which recent legislations was set to hamper. The amendments simply place an added burden on civil society actors already "propping-up" the inadequacies of the NHS.

Calls for reviewing the Overseas Visitors legislation have come from both health care professionals and NGOs. When professional bodies such as the British Medical Association are advising its members to contact the Refugee Council for assistance in treating and supporting undocumented migrants, the failure and distrust in government policy becomes highly evident.<sup>290</sup>

<sup>287</sup> Terrence Higgins Trust and National Aids Trust, *Note on access to HIV treatment for undocumented migrants and those refused leave to remain*, available at: <http://www.tht.org.uk/binarylibrary/westminsterhallbriefingonaccess.pdf>

<sup>288</sup> Frank Duvell (PICUM, 2002:34).

<sup>289</sup> Médecins du Monde offer a good example by working within the premises of Praxis, a partner organisation already close to undocumented migrants and providing complementary services. Such 'one-stop-shops' are attractive to users and enable providers to share resources.

<sup>290</sup> The British Medical Association advise GPs 'In situations where treatment is not being offered under the NHS, and the patient is unable to pay privately, GPs may wish to refer the patient to an organization such as The Refugee Council... which may now if there are any other services available in the area'. See BMA (2006:6)

# Recommendations

## 1. Respect international obligations

European Union member states should comply with international obligations and therefore progressively guarantee that the right to the highest attainable standard of physical and mental health is enjoyed by *all* regardless of administrative status.

The right to health care for undocumented migrants is guaranteed in the following United Nations conventions and declarations and European conventions:

- UDHR - Universal Declaration of Human Rights, Art 25
- ICERD - International Convention on the Elimination of All Forms of Racial Discrimination, Art 5 (e-iv)
- ICESCR - International Covenant on Economic, Social and Cultural Rights, Art 12 (1) and General Comment 14 to the ICESCR, paragraph 34
- CRC - Convention on the Rights of the Child, Art 24(1), 25, 39
- CEDAW - Convention on the Elimination of All Forms of Discrimination Against Women, Art 14 (2b)
- ESC - European Social Charter (Revised), Art 13
- ECHR - Convention for the Protection of Human Rights and Fundamental Freedoms, Art 3.<sup>291</sup>

Member states should not deny or limit equal access for all persons to preventive, curative and palliative health services.

## 2. Particularly vulnerable groups of undocumented migrants

Member states should especially address the health care needs of particularly vulnerable groups of undocumented migrants (e.g. children, pregnant women, the elderly, disabled, people with severe chronic diseases e.g. HIV / AIDS) and strive to equally meet their needs on the same basis as for the comparable national population.

## 3. Ensure implementation of entitlements

Member states should take the necessary measures to guarantee that undocumented migrants' entitlements to health care are uniformly implemented by regional and local authorities.

## 4. Ensure access to information about entitlements

Member states should ensure that information about undocumented migrants' entitlements is accessible to all actors involved and eliminate all practical barriers that prevent undocumented migrants from enjoying their entitlements to health care.

## 5. Detach health care from immigration control

Patient-related medical confidentiality should not be undermined by direct or indirect reporting mechanisms. Member states should detach health care from immigration control policies and should not impose a duty upon health care providers and health administrations to denounce undocumented migrants.

<sup>291</sup> See PICUM (2007: 12 & 29)

## 6. Civil society should always play a complementary role

The ultimate responsibility in providing health care to undocumented migrants rests on the national government. Civil society plays a role of facilitating health care to undocumented migrants, but this shall only be complementary to the duties of the government.

## 7. No criminalization of humanitarian assistance

Providing humanitarian assistance to undocumented migrants should not be criminalized. Member states should not criminalize civil society for providing health care and health-related assistance to undocumented migrants.

## 8. Include undocumented migrants in Social Inclusion-Social Protection Process

Member states and EU institutions should include undocumented migrants within the European Social Inclusion-Social Protection Process and the National Action Plans (NAPs).

## 9. Civil society involvement in consultation processes

Civil society organizations, health care providers working with undocumented migrants and local authorities responsible for public health should participate in regular reporting and consultation processes, to inform authorities and policy makers about barriers encountered by undocumented migrants in accessing health care.<sup>292</sup>

## 10. Ratify the International Migrant Workers' Convention

Member states should ratify and implement the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, which stipulates in Article 28:

*Migrant workers and the members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment.*<sup>293</sup>

<sup>292</sup> PICUM has developed a Self Description of Organization (SDO) and Reporting Template to assist local actors to advocate for specific and clear actions at the national level in the framework of the European Social Inclusion-Social Protection Process. The SDO and Reporting Template can be used to address undocumented migrants' social exclusion caused by the lack or insufficient access to health care. These reporting tools are available in nine languages (Dutch, English, French, German, Hungarian, Italian, Portuguese, Spanish and Swedish) at <http://www.picum.org>.

<sup>293</sup> See PICUM (2007: 5)

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### BELGIUM

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- Loi organique des Centers Publics d'Action Sociale of 8 July 1976 (Organic Law on Social Welfare Centers).
- Arrêté royal relative à l'aide médicale urgente, *M.B. du 31.12.1996* (Royal Decree of 12 December 1996 on state medical assistance).
- Circulaire of 20 May 1997 clarifying the Royal Order on urgent medical assistance.
- Loi de finances rectificative pour 2003 (n° 2003-1312) of 30 December 2003
- Décret n° 2005-860 du 28 Juillet 2005
- Loi du 13 Decembre 2006 portant dispositions diverses en matière de santé (National Health Law of 13 December 2006).

### FRANCE

- Act No. 92-722 of 22 July.
- *Loi Pasqua* of 1993 (*Loi n° 93-1027* of 24 August 1993 relative à la maîtrise de l'immigration et aux conditions d'entrée et de séjour des étrangers en France, *Journal Officiel de la République Française* of 29 August 1993).
- Loi n° 98-657 du 2 juillet 1998 d'orientation relative à la lutte contre les exclusions (Fight Against Exclusion Act of 29 July 1998).
- Circulaire DH/AF 1/DGS/SP 2/DAS/RV 3 n° 98-736 of 17 December 1998 relative à la mission de lutte contre l'exclusion sociale des établissements de santé participant au service public hospitalier et à l'accès aux soins des personnes les plus démunies.
- Loi n°99-641 du 27 juillet 1999. Loi portant création d'une couverture maladie universelle, (Universal

Health Coverage Act), *Journal Officiel de la République Française* of 28 juillet 1999).

- Loi n° 2002-1576 of 30 December 2002, *Journal Officiel de la République Française* of 31 December 2002, p. 22070.
- Code of Social Action and Families (Code de l'Action Sociale et des Familles)
- Loi de finances rectificative pour 2003 (n° 2003-1312) of 30 December 2003.
- Circulaire DHOS/DSS/DGAS n°141 du 16 mars 2005 relative à la prise en charge des soins urgents délivrés à des étrangers résidant en France de manière irrégulière et non bénéficiaires de l'Aide médicale de l'Etat.
- Décret n° 2005-860 of 28 July 2005 relative aux modalités d'admission des demandes d'aide médicale de l'Etat.
- Décret n° 2005-859 du 28 juillet 2005 relatif à l'aide médicale de l'Etat, J.O. n° 175 du 29 juillet 2005 (Decree No. 2005-859 of 28 July 2005 on state medical assistance).
- Circulaire DGAS/DSS/DHOS/2005/407 of 27 September 2005 relative à l'aide médicale de l'Etat.

### GERMANY

- Gesetzliche Krankenversicherung – GKV (79)
- Asylbewerberleistungsgesetz of 5 August 1997, last modified on 31 October 2006 AsylbLG Asylum Seekers Benefits Law
- Infektionsschutzgesetz Gesetz zur Verhütung und Bekämpfung von Infektionskrankheiten beim Menschen of 20 July 2000, last modified on 31 October 2006 IfSG Infectious Diseases Law
- Aufenthaltsgesetz Gesetz über den Aufenthalt, die Erwerbstätigkeit und die Integration von Ausländern im Bundesgebiet of 30 Juli 2004, last modified on 26 January 2007 AufenthG Residence Act
- Sozialgesetzbuch Siebtes Buch (VII) – Gesetzliche Unfallversicherung - of 7 August 1996, last modified on 20 April 2007 SGB VII Social Code
- Sozialgesetzbuch Zwölftes Buch (XII) - Sozialhilfe - of 27 December 2003, last modified on 20 April 2007 SGB XII Social Code
- Strafgesetzbuch of 13 November 1998, last modified on 13 April 2007 StGB Penal Code

### HUNGARY

- Hungarian Constitution (Act 20 of 1949).
- Act CLIV of 1997 on Health, promulgated on 23 December 1997.

## ITALY

- Decreto Legislativo n. 286, 25 luglio 1998, Testo Unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero, *Gazzetta Ufficiale* n. 191 del 18 agosto 1998 – Supplemento Ordinario n. 139 (Decree-Law No. 286 of 25 July 1998, known as the “The Single Text” regulating immigration).
- Decreto del Presidente Della Repubblica 31 agosto 1999, n. 394. Regolamento recante norme di attuazione del testo unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero a norma dell'articolo 1, comma 6, del decreto legislativo, 25 luglio 1998, n. 286, *Gazzetta Ufficiale* n. 190 del 3 novembre 1999 – Supplemento Ordinario n. 258 (Decree of the President of the Republic No. 394 of 31 August 1999, implementing the Decree-Law No. 286).
- Circolare 24 marzo 2000, n. 5 del Ministero della Sanità (Circular of the Ministry of Health No. 5 of 24 March 2000, implementing the Decree-Law No. 286).

## NETHERLANDS

- Social Health Insurance Act (Ziekenfondswet) of 1964
- Exceptional Medical Expenses Act (AWBZ) of 1968
- Koppelingswet 1998
- Vremdelingswet (Alien Act of 23 November 2000)
- Zorgverzekeringswet (Health Insurance Act, entered into force on 1 January 2006).

## PORTUGAL

- Constituição da República Portuguesa, Fourth Revision 1997
- Decreto-Lei n. 282/77 de 5 de Julho (Decree Law No. 282/77 of 5 July 1977)
- Decreto-lei n.º 135/99 de 22 Abril (Decree-Law No 135/99 of 22 April 1999).
- Despacho n.º 25 360/2001 (2 série), Diário da República N.º 286 12.12.2001.
- Circular Informativa. Direcção-Geral da Saúde, N.º 14/DSPCS (Circular 14/DSPCS of 02/04/02 from the Directorate General Health).
- Circular Informativa. Direcção-Geral da Saúde, N.º 48/DSPCS (Circular 48/DSPCS of 30/10/02 from the Directorate General Health).
- Decreto-lei n.º 34/2003 de 22 Abril (Decree-Law No 34/2003 of 25 February 2003).
- Decreto Lei n.º 67/2004 de 25 de Março, Diário da República – I Série A – N.º 72 (Decree-Law No 67/2004 of 25 March 2004).

- Portaria n.º 995/2004 de 9 de Agosto, Diário da República – I Série B, N.º 186.

## SPAIN

- Spanish Constitution of 1978.
- General Health Act 14/1986 of 25 April.
- Resolución de 4 de Julio de 1997, conjunta de la Presidencia del Instituto Nacional de Estadística y del Director General de Cooperación Territorial, por la que se dictan instrucciones técnicas a los Ayuntamientos sobre actualización del Padrón municipal. (Resolution of 4 July 1997 from the presidency of the National Institute of Statistics and the General Director of Territorial Cooperation on technical instructions to municipalities to update the local registry).
- Ley Orgánica 4/2000 de 11 de enero, sobre derechos y libertades de los extranjeros en España y su integración social. Texto consolidado. (Act 4/2000 of 11 January 2000 on the Rights and Freedoms of Aliens in Spain and their Social Integration as amended by the Act 8/2000 of 23 December and the Act 14/2003 of 20 November).
- Real Decreto 2393/2004, de 30 de diciembre, por el que se aprueba el Reglamento de la Ley Orgánica 4/2000, de 11 de enero, sobre derechos y libertades de los extranjeros en España y su integración social. (Royal Decree 2393/2004 of 30 December implementing the Act 4/2000).

## SWEDEN

- Sekretesslag (The Secrecy Act) 1980
- Hälso- och sjukvårdslag (Swedish Health and Medical Services Act): 1982:763, sects. 2.
- Smittskyddslagen (Disease control Act), (2004:168).

## UNITED KINGDOM

- Mental Health Act 1973
- National Health Service Act 1977
- National Health Service (Charges to Overseas Visitors) Regulations 1989' with amendments in 1994, 1991 and 2004
- National Health System (GMS) Regulations 1992
- The Human Rights Act 1998
- National Health System (Choice of medical Practitioner) Regulations 1998
- Health Service Circular 1999/018
- Immigration and Asylum Act 1999

# Index of organizations

## INTERNATIONAL

### Local Authorities

#### EUROCITIES

Founded in 1986, Eurocities is a network of major European cities that brings together the local governments of more than 130 large cities within over 30 European countries. Eurocities provides a platform for its member cities to share knowledge and ideas, to exchange experiences, to analyze common problems and develop innovative solutions. The network is active across a wide range of policy areas including: economic development and cohesion policy, provision of public services, environment, transport and mobility, employment and social affairs, culture, education, information and knowledge society, governance and international cooperation. One working group of the social affairs department focuses on research on access to health care for undocumented migrants.

#### Contact Information:

Eurocities  
Square de Meeûs 18  
1050 Brussels  
Belgium  
Tel: +32/2/552.08.88  
Fax: +32/2/552.08.89  
Email: [info@eurocities.be](mailto:info@eurocities.be)  
Website: <http://www.eurocities.org>

### Non-Governmental Organisations

#### CARITAS EUROPA

Created in 1971, Caritas Europa is a non-governmental organisation which brings together 48 organizations working in 44 European countries. It is mainly active in the fields of humanitarian relief, development, health and social services. Caritas Europa focuses its activities on issues relating to poverty, social inequality, migration and asylum, both within the European Union and all other European countries.

#### Contact Information:

Caritas Europa  
Communications Department  
Rue de Pascale 4  
1040 Brussels  
Belgium  
Tel: +32/2/235.03.94  
Email: [amazella@caritas-europa.org](mailto:amazella@caritas-europa.org)  
Website: <http://www.caritas-europa.org>

### Health Care Providers

#### EUROPEAN PUBLIC HEALTH ASSOCIATION (EUPHA)

The EUPHA serves as an umbrella organisation for public health associations in Europe. Founded in 1992, the organisation is an international, multidisciplinary, scientific platform bringing together around 12,000 public health experts for professional exchange and collaboration throughout Europe. The main aim of the organisation is to strengthen public health research and practice in Europe.

#### Contact Information:

EUPHA Office  
Otterstraat 118-124  
Postbox 1568  
3500 BN Utrecht  
The Netherlands  
Tel: +31/30/272.97.09  
Fax: +31/30/272.97.29  
Website: <http://www.eupha.org>

## AUSTRIA

### Non-Governmental Organisations

#### EVANGELISCHES HILFSWERK ÖSTERREICH

##### *Evangelic Relief Organization, Austria*

The Evangelisches Hilfswerk Österreich a non-profit association that provides, as partial organization of the deacony in Austria, all kind of social welfare services through four kindergartens, a medical center, educational institute and 17 refugee service points. The organization was established after the Second World War to provide auxiliary delivery to the suffering Austrian population.

#### Contact Information:

Evangelisches Hilfswerk Österreich  
Steinergasse 3/12  
1170 Vienna  
Austria  
Tel: +43/1/402.67.54  
Fax: +43/1/402.67.54.16  
Email: [gf.efdoe@diakonie.at](mailto:gf.efdoe@diakonie.at)  
Website: <http://www.hilfswerk.diakonie.at/>

**BELGIUM****Local Authorities****C.P.A.S BRUXELLES***Centre Public d'Action Sociale*

The C.P.A.S. Brussels is the local authority for public welfare in Belgium. It aims to provide material, social, psychological and medical support to those in need. Frequently confronted with undocumented migrants, it cooperates intensely with non-governmental organisations to implement a system of urgent medical care.

**Contact Information:**

Centre Public d'Action Sociale  
298A Rue Haute  
1000 Brussels  
Belgium  
Website: <http://www.cpasbru.irisnet.be/>

**Non-Governmental Organisations****MEDIMMIGRANT***(previously Medical Steunpunt Mensen zonder Papieren)*

Formed 1994, Medimmigrant is a non-governmental organization aiming to safeguard access to health care for undocumented migrants or those with a precarious residence status.

**Contact Information:**

Medimmigrant  
Gaucheretstraat 164  
1030 Brussels  
Belgium  
Tel: +32/2/274.14.33  
Fax: +32/2/274.14.48  
Email: [info@Medimmigrant.be](mailto:info@Medimmigrant.be)  
Website: <http://www.Medimmigrant.be>

**FRANCE****Non-Governmental Organizations****COMÈDE (Comité médical pour les exilés)***Medical Council for the Exiled*

Comède is a non-governmental organization set up in 1979 by Amnesty International (French section), Service Oecuménique d'Entraide (Cimade) and Groupe Accueil Solidarité. Comède promotes access to health care for migrants in France, providing medical, social and psychological assistance when needed and striving for a more inclusive national public health care system. Comède has 27 years of experience providing free medical care

and psychological counseling for exiles (including asylum seekers, rejected asylum seekers and other undocumented migrants, refugees and torture survivors).

**Contact Information:**

COMÈDE  
Hôpital de Bicêtre  
BP 31  
94272 Le Kremlin-Bicêtre cedex  
France  
Tel: +33/1/45.21.38.40  
Fax: +33/1/45.21.38.41  
Email: [contact@comede.org](mailto:contact@comede.org)  
Website: <http://www.comede.org>

**MÉDECINS DU MONDE***Doctors Without Borders*

Médecins du Monde, or Doctors without Borders, is an international humanitarian aid organization that recruits medical and non-medical volunteers to provide health care for vulnerable populations around the world, including France. Established in 1980, by 2004 the organisation led 90 international projects in 50 countries and 115 programs in France.

**Contact Information:**

Médecins du Monde  
62 rue Marcadet  
75018 Paris  
France  
Tel: +33/1/44.92.1515  
Website: <http://www.medecinsdumonde.org>

**GERMANY****Local Authorities****STELLE FÜR INTERKULTURELLE ARBEIT DER LANDESHAUPTSTADT, MÜNCHEN***Center for Intercultural Work, City of Munich*

A department of the local authority, the Center for Intercultural Work, City of Munich is responsible for the integration of migrants. It takes measures to reduce the social, vocational, educational, religious ethnical and cultural disadvantages of the foreign population. Munich's population is about 1.28 million of which 37% are foreigners.

**Contact Information:**

S-III-M/ik  
 (Stelle für Interkulturelle Arbeit der Landeshauptstadt  
 München)  
 Franziskanerstraße 8  
 81669 München  
 Tel: +49/89/233.405.42  
 Fax: +49/89/233.405.43  
 Email: [interkulturellearbeit.soz@muenchen.de](mailto:interkulturellearbeit.soz@muenchen.de)  
 Website: <http://www.muenchen.de/Rathaus/soz/wohnenmigration/interkulti/39732/index.html>

**Non-Governmental Organizations****MEDINETZ BREMEN**

MediNetz is a medical advice and assistance center for people without access to the public national health care system, especially asylum seekers and undocumented migrants. The Bremen branch was established in 1999 as part of the Refugee Initiative Bremen.

**Contact Information:**

MediNetz Bremen  
 c/o Flüchtlingsinitiative  
 Bernhardstr. 12  
 28203 Bremen  
 Germany  
 Tel: +49/421/790.19.59  
 Fax: +49/421/790.19.63  
 Email: [medinetz-bremen@gmx.net](mailto:medinetz-bremen@gmx.net)  
 Website: <http://www.nord-com.net/fluechtlingsinitiative.bremen/medinetz.html>

**HUNGARY****Non-Governmental Organizations****MENEDÉK**

Menedék, the Hungarian Association for Migrants, operates as a non-governmental organization and was established in January 1995 on the occasion of a civilian initiative. It aims to represent international migrants (applicants, refugees, foreign employees and immigrants) within society and promote their legal, social and cultural integration.

**Contact Information:**

Menedék  
 Josica Utca 2  
 1077 Budapest  
 Hungary  
 Tel: +36/1/322.15.02

Fax: +36/1/479.02.72  
 Email: [menedek@menedek.hu](mailto:menedek@menedek.hu)  
 Website: <http://www.menedek.hu>

**ITALY****Non-Governmental Organizations**

**NAGA - Associazione Volontaria di Assistenza Socio-Sanitaria e per i Diritti di Stranieri e Nomadi**  
*Voluntary Association of Social-Health Care Assistance for the Rights of Foreigners and Nomads*

NAGA is an independent, non-profit organisation of volunteers established in 1987. It provides health care and social services to immigrants, undocumented migrants and refugees in Milan (Italy) who do not have access to the public national health care system. Since its creation, NAGA has provided medical assistance (primary and secondary care) to more than 100,000 people and receives on average 80 people per day, mainly newcomers facing particular marginalization (e.g. socio-economic, labor and language barriers).

**Contact Information:**

NAGA  
 Viale Bligny 22  
 20136 Milano  
 Italy  
 Tel: +39/2/58.30.14.20  
 Fax: +39/2/58.30.00.89  
 Email: [info@naga.it](mailto:info@naga.it)  
 Website: <http://www.naga.it>

**NETHERLANDS****Health Care Providers****PHAROS**

Pharos is a national refugee and health knowledge center that offers knowledge, insight and skills for improving the quality of health care provided to refugees and asylum seekers. Pharos helps health care professionals and teachers to develop an 'intercultural professional attitude' and offers special knowledge, skills and methods directed to the care needs of refugees. Along with 'Lampion', Pharos is a national information and counseling office for health care for undocumented migrants and rejected asylum seekers. The center was established 2004 and gives information to health care professionals, social workers and clinic help confronted with the special circumstances of undocumented migrants who lack legal access to the public national health care system.



**Contact Information:**

Pharos  
 Herenstraat 35  
 PO Box 13318  
 3507 LH Utrecht  
 Netherlands  
 Tel: +31/30/234.98.00  
 Fax: +31/30/236.45.60  
 Email: pharos@pharos.nl  
 Website: <http://www.pharos.nl>  
<http://www.lampion.info>

**Local Authorities****GEMEENTELIJKE GEZONDHEIDSDIENST ROTTERDAM***Rotterdam Municipal Public Health Service*

The Rotterdam Municipal Public Health Service is a public health body and branch of the local government. This organisation of civil servants works on prevention, intervention, coordination, research and policy for health issues in an area of 800,000 inhabitants. One of its responsibilities is improving access to health care for undocumented migrants. The population of Rotterdam is diverse with large groups from Suriname, Turkey, Morocco and Cape Verde.

**Contact Information:**

Gemeentelijke Gezondheidsdienst Rotterdam Rotterdam e.o.  
 Postbus 70032  
 3000 LP Rotterdam  
 Netherlands  
 Tel: +31/10/4339966  
 Fax: +31/10/4339595  
 Email: [info@ggd.rotterdam.nl](mailto:info@ggd.rotterdam.nl)  
 Website: <http://www.ggd.rotterdam.nl/>

**PORTUGAL****Non-Governmental Organisations****SERVIÇO JESUITA AOS REFUGIADOS***Jesuit Refugee Service Portugal (JRS)*

Jesuit Refugee Service is an international Catholic organisation with a mission to accompany, serve and defend the rights of refugees and forcibly displaced people. Founded 1980, Jesuit Refugee Service works at international level (70 countries) within the fields of advocacy, human rights, and research. In Portugal, the Serviço Jesuíta aos Refugiados began national activity in 1994.

**Contact Information:**

Serviço Jesuíta aos Refugiados  
 Estrada da Torre, 26  
 1750-296 Lisboa  
 Portugal  
 Tel: +351/21/754.16.20  
 Fax: +351/21/754.16.25  
 Email: [jrs-portugal@netcabo.pt](mailto:jrs-portugal@netcabo.pt); [jrs-portugal@jrs.net](mailto:jrs-portugal@jrs.net)  
 Website: <http://www.jrsportugal.pt/>

**SPAIN****Health Care Providers****HOSPITAL PUNTA DE EUROPA**

Hospital Punta de Europa is a public hospital integrated with another hospital and ten primary health care centers in the health authority district of Campo de Gibraltar, which belongs to the SAS (Servicio Andaluz de Salud). The hospital is committed to improving and maintaining an optimal health level, helping to ease inequalities regarding illness and mortality in accordance with the principles defining the Health Policy of the Andalusian Public Health System (SSPA). Guaranteeing access to quality health services, Hospital Punta de Europa serves an area with 253,569 inhabitants and has approximately 290,884 consultations per year.

**Contact Information:**

Hospital Punta de Europa  
 Dirección del AGS  
 Ctra. de Getares S/N  
 Algeciras (CADIZ)  
 Spain  
 Website: <http://www.juntadeandalucia.es/servicioandaluzdesalud/centros/Detalle.asp>

**Local Authorities****FUNDACIÓN PROGRESO Y SALUD***Progress and Health Foundation*

The Fundación Progreso y Salud belongs to the Andalusian Regional Ministry of Health. It is the central entity that supports and manages Public Health System research in Andalusia and also effectively promotes health research and innovation in the region. The organization of biomedical research within the Andalusian Public Health System places the Fundación in the role of facilitator: an entity dedicated to encouraging, supporting and sharing services among research centers and groups throughout the scientific process, from the development of the necessary resources (infrastructures, financing, skills development

and mobility) to the implementation and effective execution of scientific production (in methodology, management, etc.), including the transfer of research results to industry and to society. The Fundación Progreso y Salud is also responsible for the direct management of the Regional Health Department's strategic projects in this field.

**Contact Information:**

Fundación Progreso y Salud  
Avda. Américo Vespucio 5, Bloque 2, 2ª Planta  
Isla de la Cartuja  
41092 Sevilla  
Spain  
Tel: +34/955/04.04.50  
Fax: +34/955/04.04.57  
Email: [fundacion.progreso.salud@juntaandalucia.es](mailto:fundacion.progreso.salud@juntaandalucia.es)  
Website: <http://www.fundacionprogresosalud.org>

## SWEDEN

### Non-Governmental Organizations

**ROSENGRENSKA**

Rosengrenska is a voluntary charity network of health professionals. It was formed in 1998 to provide medical support to hidden migrants (undocumented migrants, hidden refugees or rejected asylum seekers), without access to the national public health care system in Gothenburg, Sweden. Today there are more than 650 people working voluntarily within the framework of this charity.

**Contact Information:**

Rosengrenska  
Gamla Riksvrängen 51  
42832 Kålleröd  
Sweden  
Tel: +46/70/575.34.15  
Email: [kliniken@rosengrenska.org](mailto:kliniken@rosengrenska.org)  
Website: <http://www.rosengrenska.org>

## UNITED KINGDOM

### Local Authorities

**NEWHAM PRIMARY CARE TRUST**

Newham Primary Care Trust is a national health service organisation that serves the community of the London Borough of Newham. It employs around 1,050 staff based across 23 sites, and encompasses 65 General Practitioners, 69 pharmacists, 55 opticians and 80 dentists in the borough. The Annual Budget is £439,556,000. Newham's population is 247,700. The overall objective of the Newham Primary Care Trust is to improve the health of the local population and address health inequalities also concerning differences between ethnic groups.

**Contact Information:**

Newham Primary Care Trust  
Trust Board Secretary  
Warehouse K  
2 Western Gateway  
London E16 1DR  
UK  
Tel: +44/20/858.66.200  
Email: [communications@newhampct.nhs.uk](mailto:communications@newhampct.nhs.uk)  
Website: <http://www.newhampct.nhs.uk>

This report gives visibility to the problems arising from undocumented migrants' inadequate access to health care in the European Union. The situation in terms of law and practice is provided through eleven country profiles; each presenting an overview of the most common problems and obstacles preventing a realization of the right to health. The work of civil society organizations in providing assistance to undocumented migrants is illustrated, with good policies and practices highlighted to provide inspiration for future strategies and actions.

In Europe, undocumented migrants face serious problems in receiving health care. The climate of repression and the existing link between immigration control policies and access to basic social services create a tremendous fear of discovery among undocumented migrants, deterring them from exercising their entitlements and seeking health care.

While numerous international instruments in human rights law have been ratified by EU member states and refer to the right of everyone to health care as a basic human right (regardless of one's administrative status), the laws and practices in many European countries are shown to deviate from these obligations.

Undocumented migrants are not yet formally considered as being one of the most marginalized and socially excluded groups in Europe. Very few documents of the European Institutions acknowledge this fact and there is almost a total invisibility of the problem in the member states' plans to combat social exclusion.

This report provides expert insight that will prove invaluable to NGOs and health care providers working with undocumented migrants. It will also prove a useful tool in convincing the governments of EU member states to speak more, to do more, and to take on their responsibilities and comply with international human rights obligations, instead of continuing to rely upon civil society as an alternative provider of health care for undocumented migrants.

Making a strong case for action, this report may be used as a tool of influence, pressure, empowerment and innovation. Ten practical recommendations are provided to help national and European policymakers to better address the problems arising from a lack of or an insufficient access to health care for undocumented migrants in the EU.

## **PICUM - Platform for International Cooperation on Undocumented Migrants**

Gaucheretstraat 164

1030 Brussels

Belgium

tel. +32/2/274.14.39

fax +32/2/274.14.48

[www.picum.org](http://www.picum.org)

[info@picum.org](mailto:info@picum.org)



PLATFORM FOR INTERNATIONAL COOPERATION ON UNDOCUMENTED MIGRANTS